

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

District of Columbia Comprehensive Program Integrity Review

Final Report

February 2014

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February 2014**

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Executive Summary and Introduction

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, the CMS Medicaid Integrity Group (MIG) identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Program Integrity Review Annual Summary Report*.

The purpose of this review was to determine whether Washington, D.C.'s (DC or the District) program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with the Medicaid Fraud Control Unit (MFCU) in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to: provider enrollment, disclosures, and reporting; program integrity activities including pre-payment and post-payment review, methods for identifying, investigating, and referring fraud, appropriate use of payment suspensions, and False Claims Act education and monitoring; managed care oversight at the state level; and program integrity activities conducted by managed care entities (MCEs).

Our review of the District's program integrity activities found the District to be in compliance with many of the program integrity requirements. However, the review team did note the District's Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities for fee-for-service (FFS) and managed care. Ranked below in order of risk to the program these are:

- 1) Inadequate program integrity activities, stemming in no small part from the District's failure to follow its own program integrity policies and procedures.
- 2) Inadequate attention to fraud and abuse detection, including failing to suspend \$60 million in payments for providers referred to the Medicaid Fraud Control Unit (MFCU) for investigation and conducting its own audits with ineffectively short audit time periods.
- 3) Poor program integrity oversight of managed care operations, including but not limited to, having no written policies and procedures for oversight, failure to verify services received directly with managed care beneficiaries, and failure to ensure plans report adverse actions taken against providers for program integrity reasons.
- 4) Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment or properly handle the termination of providers being removed from the program.
- 5) Poor working relationship with the MFCU, including making too few timely fraud referrals, simultaneously referring suspect providers to multiple investigative agencies

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and ineffective inter-agency communication with the MFCU.

These vulnerabilities include instances of regulatory non-compliance by the District as well as failure to incorporate program safeguards which, while not legally mandated, would generally be considered prudent and reasonable. These vulnerabilities and CMS's recommendations for improvement are described in detail in this report.

CMS is concerned that several of the risks described in this review were also identified in CMS's 2009 review and are still uncorrected. CMS will work closely with the District to ensure that all issues, particularly those that remain from the earlier review, are satisfactorily resolved as soon as possible.

Methodology of the Review

In advance of the onsite visit, the review team requested that DC complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A three-person team reviewed the responses and materials that the District provided in advance of the onsite visit.

During the week of August 27, 2012, the MIG review team visited the Department of Healthcare Finance (DHCF) office. The team conducted interviews with several program integrity and DHCF officials. To determine whether MCEs were complying with the contract provisions and other federal regulations relating to program integrity, the MIG team reviewed the District's managed care contracts. The team conducted in-depth interviews with representatives from three MCEs and met separately with DHCF staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications and program integrity cases and reviewed other primary data to validate DC's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the Program Integrity Division (PID) within DHCF but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. The District operates its Children's Health Insurance Program (CHIP) both as a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as the District's Title XIX program. The same effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, the District provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the PID provided.

Program Integrity Section

In DC, the PID is the organizational component dedicated to fraud and abuse activities. The PID

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is located in the Health Care Operations Administration within DHCF. At the time of the review, the PID had 20 full-time equivalent positions allocated to Medicaid program integrity functions. The table below summarizes the investigative and administrative actions undertaken by the PID in the last four complete state fiscal years (SFYs). It also lists the overpayments identified and collected over the same time period.

Table 1

SFY	Number of Preliminary Investigations Initiated*	Number of Cases Referred to MFCU	Number of Cases Involving Administrative Sanctions**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2008	8	4	27	\$527,334	\$459,308
2009	62	21	42	\$12,830,977	\$523,155
2010	38	25	120	\$13,836,082	\$5,147,568
2011	38	22	99	\$5,468,286	\$293,846

*Preliminary investigations of fraud or abuse complaints are conducted by investigative staff within the PID to determine if there is sufficient basis to warrant a referral to the MFCU or administrative sanction. The workup on administrative sanctions is performed by surveillance and utilization review (SURS) staff within the PID.

** Consists of cases developed by SURS staff independently through audits as well as preliminary investigations referred from PID investigative staff.

***The figures on overpayments identified and collected are based on SURS data analysis. The District reported large discrepancies between the amounts identified and the amounts collected partly as a result of appeals processes in which lower recoupments are regularly negotiated with providers. In SFY 2009, a \$10 million recoupment went uncollected after the provider in question was terminated. In SFYs 2009-2010, a reorganization of the District’s General Counsel took place, also resulting in diminished collections. In SFY 2011, SURS staff conducted audits on assisted living and waiver programs that identified large overpayments which were still tied up in court appeals with no recoupments at the time of the review.

Results of the Review

The CMS review team found a considerable number of regulatory compliance issues and vulnerabilities related to program integrity in the District’s Medicaid program. Several of these issues are significant and represent risks to the integrity of the District’s Medicaid program. These issues fall into five major categories listed in order of risk and discussed below. To address them, the District should improve oversight and build more robust program safeguards.

RISK 1: Inadequate program integrity activities, stemming in no small part from the District’s failure to follow its own program integrity policies and procedures.

Statutory Violation: 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)]

The District would more adequately protect the Medicaid program if it strengthened its program integrity infrastructure and capabilities and improved intra-agency coordination. Despite some effective program integrity activities, the District’s weaknesses were evident in several essential program areas and stem in no small part from a failure to follow its own policies and procedures. A major example of failure to follow existing policy commitments involves the monitoring of False Claims Act education. The District’s Medicaid State Plan describes a legally defensible plan for overseeing provider compliance with False Claims Act education requirements and whistleblower protections. However, the District acknowledged that it had not fulfilled its

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obligation to verify compliance with this requirement. The PID stated that it expected a yearly verification and compliance process to be up and running soon, but the monitoring system was not yet in place at the time of the review.

CMS's concern about the District's inadequate program integrity capacity is a theme that cuts across the other risk areas emphasized in this report, such as problems in fraud and abuse detection, managed care and provider enrollment. In some cases, there is a need to create policies and procedures that can ensure effective oversight of specific program areas, but in others the problem lies with not carrying out policies and procedures already in place. Within the PID, there is also a lack of coordination between the work of investigative staff and SURS staff which contributes to the significant gap that was observed in most years between overpayments identified and overpayments collected. This could be addressed by greater cross-training and reciprocal communications.

Finally, the organizational components of the state agency that oversees the managed care and Non-Emergency Medical Transportation (NEMT) programs reported they were unaware of federal program integrity requirements governing their areas.

Recommendations: Strengthen intra-agency communication and training on program integrity requirements throughout the Medicaid agency, with special emphasis on the District's managed care and NEMT programs, and also within the PID. Ensure that appropriate policies and procedures currently in place are implemented in practice and develop and implement policies and procedures where none are in place to meet the regulatory requirements and program weaknesses described elsewhere in this report. Implement compliance reviews to ensure appropriate providers are meeting the False Claims Act education requirements as stated in the Social Security Act and the District's Medicaid State Plan.

RISK 2: Inadequate attention to fraud and abuse detection, including failing to suspend \$60 million in payments for providers referred to the MFCU for investigation and conducting its own audits with ineffectively short audit time periods.

Regulatory Violation: 42 CFR 455.23

The PID did not suspend payments to providers upon referring credible allegations of fraud to the MFCU. During case sampling, the team found that the PID referred 22 cases to the MFCU from March 25, 2011, the effective date of this regulation, until the week of the program integrity review. A total of \$59,915,759 was paid to these providers after these referrals were made to the MFCU.

The PID had no policy or procedures in place or evidence of an action plan for suspending payments or making any good cause exceptions for these referrals. The SURS unit's scope of audit currently involves an unrealistically short timeframe in which to look back and review provider claims. SURS staff revealed that due to current staff shortages, the audit period had been reduced to no more than three months. The PID director acknowledged that prior to this staff shortage, the District's practice was to go back two years when reviewing billings. However, DHCF did not have regulatory guidance addressing audit look-back periods, and there

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had been resistance from the provider community against the recoupment of more than a year's worth of improper payments because such an approach would put some providers out of business. Further, the District's legal counsel advised a conservative approach because providers often prevailed in the appeal process and successfully negotiated lesser amounts.

The District's overall audit capacity thus is greatly limited by current policy and practice, and the Medicaid agency remains out of compliance with the federal regulation governing payment suspension actions. Together, these two weaknesses make it difficult for the District to protect Medicaid dollars and recover improper payments as aggressively as the Medicaid agency should.

Recommendations: Develop and implement policies and procedures to meet the requirements of 42 CFR 455.23 concerning the suspension of payments to providers upon MFCU referral. Substantially increase the District's audit look back period. Initiate aggressive recovery strategies for improper Medicaid payments that have already been issued. Review all audit practices to ensure that audits are conducted in a manner which will be upheld upon appeal.

RISK 3: Poor program integrity oversight of managed care operations, including but not limited to, having no written policies and procedures for oversight, failure to verify services received directly with managed care beneficiaries, and failure to ensure plans report adverse actions taken against providers for program integrity reasons.

The District has not adequately incorporated program integrity principles and policies in its managed care program. DHCF's contract with the MCEs outlined some program integrity requirements. However, in several instances, the District did not check to see if current contractual obligations are actually being followed. For example, only one of the District's three MCEs verified the receipt of services with beneficiaries at the time of the review, although such verifications are a contract requirement.

Also, the contract did not address several fundamental issues, such as minimum MCE program integrity staffing requirements, reporting on the status of MCE fraud and abuse provider investigations or procedures by which MCEs must report and refer cases of suspected provider fraud to either the District or the MFCU. Furthermore, the District's MCE contract did not address the new program integrity requirements of the Affordable Care Act.

The District had also not developed and implemented adequate Medicaid agency policies and procedures for monitoring MCE program integrity and enrollment activities to ensure that the baseline standards were actually being met. There were no written policies and procedures which address how the District would:

- monitor the program integrity activities of MCEs;
- analyze MCE utilization and referral patterns to detect possible fraud and abuse in the managed care program;
- communicate across the managed care and FFS programs about problem providers;
- ensure that plans report denials of provider enrollment or adverse actions taken against already enrolled providers for program integrity reasons; and

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- conduct look behind activities to ensure that MCEs and network providers do not have prohibited affiliations with individuals debarred from federal contracting.

The PID director acknowledged that the District's policies and procedures were insufficient and that communications across relevant organizational components on managed care program integrity issues were inadequate. PID and managed care oversight staff did not hold regular meetings. Moreover, MCE contractor staff was tasked with performing all the data mining and SURS functions although they have limited training in basic fraud detection. This resulted in few referrals being sent to the PID. There was no record of PID-furnished training on program integrity issues for managed care oversight staff. MCE contractor staff also had not been trained in basic fraud detection techniques. The PID unit provided no oversight of or feedback on the surveillance work performed by MCEs and, therefore, could not determine if an MCE's level of effort was appropriate. The PID unit was unaware of the few provider referrals and terminations made by MCEs.

The District also did not adequately monitor MCE provider enrollment activity to ensure that essential provider enrollment standards were being met and safeguards were in place. See the next section for a discussion of provider enrollment and disclosure issues affecting managed care.

Recommendations: Develop and implement policies and procedures to facilitate stronger DHCF oversight of MCE program integrity activities. Organize periodic meetings and cross-trainings between PID staff and managed care program personnel. Ensure at a minimum that managed care oversight staff in DHCF meet with MCEs to discuss program integrity issues and provide fraud and abuse prevention and detection training. Include PID staff in these discussions and trainings. Require participating MCEs to report fraud, waste and abuse cases on an ongoing basis, proactively offer guidance on cases of interest discussed in the reports, and instruct MCEs to inform the PID of terminated providers. Develop and implement policies and procedures for the collection, review, and analysis of managed care encounter data by the MCE plans.

RISK 4: Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment or properly handle the termination of providers being removed from the program.

Exclusion Searches

Regulatory Violation: 42 CFR 455.436

Upon enrollment and monthly thereafter, all providers as well as persons with ownership and control interests in, and agents and managing employees of, the provider must be checked against the General Services Administration's Excluded Parties List System (EPLS) and the U.S. Department of Health and Human Services – Office of Inspector General's (HHS-OIG's) List of Excluded Individual and Entities (LEIE) to ensure that programs are free from excluded and debarred providers and individuals.

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The District acknowledged it had no process for checking providers against the EPLS. The District also did not check the required affiliated parties such as persons with ownership and control interests, directors, officers, and managing employees. The District had policies and procedures for complying with this requirement but had not implemented them at the time of the review.

The District provided no evidence that it checked MCE ownership and administrative personnel, the NEMT broker, and the fiscal agent itself. The District's contract with the NEMT broker addressed EPLS checks of the contractor's status and that of its principals. However, there was no reference to exclusion checks in the LEIE; and the District did not solicit information on all the affiliated parties referenced in 42 CFR 455.436.

In the managed care program, all MCEs checked network providers, vendors and contractors for exclusions in both the LEIE and the EPLS upon enrollment, re-enrollment and monthly thereafter. However, none of the MCEs were checking persons with ownership or control interests, agents and managing employees as would be required for FFS providers. While not legally mandated for managed care, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care settings.

In addition, the NEMT broker was unaware of its obligation to conduct exclusion searches of contracted transportation providers and the same affiliated personnel. Consequently, it did not perform such searches either at the time of contracting or on a monthly basis thereafter.

Capturing Ownership and Control Disclosures at Enrollment

Regulatory Violation: 42 CFR 455.104

The District failed to properly capture ownership and control information during the enrollment process in several respects. First, it did not capture all required ownership and control disclosures from disclosing entities in the FFS or waiver programs during the enrollment process. The District's forms and web-based enrollment process do not reflect the ownership and control disclosure requirements that became effective on March 25, 2011. Its definitions of persons with ownership or control interests were also inconsistent with the federal definition. Specifically, the District did not capture:

- enhanced address information for corporations, date of birth (DOB) and Social Security Number (SSN) for individuals;
- subcontractors in which the disclosing entity has five percent or more interest;
- relationship information among parties disclosed that includes the Board of Directors;
- relationship information about persons with ownership or control interests in both subcontractors and the primary disclosing entity; and
- information on managing employees.

The District also did not collect the required ownership and control disclosure information from MCEs. Despite contractual requirements to do so, there was no evidence that this information was collected. The contractual requirements were also insufficient in that they did not address

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all required disclosure elements, such as enhanced address information for corporations or DOB and SSN for individuals. The contract also did not direct MCEs to identify relationships among the parties disclosed.

The District staff reported that a new policy and procedure had been developed in response to the last review addressing these omissions. However, nothing was available at the time of the review, and the District acknowledged that the revised policy did not contain the new disclosure requirements that went into effect on March 25, 2011.

Neither the NEMT broker's contract nor the fiscal agent contract in the District adequately addressed ownership and control disclosures, and the District provided no evidence it captured the required information in practice from these entities.

Capturing Criminal History Disclosures at Enrollment

Regulatory Violation: 42 CFR 455.106.

In the 2009 review, the District's providers did not comply with requirements to disclose health care-related criminal convictions. The District improved in this review but was still not fully compliant for FFS providers, MCEs or its NEMT program. The District's FFS enrollment forms failed to specify that health care-related criminal convictions going back to the inception of Medicaid, Medicare and Title XX must be reported. They further contained an incorrect reference to the Medicare program. There was also no evidence that health care-related criminal convictions were being captured for the MCEs despite contractual requirements for disclosure. Similarly, the District provided no evidence that it solicited health care-related criminal convictions from the NEMT broker; and the agency's contract with the broker was silent on the collection of criminal history disclosures from key personnel affiliated with NEMT network providers.

Requesting Business Transaction Information

Regulatory Violation: 42 CFR 455.105

The District was also cited during the previous CMS review for not requiring providers and MCEs to provide certain business transaction information upon request from the Secretary of the U.S. Department of Health & Social Services or the State Medicaid agency. This regulatory requirement remains uncorrected and the NEMT contract is silent on it as well. Moreover, although the District made the disclosure obligation a contract requirement for MCE network providers after the previous review, only one of the three MCEs had placed this requirement in its standard provider agreements. It was also missing from the NEMT provider agreement. While the absence of this disclosure obligation from the network provider agreements is not legally mandated for managed care, CMS considers this to be a program safeguard that would generally be considered prudent to apply to managed care network provider settings.

Reporting Adverse Actions Taken Against Providers and Providing Public Notice

Regulatory Violations: 42 CFR 1002.3, 1002.212 & 1002.214

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The District had not reported to HHS-OIG any of the approximately 105 provider terminations it had taken since 2009, nor did it have policies and procedures for doing so. In addition, the District violated both federal and municipal notification requirements when terminating or reinstating a provider. The District did not notify all required parties listed in the federal regulation when removing a provider from the program. Similarly, the District acknowledged that it did not properly notify all parties when reinstating providers.

Recommendations: Implement procedures to ensure that provider enrollment and contracting processes include the collection of complete and accurate disclosure information. Ensure that every party affiliated with the District's program is checked against the EPLS and the LEIE during the enrollment process and monthly thereafter and that adverse action reporting and provider notification requirements are met when terminating and reinstating providers.

RISK 5: Poor working relationship with the MFCU, including making few timely fraud referrals, simultaneously referring suspect providers to multiple investigative agencies and ineffective inter-agency communication with the MFCU.

The District's Memorandum of Understanding (MOU) with the MFCU calls for quarterly meetings, but they have not taken place. The failure to hold regular meetings has contributed to a decline in the number of fraud referrals.

The District made only two MFCU referrals in the first 10 months of federal fiscal year (FFY) 2011 despite averaging 19 referrals from FFY 2008 through 2010. While the referrals submitted generally followed the fraud referral performance standards in 42 CFR 455.23, the District took too long to make many of the referrals that it sent to the MFCU. In contravention of its MOU, the District also unilaterally made simultaneous referrals to the MFCU, HHS-OIG and the Federal Bureau of Investigation (FBI). This is not a regulatory violation, but the practice creates confusion in the absence of a comprehensive agreement among all parties.

Joint training across units has also not occurred, and both the MFCU and PID directors acknowledged that the communication between the two agencies had deteriorated in the past two years.

Recommendations: Develop and implement policies and procedures to ensure that quarterly meetings between the PID and MFCU take place on a regular basis to discuss fraud referrals and that the units build a more effective and coordinated approach to Medicaid fraud investigations. The PID should refer cases of alleged fraud to the MFCU first to enable the MFCU to make appropriate referral decisions and involve other law enforcement agencies where cases require support or go beyond the MFCU's jurisdiction. Every effort should be made to initiate reciprocal trainings. Update and strengthen the MOU between the state agency and the MFCU to improve the referral process and facilitate the sharing and discussion of case information at regular meetings. Updates should also include development of procedures to suspend payments upon referral to MFCU. Include HHS-OIG and FBI in the MOU if the District continues the practice of making trilateral referrals.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. The District reported that it requires personal care aides (PCAs) to obtain a National Provider Identifier (NPI) and mandates an orientation session for high risk durable medical equipment (DME) providers.

NPI Requirement for PCAs

To help track PCA activity and claims, since July 2012 the District requires PCAs to have an NPI number. Although the PCAs are employed by home health agencies, when submitting claims for personal care services, the agencies must list the NPI number of the PCA on the claim under the rendering provider. This makes it easier for Medicaid agency reviewers to hold individual PCAs accountable when appropriate for certain types of aberrational billings.

Enhanced enrollment procedures for DME providers

In May 2008, DHCF published new regulations designed to reduce fraud and abuse by strengthening the District's DME supplier enrollment process. These regulations include a requirement that providers attend an orientation before they can be enrolled in the District's Medicaid program. The orientation session includes fraud and abuse training. DME suppliers must send representatives who have the fiduciary authority to enter into a provider agreement with the District, and who have responsibility for Medicaid billing or claims processing.

Technical Assistance Resources

To assist the District in strengthening its program integrity operations, CMS offers the following technical assistance resources for the District to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. More information can be found at <http://www.justice.gov/usao/eousa/ole/mii/mii.courses.html>.
- Consult with other states regarding the development of a revised MOU that makes clear the responsibilities of the PI Unit and contains clear statements of procedures to suspend payments immediately upon referral to the MFCU. The MIG staff can assist the District in identifying other states in which appropriate MOU models exist.
- Consult with other states identified by the MIG that can share appropriate provider enrollment applications and provider agreements that meet the full disclosure requirements in the CFR to assist the District in complying with the full range of current disclosure requirements.
- Consult with other states that have large Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed with the conduct of exclusion searches and training of managed care staff in program integrity issues.

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- Consult with other states that have effectively implemented compliance reviews to ensure that qualifying providers are meeting the False Claims Act education requirements.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the District's program integrity efforts.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Work with the assigned CMS MIG State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the MIG's website at www.cms.gov/medicaidintegrityprogram. The website is frequently updated and contains resources for states including annual program integrity review summary reports, best practices reports, and educational toolkits developed by CMS for training purposes.

Conclusion

The District of Columbia applies some effective practices that demonstrate program capabilities and the District's commitment to program integrity. CMS supports the District's efforts and encourages it to look for additional opportunities to improve overall program integrity. However, the identification of significant areas of risk and numerous findings of non-compliance with federal regulations is of great concern and should be addressed immediately. CMS is also particularly concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

To that end, we will require the District to provide a corrective action plan (CAP) for each of the five areas of concern within 30 calendar days from the date of the final report letter. The CAP should address all specific problems identified in this report and explain how the District will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the District expects will occur and identify which area of the state is responsible for correcting the issue. The state should provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. Please provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the District has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the District to build an effective and strengthened program integrity function.

**Official Response from District of Columbia
May 2014**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance**

**Health Care Operations
Administration**



May 29, 2014

Mr. Richard Colangelo
Medicaid Integrity Specialist
Centers for Medicare & Medicaid Services
Medicaid Integrity Group
Division of Field Operations
26 Federal Plaza
New York, NY 10278
Richard.Colangelo@cms.hhs.gov

Dear Mr. Colangelo:

On behalf of Claudia Schlosberg, Acting senior Deputy Director, DHCT, please find enclosed the District of Columbia update to the Corrective Action Plan in response to the findings of CMS' 2012 Comprehensive Program Integrity Review.

If you have any questions, please contact me at 202-698-1718 or Karen.shaw2@dc.gov

Sincerely,

A handwritten signature in cursive script that reads "Karen Shaw".

Karen Shaw, J.D., M.P.H.
Program Manager

Enclosure