**APPENDIX I- FINANCIAL ACCOUNTABILITY-PLEASE SEE PROPOSED CHANGES IN TRACK**

**I-1- Financial Integrity and Accountability**

Financial integrity is promoted through pre- and-post payment processes. Pre-payment activities are described in section I- 2-d Billing Validation Process.

The State Agency is required to perform post payment audits under Chapter 42 of Title 29, DC Municipal Regulations (29 DCMR § 4236). To fulfill this requirement, a random sample of claims for selected waiver services is annually audited by the State Agency’s Division of Program Integrity - Surveillance and Utilization Branch. These audits consist of visits to waiver providers offices to compare information submitted on the claims to patient care documentation and assess whether or not the services billed for are: included in the participant’s approved service plan, were provided, and meet other requirements of the waiver. In instances in which claims appear to be unsubstantiated the state agency begins a recoupment process and returns the federal share, when recoupment is upheld through reconsideration and appeals processes, consistent with federal regulations. Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because the rate of denied claims in the sample can be applied to the universe of similar claims from the provider and a percent of payment equal to the error rate observed in the sample can be recovered.

In addition, the District of Columbia Office of the Inspector General conducts audits, as indicated.

Finally, every year, the entire Medicaid grant, including the portions funding the EPD Waiver, is audited as part of the Single Audit of all the federal grants awarded to the District. The Office of Integrity and Oversight within the Office of the Chief Financial Officer (of the District) oversees the Single Audit. In FFY 2010, KPMG conducted the Single Audit.

The DHCF’s Division of Program Integrity shall perform ongoing audits and post-payment reviews. DHCF’s Long Term Care Administration’s EPD Waiver Monitoring/Oversight team shall also conduct ongoing reviews of providers to ensure adherence with various programmatic standards. Both processes are outlined below in accordance with the EPD Waiver’s proposed regulations**.**

Please see Appendix E(i)(iv) for a description of the post-payment review processes specific to the VF/EA FMS-Support Broker entity for the *Services My Way* program.

 **AUDITS AND MONITORING/OVERSIGHT REVIEWS**

 The DHCF’s Division of Program Integrity shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with programmatic duties, documentation, and reimbursement requirements as required under Chapter 42 of Title 29 of the DCMR.

 The audit process shall be routinely conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services rendered to EPD Waiver program beneficiaries and billed to Medicaid.

 Each EPD Waiver provider shall allow access, during an on-site audit or review (announced or unannounced) by DHCF, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

 The failure of a provider to timely release or to grant access to program documents and records to the DHCF auditors, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement.

 If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following notice and the period of Administrative Review set forth in accordance with EPD regulations.

 The recoupment amounts for denied claims during audits shall be determined by the following formula:

 (a) The number of denied paid claims resulting from the audited sample shall be divided by the total number of paid claims from the audited sample; and

 (b) The amount derived from (a) as referenced under Subsection 4252.6 shall be multiplied by the total dollars paid by DHCF to the provider during the audit period to determine the amount to be recouped. For example, if a provider received Medicaid reimbursement of ten thousand dollars ($10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars ($1000), would be recouped.

 The DHCF shall issue a Notice of Proposed Recovery for Medicaid Overpayment (NPRMO) which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

 The timelines for responding to the NPRMO and the provider’s appeal rights are governed under Chapter 42 of Title 29 of the DCMR.

 In addition to audits, the DHCF’s Long Term Care Administration’s EPD Waiver Oversight and Monitoring team shall conduct two types of reviews:

 (a) Annual oversight and monitoring reviews to ensure compliance with established federal and District rules, regulations and applicable laws governing the operations and administration of the EPD Waiver Program; and

 (b) Quarterly compliance reviews to ensure adherence with the EPD Waiver Program’s performance measures.

 Each waiver services provider shall allow the EPD Waiver oversight and monitoring team access, during an on-site oversight/monitoring process (announced or unannounced).

 As part of the oversight and monitoring process, providers shall grant access to any of the following documents, which may include but shall not be limited to the following:

1. Person-Centered Service Plan (PCSP) and Plan of Care/ service delivery plan;
2. Employee records;
3. A signed, and current copy of the Medicaid Provider Agreement;
4. Licensure information;
5. Policies and Procedures;
6. Incident Reports and Investigation Reports; and
7. Complaint related reports.

 DHCF’s EPD Waiver Oversight and Monitoring Team shall issue a Statement of Findings and Opportunities for Improvement Plan ( “improvement plan”) within fifteen (15) calendar days of the annual oversight and monitoring exit meeting. Providers shall submit a plan of correction within fifteen (15) calendar days of the date of receipt of DHCF’s improvement plan

 DHCF’s EPD Waiver Oversight and Monitoring team shall generate a performance measures discovery/remediation report (“remediation report”) within five (5) business days of completion of the quarterly performance measures-related review.  Providers shall submit a performance measures-related remediation plan (“remediation plan”) within ten (10) business days of receipt of the report.

 The failure to provide an acceptable plan of correction, remediation plan or adherence to the improvement plan or remediation report, may result in a prohibition of new admissions, referral to the DHCF’s Division of Program Integrity for further investigation or imposition of a sanction or termination of the Medicaid Provider Agreement.

**I-2 (1 of 3) RATES, BILLING, AND CLAIMS**

**a. Rate Determination Methods**

The following principles apply to provider payment rate development for waiver services: Provider payment rates are uniform for every provider; DHCF, the Medicaid Agency for the District of Columbia, elicits public comments through the District rule-making process, which provides a 30 day public comment period, and Information regarding payment rates are available to waiver participants via publication of the proposed and ratified rules, which is publicly available. DHCF is responsible for all rate development with assistance of staff from LTCA/EPD Branch and the Office of Rates, Reimbursement and Financial Analysis (ORRFA). Together, these units develop rates for each EPD waiver service. Rate information is available to Medicaid participants and community members upon request and on DHCF website at http://dhcf.dc.gov. Transmittals are sent to providers indicating modification in rates and rate structure. The rate process includes market analysis, review of rate structure and methodology in surrounding jurisdictions. Meetings are held with providers, community stakeholders, DC Council and Long Term Care Coalition to assess outstanding issues and community needs, discuss rates and rate structure as rates for direct care workers (Personal Care Aide (PCA) and Home Health Aide (HHA) and review assessment of expertise and capacity of providers and services.

The aforementioned rate structures are determined based on a geographic market analysis. Each service is reviewed and compared to providers offering services in surrounding jurisdictions. There is no automatic inflation increase. In January 2006 direct care worker rates, (not nursing) were adjusted to provide a realistic rate in line with neighboring jurisdictions and consistent with DC Council mandate to provide a rate more acceptable for direct care workers (a living wage rate). The change in rate was designed to stabilize the pool of workers. Personal care aides reimbursement methodology was updated (see below). The rate setting methodology used for Medicaid services delivered through the traditional agency-based model will remain the same for those services that are participant-directed. Participants who elect to use PDS will determine the hourly rate paid to their participant-directed workers within the range set by DHCF, which falls between the District’s established living wage and the rate paid to personal care aides delivering Waiver services through the agency-based model. The Vendor F/EAFMS-Support Broker entity will assist participants who elect to use PDS through the provision of financial management and support broker services, and will receive a per-member-per-day payment for the provision of these services. In addition to the per-member-per-day payment, the Vendor F/EA FMS-Support Broker entity will receive a one-time payment for enrolling each participant/representative employer into its employer database and a one-time payment for enrolling each participant-directed worker into its payroll system. Rates for all three (3) types of payment made to the Vendor F/EA FMS-Support Broker entity will be determined after the competitive bidding process for the Vendor F/EA Support Broker entity contract is complete.

The reimbursement methodology and rate for Assisted Living services has been updated to better reflect the reasonable cost of providing the service in the District.

The daily rate is predicated by the following factors:

1. A Personal Care Aide (PCA) wage, which is based on the District Living Wage rate of $13.84 per hour, plus overtime and time off calculations.
2. The rate includes a number of hours for Licensed Practical Nurse (LPN) staffing plus overtime and time off calculations to address the Medication Administration rules of the District.
3. The rate includes the compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.
4. The rate includes the compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.
5. Each employee wage above has a 20% fringe benefit rate applied so as to reflect actual costs in the District.
6. A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on a reasonable comparison with other comparable residential care provider categories.
7. Lastly a 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to the HCBS waiver program. The 93% factor was used, so as to promote parity with all other residential services which also have a vacancy factor.

Based on the computation of these factors, the daily reimbursement rate for Assisted Living services shall be one hundred and fifty five ($155).

The rate will be inflated annually beginning with FY 2016, by any adjustment to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Medicaid reimbursement for Community Transition services shall be limited to a maximum of five thousand dollars ($5,000) per person for the duration of the EPD Waiver period as a one-time, non-recurring expense.

A. By adding section 4239 (Specific Provider Requirements: Assisted Living Services) to read as follows: Each facility providing assisted living services shall be licensed by the District of Columbia and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-101.01 et seq.) and attendant rules, and meet all other District regulatory requirements. Assisted living services may consist of any combination of the Services which meet the resident’s needs as outlined in the written individualized service plan. Services may include the following: (a) PCA; (b) Chore Aide; (c) Therapeutic social and recreational services.

The new case management methodology under the EPD Waiver is as follows: The reimbursement methodology and rates for case-management services under the EPD Waiver, is designed as an all-inclusive monthly (PMPM) capitation rate. The capitation rate approach provides a better correlation between reimbursements and the number of beneficiaries receiving case management services. The methodology used for establishing the capitation rate includes: A reasonable cost/ average industry salary for typical case managers. In determining the reasonable salary, DHCF relied on the most current compensation scale of case managers providing similar case management services at the District’s Department of Disability Services (DDS). All case managers at DDS are now called “Service Coordinators” with job functions generally classified in grade 11. While the compensation amounts “fully loaded” for grade 11-1 and 11-10, including salary and benefits is $73,489.22 and $94,748.61. The caseload assigned to each case manager at DDS crosses a large span of cases, and it is captured numerically on a client’s-to-case manager ratio. The ratio ranges from 45:1 for DDS waiver population, or 20:1 for more intense cases. However, for purposes of the EPD waiver population, an estimated caseload of 30:1 will be used. This estimated ratio is preferable for EPD waiver population given the intensity of service required. HHs providing case management to EPD beneficiaries will ONLY be able to bill for HH case management (and will NOT be able to bill for EPD case management services).

The new Chore Aide and Homemaker methodology under the EPD Waiver is as follows: Reimbursement for Chore Aide and Homemaker Services under the EPD Waiver Home care services are usually provided by Home Health Agencies, but may also be obtained from independent providers. Home Health Agencies employ homemakers or chore aid workers, who support individuals through heavy cleaning, meal preparation, bathing, and housekeeping. Personnel are assigned according to the needs and wishes of each client. Prior authorization (PA) is required to provide those services. DHCF reimbursed Home Health Agency for both Chore Aide and Homemaker services under the EPD Waiver. Chore Aide professionals are currently reimbursed at an hourly rate of $15.00 and Homemaker at $10.48. The current living wage in the District is $13.80 hourly, and at minimum chore aide and homemaker professionals must be reimbursed at this wage. To attract providers and provide access to services for beneficiaries, DHCF is increasing the reimbursement rates for both Chore Aide and Homemaker services to reimburse providers at rates that cover necessary employment related taxes, benefits and other administrative overhead costs. The reimbursement methodology was established as follows: The reimbursement rate is calculated using the living wage of $13.80 as the base, with an addition of 30% for employee related taxes, benefits and overhead costs.

Computation

• 1. Base Rate (Living Wage) = $13.80 + $4.14 (30%)

• FY 2016 Rate – October 1, 2015 $17.94 x 2.3% (CPI) = $18.35

The rate will be inflated annually beginning with FY 2016, by any adjustment to the living wage and inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

The EPD Waiver Amendment is adding three new services:

1) Physical Therapy

2) Occupational Therapy

3) Adult Day Health.

Home Care Agencies (HCA) can now provide OT and PT services, as well as independent OT and PT practitioners services will be covered under the EPD Waiver program.

Reimbursement Methodology

Each provider shall be reimbursed at the current reimbursement rate for OT and PT under the current State Plan reimbursement methodology and rates.

ADHP is a new service under the EPD Waiver Program. To be reimbursed for ADHP services under the EPD Waiver program, providers are required to meet the same qualifications and licensing requirements for the ADHP covered in the State Plan.

Each provider shall be reimbursed at the current reimbursement rate for Acuity Level 2, ADHP under the current 1915 (i) State Plan reimbursement methodology and rate. The daily rate for a program serving participants with a maximum acuity level with at least one staff member shall be one hundred and twenty five dollars and seventy eight cents ($125.78) per day. Acuity Level 2 represents the health and support needs of a beneficiary whose needs based assessment reflects a score of 6 or higher.

Effective October 1, 2015 (FY 2016) and thereafter, the uniform per-diem rates, shall be inflated by the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

The following change was made during the District's August 2015 Informal Request for Information questions- DHCF updated the reimbursement rates for Personal Care Aide (PCA) based on an audit of Home Health Agency (HHA) cost reports. The new rate covers the DC Living Wage increases, employment related taxes, employee benefits and a reasonable administrative overhead costs. The reimbursement methodology was established based on the following components;

• District’s living wage of $13.80 as established by the DC Department of Employment Services

• 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%)

• 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision

• 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.

The rate will be inflated annually beginning with FY 2016, by any adjustment to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

**I-5 Exclusion of Medicaid Payment for Room and Board**

 **b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings**

The reimbursement methodology and rate for Assisted Living services has been updated to better reflect the reasonable cost of providing the service in the District.

The daily rate is predicated by the following factors:

1. A Personal Care Aide (PCA) wage, which is based on the District Living Wage rate of $13.84 per hour, plus overtime and time off calculations.
2. The rate includes a number of hours for Licensed Practical Nurse (LPN) staffing plus overtime and time off calculations to address the Medication Administration rules of the District.
3. The rate includes the compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.
4. The rate includes the compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.
5. Each employee wage above has a 20% fringe benefit rate applied so as to reflect actual costs in the District.
6. A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on a reasonable comparison with other comparable residential care provider categories.
7. Lastly a 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to the HCBS waiver program. The 93% factor was used, so as to promote parity with all other residential services which also have a vacancy factor.

Based on the computation of these factors, the daily reimbursement rate for Assisted Living services shall be $155.

The rate will be inflated annually beginning with FY 2016, by any adjustment to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.