GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

January 4, 2008

VIA EMAIL AND
REGULAR MAIL DELIVERY

Dennis R. Jones, Monitor
1730 Rhode Island Avenue, NW, Suite 206
Washington, D.C. 20036

Re: Dixon, et al. v. Fenty, et al.
CA No. 74-285 (TJH)
Evidence of Compliance with Exit Criteria #19 – Demonstrated Maximization of Use of Medicaid Funding to Support Community-Based Services

Dear Mr. Jones:

I am pleased to report that DMH has met and exceeded the performance target for Exit Criteria # 19 for Fiscal Year 2006. Therefore, in accordance with the December 12, 2003 Consent Order Approving Agreed Exit Criteria With Measurement Methodology and Performance Levels (the "Exit Criteria Order"), the Department of Mental Health ("DMH") is formally submitting evidence that the District of Columbia has achieved compliance with Exit Criteria #19, Demonstrated Maximization of Use of Medicaid Funding to Support Community-Based Services. Exit Criteria # 19 is one of the exit criteria characterized as "Demonstrated Efficient Use of Resources" in the Exit Criteria Order.

Exit Criteria #19 Requirements.

The Exit Criteria Order includes the following requirements for demonstrating compliance with the performance levels established in Exit Criteria #19:

> General Methodology for Measurement: The Medicaid reimbursement dollars for DMH (federal dollars only) will be measured as a percentage of total community-based MHRS billings for Medicaid-approved services.

Required Performance Levels: 49% of total MHRS billings for community services (Medicaid-approved services) will be reimbursed by Federal Medicaid dollars.

Operational Definition: Federal Medicaid dollars as a percentage of total MHRS billings for Medicaid-approved community services.

Community-based MHRS: The total documented MHRS billings for all Medicaid approved services for an annual period.

Medicaid Reimbursement: The federal portion of reimbursement as documented and received by DMH.

Reporting Period: The annual DMH fiscal year.

Evidence of Compliance with Measurement Methodology and Performance Level

1. Practice Requirements. DMH has been working with KPMG to refine its methods for tracking the collection of federal Medicaid revenue for several months. However, for purposes of this letter, DMH is submitting only data collected and analyzed for Fiscal Year 2006 as evidence of compliance with the required performance levels.

2. Data Collection Methods. The data used to develop the reports on revenue collection is extracted from DMH's claims processing system, which is known as eCura and from the remittance advices provided to DMH by the District of Columbia Department of Health, Medical Assistance Administration ("MAA"). Information about claims that have been processed by DMH and approved for payment (with either local funds or Medicaid funds) is extracted from eCura. Information about the claims that are submitted to MAA for processing (and collection of federal financial participation) is also extracted from eCura. Information about the revenue that DMH has received from MAA is extracted from the MAA remittance advices. The information extracted from eCura and the information extracted from the MAA remittance advises is used to develop the Remittance Summary by fiscal year report.

You reviewed and approved DMH's detailed methodology for extracting the needed information from eCura and the MAA remittance advices and preparing the Remittance Summary by Fiscal Year Report.

A copy of DMH's validated metric for measuring the collection of revenue attached and marked as ***Exhibit A***. In addition, a copy of the Remittance Summary by Fiscal Year Report for FY 2006, which was prepared on December 13, 2007 is attached and marked as ***Exhibit B***.

3. Performance Levels for Fiscal Year 2006. DMH has provided the Court Monitor with the calculations used to determine whether DMH met the performance levels established in

the Exit Criteria Order regarding the maximization of federal Medicaid revenue. Those calculations are as follows:

TOTAL MHRS BILLINGS (MEDICAID AND NON-MEDICAID[1]	TOTAL MEDICAID – ELIGIBLE BILLINGS SUBMITTED TO MAA	EXPECTED MEDICAID PAYMENTS FROM MAA	ACTUAL MEDICAID PAYMENTS RECEIVED FROM MAA	TARGET PERFORMANCE LEVEL	FISCAL YEAR 2006 PERFORMANCE LEVEL
$42,294,378	$32,790,911	$22,790,911	$21,833, 212[2]	49%	51.62%

DMH has met the applicable policy and practice requirements for achieving performance with regard to demonstrating maximization of federal Medicaid revenue established in the Exit Criteria Order. Therefore, DMH has met and exceeded the performance target for Exit Criteria # 19 for FY 2006.

Accordingly, DMH hereby requests that the Dixon Court Monitor find that DMH has achieved the performance levels required for Exit Criteria #19; report on the performance levels to the U.S. District Court prior to the February 5, 2008 status hearing; and cease active monitoring of Exit Criteria #19.

If you have any questions or wish to discuss this matter further, please feel free to call me.

Respectfully,

Stephen T. Baron
Director

Enclosures (2)

Cc: Anthony A. Herman, Counsel to the Dixon Plaintiffs
Daniel R. Rezneck, Counsel for the District of Columbia

[1] As of January 4, 2008. This includes 2.4 million dollars in FY 2006 claims submitted by the DCCSA during the week of November 26, 2007. For purposes of this calculation, we have assumed that every claim is valid (either Medicaid or non-Medicaid) and will be paid.
[2] Total amount received from MAA as of January 4, 2008.

EXHIBIT A

METRIC #19
MEDICAID UTILIZATION

Demonstrated maximization of use of Medicaid funding to support community-based services.

DATA METHODS	
Operational Definition	Federal Medicaid dollars as a percentage of total MHRS expenditures for Medicaid-approved community services. Medicaid-approved community services include both Medicaid reimbursable services and services paid by Local funds.
Target	For one full year 49% of the total MHRS expenditures for community services (Medicaid-approved services) will be reimbursed by Federal Medicaid dollars
Method	1) ***MHRS Expenditures*** = Select and record all DCMHRS (Local) and Medicaid approved and paid claims from eCura system Main Menu: Reporting/Reports/ADD/Adjudication Status Summary. Selection criteria: Insurer-All; Level of Care-All; Provider-All ; Service Date-Fiscal period dates; 2) ***Paid Claims*** = Select and record all Medical Assistance Administration (MAA) remittance advice payment amounts from: GlobalShared/Fiscal Admin Claims/MAA Billing File Export Reports/Remittance Summary By Fiscal Year;3) ***Data Time Frame*** = Select data using selection criteria for the specific fiscal period.
Sources	1) The District of Columbia's Accounting System (SOAR); 2) MAA Remittance Advices; and 3) ECURA Claims Processing Reports.
Collection Process	1Claims expenditure information is accumulated in and collected from the ECURA system through the adjudication process; 2) Paid claims information is collected through the MAA remittance advice and recorded in the Remittance Summary by Fiscal Year report
Training	All DMH claims processing staff are trained on 1) processing claims; 2) generating an MHRS Medicaid billing; 3) generating reports on Medicaid paid claims and remittance advice reports; and 4) generating reports on paid and denied claims (Medicaid and non-Medicaid) for providers.. The training is for the claims and accounts receivable staff.
Dictionary	Federal Medicaid dollars – the portion of the payment for each Medicaid eligible service that is reimbursed by the Federal government. Medicaid-approved community services - includes both Medicaid reimbursable services and services paid by Local funds. Local funds – (1) the portion of the payment for Medicaid eligible services that is not reimbursed by the Federal government; (2) payments for non-Medicaid funded services rendered to Medicaid eligible consumers; and (3) payments for claims rendered to consumers who are not Medicaid eligible.
User Manual	Not Applicable
Quality Assurance	Periodic review and reconciliation of the MHRS billing process for accuracy and completeness.

Revised: November 9, 2007

METRIC #19
MEDICAID UTILIZATION

PROCESS VALIDATION	
Validation	1) Paid Claims Remittance information can be cross checked with the District's SOAR system; 2) Billed amount and paid claims can be cross checked with the Remittance Advice from MAA
Persons Validating Process	Director of Claims Operations; Deputy Director of Finance and Administration; Agency Chief Fiscal Officer.
Date	December 13, 2007
Type	Matching data from different files and sources
Process	Trace and agree data from different files and sources
Results	All of the data are properly accounted

Revised: November 9, 2007

EXHIBIT B

Fiscal Year	R3-REMIT-DATE	R3-REMIT-NUMBER	Billed Amount		Net Amount
2006	16-Dec-05	227069	$9,469.61		$6,628.68
	24-Feb-06	239022	$6,375.00		$0.00
	10-Mar-06	241723	$11,475.00		$0.00
	05-May-06	251935	$17,850.00		$0.00
	01-Jul-06	262011	$251,826.52		$154,245.92
	07-Jul-06	263210	$1,366.74		$956.73
	21-Jul-06	265751	$8,579,812.76		$4,955,023.60
	04-Aug-06	268459	$2,168,297.77		$0.00
	11-Aug-06	269746	$496,063.56		$0.00
	18-Aug-06	270912	$1,178,813.74		$1,739,301.20
	25-Aug-06	272138	$285,024.73		$160,975.40
	01-Sep-06	273381	$772,712.46		$425,886.71
	08-Sep-06	274475	$435,394.26		$161,656.78
	15-Sep-06	275624	$195,855.60		$109,781.38
	22-Sep-06	276812	$994,506.70		$529,604.36
2006	02-Oct-06	277986	$780,677.42		$391,433.12
	06-Oct-06	279475	$1,730,036.67		$891,755.68
	13-Oct-06	280757	$1,115,569.74		$459,907.55
	20-Oct-06	281973	$413,639.28		$103,236.55
	01-Nov-06	283144	$2,340,987.74		$618,147.22
	03-Nov-06	284381	$483.96		$161.12
	10-Nov-06	285650	$719,803.85		$306,993.78
	17-Nov-06	286880	$705,037.45		$389,393.67
	24-Nov-06	288039	$650,769.49		$317,392.06
	02-Dec-06	289329	$801,700.79		$471,744.09
	08-Dec-06	290651	$1,272,457.96		$636,381.57
	15-Dec-06	291953	$883,059.28		$1,634.15
	22-Dec-06	293173	$402,400.39		$201,279.29
	05-Jan-07	295421	$704,632.35		$320,031.25
	12-Jan-07	296636	$14,672.16		$10,251.66
	19-Jan-07	297839	$4,047,093.12		$738,580.16
	01-Feb-07	298959	$408,662.51		$172,252.59
	04-Feb-07	300206	$592,156.04		$301,806.97
	16-Feb-07	302652	$215,028.32		$49,032.47
	23-Feb-07	303758	$197,281.36		$8,116.59
	01-Mar-07	304922	$585,523.03		$52,958.63
	09-Mar-07	306211	$218,662.11		$8,038.00
	16-Mar-07	307465	$268,298.59		$33,681.70
	23-Mar-07	308690	$67,736.50		$11,269.34
	01-Apr-07	309960	$1,608,669.11		$449,118.40
	06-Apr-07	311263	$919,188.91		$345,181.25
	13-Apr-07	312683	$174,002.41		$22,156.75
	01-May-07	315673	$313,269.25		$186,460.65
	04-May-07	317074	$1,114.79		$621.26
	18-May-07	319638	$125,698.49		$30,414.27
	25-May-07	320931	$237,837.29		$81,581.75
	14-Jun-07		$4,982,842.15	SDS Claims	$3,447,476.87
	15-Jun-07	324802	$506,600.86		$280,028.88
	22-Jun-07	325999	$5,521.62		$0.00
	01-Jul-07	327320	$435,346.35		$258,702.58
	06-Jul-07	328670	$271,793.90		$120,961.18
	13-Jul-07	329968	$595,756.03		$318,951.46

20-Jul-07	331313	$139,421.95		$51,227.72
01-Aug-07	332699	$11,974.93		$2,316.72
04-Aug-07	334027	$398,984.89		$19,786.95
10-Aug-07	335343	$17,337.00		$1,621.44
17-Aug-07	336654	$839,182.66	Eligibility Re-process	$178,126.76
24-Aud-07	337881	$35,888.70		$522.09
02-Sep-07	339184	$455,917.83		$202,145.70
23-Nov-07	355244	$52,462.51	252 Processing	$36,629.76
01-Jan-08	362556	$1,887,291.74	CPEP	$1,109,639.65
2006 Totals		$48,557,317.93 *		$21,883,212.06

**Based on billed amounts from providers. Use Medicaid amount on Claims status report*