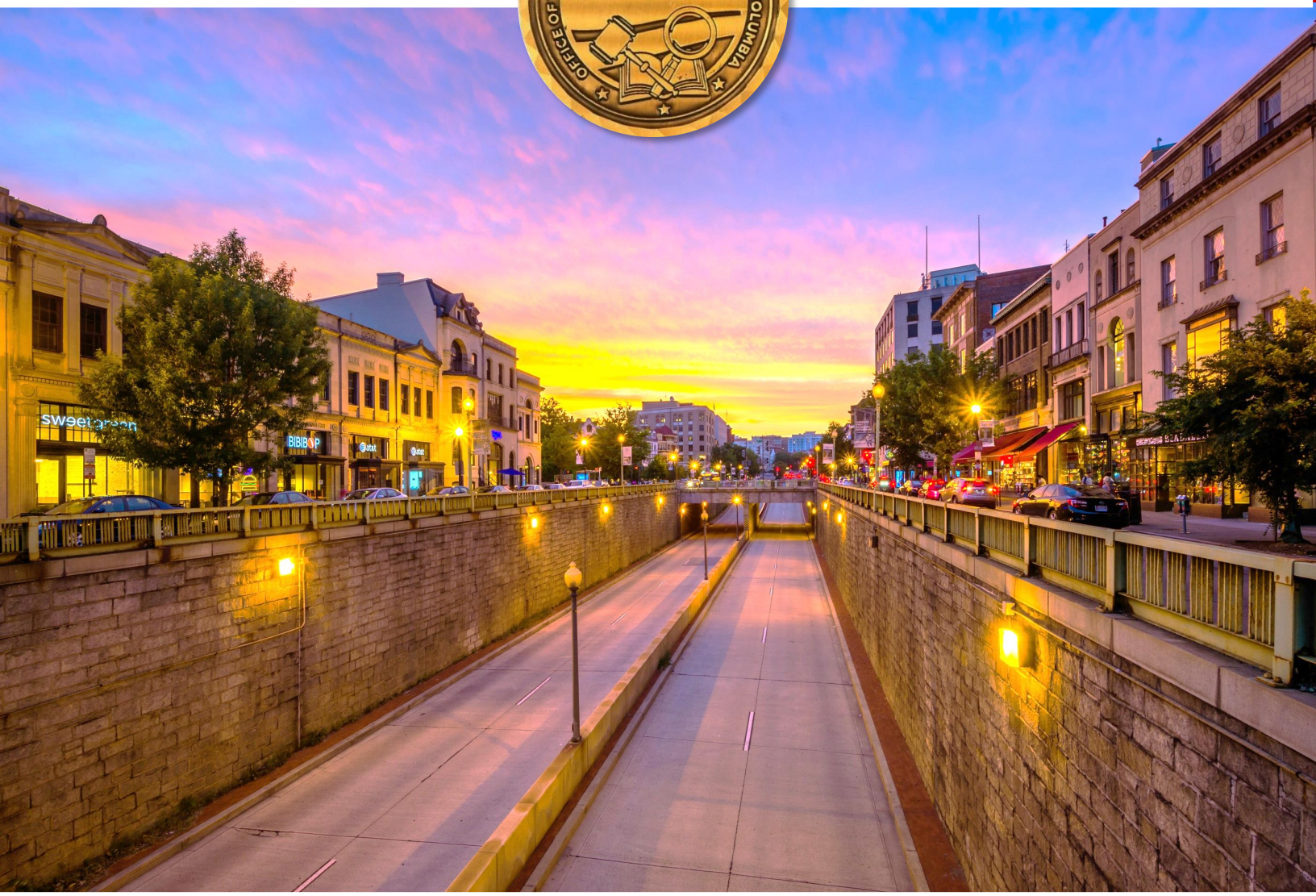
OFFICE OF THE
INSPECTOR GENERAL
DISTRICT OF COLUMBIA GOVERNMENT

AUDIT REPORT

Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations

OIG No. 23-1-07HT

September 5, 2025



DANIEL W. LUCAS
INSPECTOR GENERAL

OUR MISSION

We independently audit, inspect, and investigate matters pertaining to the District of Columbia government in order to:

- prevent and detect corruption, mismanagement, waste, fraud, and abuse;
- promote economy, efficiency, effectiveness, and accountability; inform stakeholders about issues relating to District programs and operations; and
- recommend and track the implementation of corrective actions.

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Continuous Improvement: We view challenges not as obstacles, but as opportunities for growth. Our commitment to continuous improvement drives us to evolve, adapt, and enhance our practices.

Excellence: Mediocrity has no place in our lexicon. We strive for excellence in every facet of our work.

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Transparency: Sunlight is our ally. Transparency illuminates our processes, decisions, and outcomes. By sharing information openly, we empower stakeholders, promote understanding, and reinforce our commitment to accountability.

MEMORANDUM

To: Wayne Turnage, M.P.A.
Deputy Mayor for Health and Human Services and
Director, Department of Health Care Finance

From: Daniel W. Lucas
Inspector General

Date: September 5, 2025

Subject: **Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations | OIG No. 23-1-07HT**

This report presents our findings on the District's oversight of Medicaid Managed Care Organizations (MCOs). Our objectives were to determine whether the Managed Care health care delivery system (1) reduced costs, and (2) increased access to health care services.

While DHCF established oversight frameworks, implementation gaps could limit the agency's ability to ensure MCOs are reducing costs and improving access. Identified issues included incomplete monitoring policies, inadequate overpayment controls, and limited review of MCO service denials that may have affected beneficiary care.

We made 16 recommendations to DHCF to strengthen its MCO oversight and better protect District funds while ensuring residents receive needed health care services. DHCF agreed with the intent of only two recommendations and committed to implementing them by specified target dates. DHCF disagreed with the remaining 14 recommendations, citing existing compliance measures, different interpretations of federal requirements, or asserting that current processes are adequate.

The control deficiencies identified during our audit period demonstrate the need for strengthened monitoring mechanisms, regardless of subsequent improvements made after the audit timeframe. The agency should adopt a proactive approach to internal control management, prioritizing timely and incremental improvements to address identified deficiencies.[1] To that end, we reiterate the critical importance of implementing comprehensive oversight measures to enhance accountability, ensure regulatory compliance, and protect both taxpayer funds and beneficiary access to care. Without corrective measures, DHCF's internal control environment

[1] Internal control management refers to an agency's approach to designing, implementing, and maintaining safeguards that protect resources, ensure accurate reporting, and achieve operational objectives. It includes management's responsibility to identify weaknesses in these safeguards, take accountability for deficiencies, and implement timely corrective actions to address identified problems. US Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, DC: September 2014), §§ 1.04, 1.05, 5.06 (last accessed August 19, 2025).

leaves the $8.8 billion awarded to the Medicaid Managed Care health care program vulnerable to mismanagement and improper use of funds.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions.

We appreciate the cooperation and courtesy extended to our staff during this audit. If you have any questions, please contact Dr. Slemo Warigon, Assistant Inspector General for Audits, at slemo.warigon@dc.gov or (202) 792-5684.

Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations

Summary

In FY 2023, the District of Columbia (DC or the District) government signed three contracts valued at $8.8B to provide healthcare services to approximately 261,000 low-income and disabled residents through Medicaid, using a Managed Care health care delivery system model. Under this system, the District pays private insurance companies called Managed Care Organizations (MCOs) a fixed monthly amount per beneficiary, and the MCOs coordinate care, manage provider networks, and ensure beneficiaries receive appropriate health services. The Department of Health Care Finance (DHCF) serves as the District's Medicaid agency and is responsible for overseeing these MCO contracts.

The Office of the Inspector General (OIG) identified this audit through its risk assessment process due to the significant impact Medicaid program reforms and MCO contracts have on District operations and the wellbeing of District residents.

Objectives

The objectives of this audit engagement were to determine whether DHCF's oversight of the Managed Care health care delivery system:

1. reduced cost, and
2. increased access to health care services.

The scope of this audit was for fiscal year (FY) 2023.

Findings

Our audit identified both strengths and opportunities for improvement in DHCF's oversight of Medicaid MCOs.

DHCF established frameworks for quality assessment, monitoring, and oversight. However, the following significant implementation gaps affect both cost and health care access:

- Incomplete monitoring policies and inadequate overpayment controls limited DHCF's ability to ensure cost efficiency.
- Data integrity issues prevented verification of MCO-reported overpayments and health services encounters.
- DHCF did not review prior authorization denials despite MCOs denying 46% of requests, potentially limiting beneficiary access to care.
- Contract administrators lacked required training.
- DHCF did not conduct the required MCO readiness assessments.

Recommendations

Our 16 recommendations address these gaps with specific actions to strengthen oversight and improve DHCF's ability to ensure the Managed Care system achieves its goals of reducing costs and increasing healthcare access.

On August 8, 2025, DHCF provided feedback, concurring with the intent of two recommendations and disagreeing with fourteen. This response pattern raises concerns about the strength of the agency's control environment and reflects missed opportunities to adopt measures that would enhance internal controls. Detailed analysis of DHCF's management response appears in the Management Response section, with the full text in Appendix 3.

Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations

CONTENTS

INTRODUCTION

Understanding Medicaid in the District

Medicaid is a joint federal-state health insurance program that provides essential health care services to eligible low-income and disabled residents.[2] For District residents who qualify, Medicaid covers a wide range of services including doctor visits, hospital care, prescription medications, mental health services, and transportation at little or no cost.

The Department of Health Care Finance (DHCF) serves as the District's Medicaid agency.[3] Its mission is to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia.

What is the Managed Care Health Care Delivery System?

Since 1998, the District has used a Managed Care approach to deliver Medicaid services. Under this system:

1. The District contracts with private insurance companies called MCOs.
2. The District pays these MCOs a fixed amount per beneficiary per month (known as a "capitation payment").
3. MCOs have networks of healthcare providers who serve beneficiaries.
4. MCOs are responsible for coordinating care, processing claims, and ensuring beneficiaries receive appropriate services.[4]

The intent of the Managed Care system is to better control costs while improving care coordination. According to DHCF data, approximately 261,000 District residents were enrolled in Managed Care programs by FY 2023.[5] The District contracted with three MCOs during our audit period to provide these services.[6]

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[2] Title XIX of the Social Security Act established Medicaid. The program is governed by 42 USC § 1396 et seq.

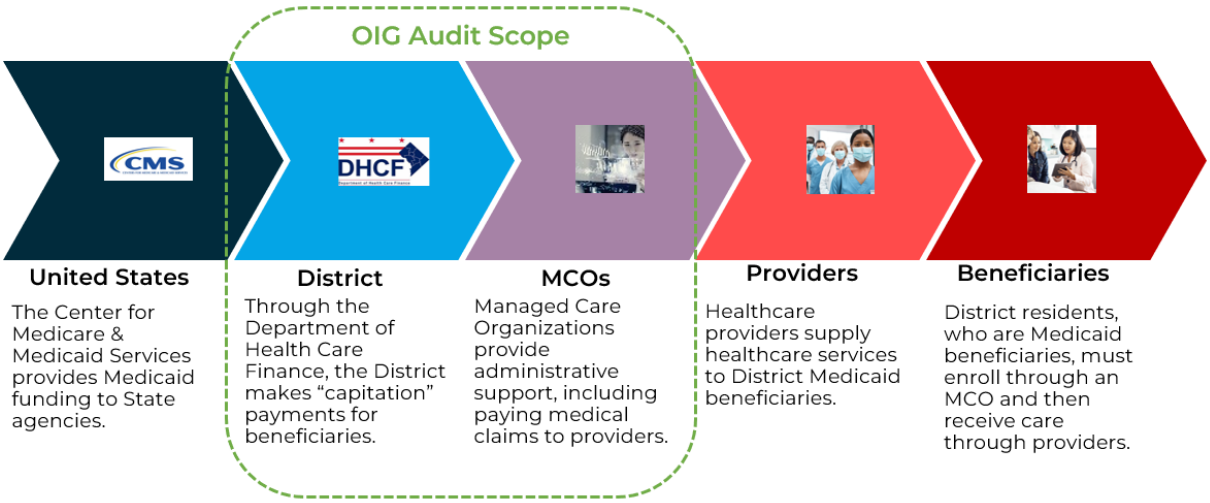
[3] DC Code § 7-771.03 establishes DHCF's purpose and responsibilities as the District's Medicaid agency.

[4] The District received authority to operate a Medicaid Managed Care program in 1998 through a waiver approved by the Centers for Medicare and Medicaid Services (CMS).

[5] DC Department of Health Care Finance, Monthly Enrollment Report – FY 2023, https://dhcf.dc.gov/node/1758206 (last visited June 16, 2025).

[6] See DHCF Contract Numbers CW99927, CW99929, and CW99931 for Medicaid Managed Care services, FY 2023.

Figure 1. The District's Medicaid Managed Care System



Why This Audit Matters

DHCF is required to provide oversight of the MCOs to ensure they comply with federal and District laws, regulations, contracts, and policies.[7] Effective oversight is essential because:

- The District spends significant public funds on these contracts, totaling $8.8B over five years, with the option to extend the period of performance by another five years;
- MCOs must support adequate provider networks to ensure access to care;
- Beneficiaries depend on these services for their health care needs; and
- Program integrity activities help prevent and identify fraud, waste, and abuse.

Our audit examined whether the District's internal controls over the Managed Care system can better ensure its goals of reducing costs and improving access to health care services for District residents.

[7]Title 42 CFR § 438.66 requires state Medicaid agencies to implement a monitoring system for all Managed Care programs.

AUDIT METHODOLOGY

How We Conducted This Audit

Our audit focused on DHCF's oversight of the three MCOs that provided Managed Care services to District residents during FY 2023. We designed our approach to evaluate the agency's oversight as related to the following questions:

1. Has DHCF's oversight of the MCOs impacted costs?

2. Has DHCF's oversight of the MCOs increased access to health care services?

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Risk-Based Auditing Approach

We began with a formal risk assessment to identify the highest-risk areas that might affect costs and access to care. This assessment led us to focus on six key areas:

- Oversight and contract compliance;
- Overpayments to providers;
- Enrollment processes;
- Data tracking of health services (encounters);
- Service use or utilization; and
- Payment rates to MCOs.

What We Reviewed

To thoroughly evaluate DHCF's oversight of the MCOs, our audit team:

- Examined federal and District laws and regulations that govern Medicaid Managed Care, such as the CFR, DCMR, and DC Code;[8]
- Reviewed DHCF policies and procedures, annual technical reports, external quality reviews, contract administrator delegation letters, and other documents;

[8] Key federal regulations governing Medicaid Managed Care include 42 CFR Part 438. District regulations are found in DCMR Title 29.

- Reviewed DHCF's contracts and contract modifications with the three MCOs and related vendors in the Managed Care system;
- Analyzed reports and attestation forms that the MCOs submitted to DHCF;
- Interviewed key personnel from multiple DHCF divisions and other District agencies to complete process walkthroughs and interviews;
- Analyzed data from FY 2023 on enrollment, health care services provided to beneficiaries, and overpayments;
- Identified 60 potential instances of duplicate enrollment and performed a 100% examination of these cases using the DC OMNICAID platform to verify whether beneficiaries were abnormally enrolled in more than one program;
- Examined how DHCF identifies, monitors, and recovers overpayments;
- Reviewed DHCF's processes for ensuring MCOs maintain adequate provider networks; and
- Assessed prior authorization requests and appeals.

Audit Framework

We used the U.S. Government Accountability Office's (GAO) "Standards for Internal Control in the Federal Government" (the Green Book) as our evaluation framework.[9] This framework helped us assess whether DHCF had effective systems in place to:

- Ensure MCOs meet their contractual obligations
- Monitor the quality of care provided to beneficiaries
- Identify and prevent fraud, waste, and abuse
- Maintain program integrity

Scope and Limitations

Our audit covered the FY 2023 operations of the Managed Care system. We recognized that during this period, DHCF was managing the final months of the federal COVID-19 Public

[9] Standards for Internal Control in the Federal Government, GAO-14-704G (September 2014), also known as the 'Green Book,' provides a framework for establishing and maintaining effective internal control. *See* https://www.gao.gov/products/GAO-14-704G (last visited June 16, 2025).

Health Emergency, which created unique challenges.[10] Our findings and recommendations acknowledge these challenges while identifying opportunities for improvement.

It is important to note that our audit did not question the District's decision to use the Managed Care approach. Instead, we focused on how DHCF implemented and monitored this approach with oversight over the MCOs. Without internal controls, the District risked not being able to ensure effective Managed Care program operations, the protection of beneficiary interests, and the safeguarding of District funds.

KEY FINDINGS AND RECOMMENDATIONS

Our audit of DHCF's oversight of the Medicaid Managed Care health care system revealed both strengths and opportunities for improvement. We organized our findings into five categories to help readers understand how they relate to the audit objectives of cost reduction and improved access to health care.

The first three findings highlight effective frameworks DHCF has established, which serve as a foundation for program oversight. The later findings identify specific areas where strengthening internal controls and oversight mechanisms would better ensure that the Managed Care system effectively reduces costs and improves access to health care for District residents.

For each finding, we provide specific recommendations to DHCF for addressing the identified issues. Implementation of these recommendations would help the District maximize the benefits of the Managed Care approach while safeguarding public funds and improving health outcomes for beneficiaries.

Development of Systems and Frameworks

Finding 1 – DHCF Developed a Framework to Assess Quality and Appropriateness of Care for the MCOs

The applicable federal regulation, 42 CFR § 438.340, requires state Medicaid agencies to develop a quality strategy to assess care provided by MCOs. DHCF met this requirement by developing its Medicaid Managed Care Quality Strategy framework, which includes mechanisms for contract management, data collection, performance improvement projects, and quality assessment.[11] DHCF developed this framework to respond to federal requirements and ensure MCOs deliver quality care to beneficiaries. This framework allows DHCF to monitor MCO performance, hold them accountable to standards, and

[10] The federal Public Health Emergency ended on May 11, 2023. The District's Public Health Emergency ended on July 25, 2021, per Mayor's Order 2021-096, § 11.

[11] DHCF, Medicaid Managed Care Quality Strategy: January 30, 2020 https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20Medicaid%20Managed%20Care%20Quality%20Strategy%202020.pdf.

improve the quality of care for Medicaid beneficiaries, supporting the audit objective of increased access to health care services.

Finding 2 – DHCF Developed a Monitoring and Compliance Framework for the MCOs

Federal regulations (42 CFR §§ 438.66 and 438.3) require state Medicaid agencies to implement procedures for regular oversight, monitoring, and evaluation of MCO performance. DHCF established a monitoring and compliance framework within its Medicaid Managed Care Quality Strategy. This framework requires MCOs to submit comprehensive reports covering case management, performance improvement projects, financial status, quality outcomes, and provider network accessibility. DHCF implemented this framework to fulfill regulatory requirements and strengthen MCO accountability.

The monitoring framework enables DHCF to systematically track MCO performance, identify compliance issues, and address them during bi-monthly operational meetings with MCOs led by its Division of Program Integrity. This supports both audit objectives by helping control costs and ensure beneficiaries have appropriate access to services.

Finding 3 – DHCF Had a System of Oversight for the Managed Care Health Care System

DHCF created a structured oversight system with distinct divisions responsible for different aspects of Medicaid Managed Care:

- The Health Care Delivery and Management Administration (HCDMA) oversees MCO contracts and supports other activities related to health care delivery;
- The Division of Program Integrity monitors MCO activities to identify and prevent fraud, waste, and abuse;
- The Division of Analytics and Policy Research evaluates health care delivery systems using data, research, and analysis; and
- The Health Care Operations Administration manages claims payment and administrative contracts along with the District's Medicaid Management Information System (MMIS)

DHCF designed this structure to establish clear lines of authority and responsibility for Managed Care oversight. By maintaining divisions with specific roles and responsibilities, DHCF created an organizational foundation for oversight of the Medicaid Managed Care program. This aligns with the Green Book's emphasis on management's role in establishing an effective

internal control environment to mitigate risks, maintain lines of communication, and monitor results to remediate deficiencies.[12]

Oversight and Accountability

While DHCF established several foundational frameworks, our audit identified specific areas where oversight and accountability mechanisms need strengthening. The following findings highlight gaps in policies, procedures, and contract language that affect DHCF's ability to effectively monitor MCOs and hold them accountable. Addressing these issues would improve the District's ability to control costs and ensure appropriate access to care for Medicaid beneficiaries.

Finding 4 – Not All DHCF Division Policies and Procedures for Monitoring MCOs Were Complete

DC Code § 7-771.03(3) requires DHCF to "develop eligibility, service coverage, and service delivery and reimbursement policies for the District's health-care-financing programs that ensure improved access and efficient delivery of service." The Green Book emphasizes that management must communicate policies and procedures so personnel can implement control activities for their assigned responsibilities effectively.[13]

DHCF's HCDMA division lacked complete policies and procedures for monitoring MCO compliance during FY 2023. Specifically, its policies did not include guidance on using dashboards, tools, and other resources needed to verify MCO compliance.

The division relied heavily on contracts and reports rather than comprehensive monitoring policies. HCDMA officials acknowledged that a review of their policies found that many were incomplete because they duplicated contract language without explaining how to use oversight tools.

Without complete, documented procedures, HCDMA staff lacked clear guidance on how to monitor MCOs effectively. While the division pointed to compensating controls (program monitors and quarterly meetings), these do not provide the same level of assurance as documented procedures. This gap in internal controls may have limited HCDMA's ability to ensure MCOs were reducing costs and providing adequate access to care for beneficiaries.

Incomplete monitoring procedures may have limited HCDMA's ability to identify instances where MCOs were not controlling costs effectively or to take timely corrective action. Without standardized monitoring procedures, HCDMA

[12] GAO Green Book § 1.05.

[13] GAO Green Book § 12.04.

could not consistently verify that MCOs responded appropriately to beneficiaries' health care needs.

Recommendation 1

We recommend that the Director, DHCF:

Develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.

Management Feedback:

DHCF disagrees in part with this recommendation. While the agency acknowledges that broader policies and procedures across all divisions could further strengthen the managed care program, they contend that their managed care division already has a well-established and documented compliance monitoring program in place. DHCF indicates they are reviewing the suite of activities that comprise their managed care compliance monitoring program and identifying corresponding policies and procedures that need to be strengthened. The agency commits to completing the corresponding updates and additions to its compliance monitoring program by March 1, 2026.

Our notes:

We acknowledge DHCF's partial agreement and planned corrective actions to complete updates and additions to its compliance monitoring program by March 1, 2026.

We consider this recommendation open and resolved, pending verification of implementation.

Finding 5 – MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies

Federal regulations require MCO contracts to address overpayment retention policies—governing whether the MCO that identified and recovered the overpayment gets to keep some or all of those funds or must return them to DHCF.[14]

In FY 2023, the District's MCO contracts did not include the detailed overpayment retention policy language mandated by 42 CFR § 438.608(d)(1)(iii). While DHCF had an unwritten "finder's keepers" arrangement

[14] 42 CFR § 438.608(d)(1)(iii) requires contracts to specify "processes, timeframes, and documentation required for payment of recoveries of overpayments [to the state agency] where the MCO… is not permitted to retain some or all of the recoveries of overpayments."

with the MCOs (allowing them to keep overpayments they found through their own efforts), the agency did not formalize this arrangement in the contracts as required by federal regulations.

Further, DHCF operated under this informal arrangement rather than setting up formal contractual language despite a July 2017 federal implementation deadline. Although the District created contract modifications in FY 2024, the language is still incomplete and does not meet federal requirements specifying timeframes and documentation for payment of overpayment recoveries to the District in situations where MCO retention is not permitted.

The missing contractual language relates to our cost savings audit objectives. Without clear recovery and retention provisions, the District lacked contractual authority to hold MCOs accountable for properly handling overpayments. This potentially allowed MCOs to keep funds that should have been returned to the District.

Recommendation 2

We recommend that the Director, DHCF:

Modify the MCO contracts to specify the timeframes and documentation required for payment of overpayment recoveries to the District in situations where MCO retention is not permitted and establish procedures for refunding the federal share of these overpayments to CMS as required by federal regulations.

Management Feedback:

DHCF disagrees with this recommendation. The agency asserts that they are already in compliance with 42 C.F.R. Sec. 438.608(d)(3) and cites specific contract language (sections C.5.33.1.6 and C.5.33.1.7) that they believe addresses the required overpayment recovery and retention policies. DHCF further notes that CMS confirmed their compliance with 42 C.F.R. 438.608(d) at page 9 of its FY 22 Focused Program Integrity Review of the D.C. Medicaid Program Report. The agency does not indicate any planned corrective action, as they maintain they are already compliant with federal requirements.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. Our audit found that in FY 2023, DHCF lacked binding, enforceable contractual provisions to guide recovery of overpayments from MCOs. Without explicit contractual or procedural mandates, recovery efforts were ad hoc, increasing the risk of uncollected funds. Based on DHCF's response, we understand the agency does not intend to implement corrective actions to address this gap and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Data Management and Reporting

Effective oversight of MCOs requires robust data management systems and accurate reporting mechanisms. Our audit identified several issues with how DHCF collects, verifies, and uses data from MCOs, particularly related to overpayment reporting. These findings directly impact the District's ability to control costs and ensure that resources are available to support healthcare access for beneficiaries.

Finding 6 – DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance

Federal regulation 42 CFR § 438.608(a)(2) requires MCOs, through their contracts with the State, to report all overpayments identified or recovered to the state Medicaid agency. The Green Book emphasizes that management should use quality data and information from reliable sources to make informed decisions and evaluate performance.[15]

DHCF could not accurately determine whether MCOs reported all identified overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR.[16]

DHCF relied primarily on MCOs' monthly attestations certifying the completeness and accuracy of the data provided, rather than implementing robust verification processes. The agency's standard operating procedures did not include sufficient mechanisms to compare reported overpayments for completeness and accuracy.

These data validation weaknesses relate to both of our audit objectives. Without reliable overpayment data, DHCF cannot effectively verify whether MCOs are identifying and recovering all overpayments, potentially allowing

[15] GAO Green Book § 13.04.

[16] Reviewed documentation included the FY 2024 PIMR because it also contained FY 2023 transactions.

improper payments to go undetected and unrecovered. This may increase program costs and reduce funds available for beneficiary services.

DHCF officials acknowledged that the agency lacks the capability to independently confirm overpayment data, creating a risk that MCOs could be incentivized to underreport overpayments to keep funds.

Recommendation 3

We recommend that the Director, DHCF:

Implement a comprehensive data validation system that requires unique Transaction Control Numbers (TCNs) for all encounters across all systems, establishes clear standards for format and content, and ensures consistent tracking between encounter data and all reports to improve overpayment monitoring and cost recovery.

Management Feedback:

DHCF disagrees with the corresponding finding. The agency states that the PIMR is not a financial reconciliation report but a tool for consolidating program integrity activities to support utilization review and investigatory priorities. DHCF reports that encounter data validation and reconciliation occur through other ongoing functions, and that these activities have been reviewed with its contracted actuary and the DC OIG. Regarding the cited transaction control numbers, DHCF states that all listed TCNs were present in MMIS, that differences reflect the retrospective nature of the PIMR, and that applicable TCNs may fall outside the time periods used in OIG's comparisons.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. Our audit found that the PIMR is a certified statement by the MCO's top executive, serving as a critical accountability control for encounter data accuracy. By downplaying its function, DHCF overlooked its role as a fraud prevention mechanism. In 2023, without standardized encounter data tracking, regular audits, or PIMR training, the agency lacked the assurance needed to detect or correct data manipulation or inaccuracies. The control deficiency persisted throughout the audit year. Based on DHCF's response, we understand the agency does not intend to implement corrective actions to address these data validation gaps and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Recommendation 4

We recommend that the Director, DHCF:

Independently audit the accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports.

Management Feedback:

See Management Feedback for Recommendation 3.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. As noted in our response to Recommendation 3, DHCF's position overlooks the critical role of independent audits in ensuring data integrity and fraud prevention. Without independent verification of encounter data submitted through financial reconciliation reports, the agency lacks adequate assurance to detect potential data manipulation or inaccuracies. Based on DHCF's response, we understand the agency does not intend to implement corrective actions to establish independent audit processes and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Recommendation 5

We recommend that the Director, DHCF:

Establish a regular independent audit process for accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports, rather than relying solely on attestations, to verify completeness, identify potential overpayments, and improve cost control.

Management Feedback:

See Management Feedback for Recommendation 3.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. As noted in our response to Recommendation 3, DHCF's position overlooks the critical role of independent audits in ensuring data integrity and fraud prevention. Without independent verification of encounter data submitted through financial reconciliation reports, the agency lacks adequate assurance to detect potential data manipulation or inaccuracies. Based on DHCF's response, we understand the agency does not intend to implement corrective actions to establish independent audit processes and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Recommendation 6

We recommend that the Director, DHCF:

Ensure MCOs receive uniform training and feedback about how to complete the PIMR data before submission to DHCF.

Management Feedback:

See Management Feedback for Recommendation 3.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. As noted in our response to Recommendation 3, DHCF's position overlooks the critical role of independent audits in ensuring data integrity and fraud prevention. The PIMR is a certified statement by the MCO's top executive, serving as a critical accountability control for encounter data accuracy. Our audit found several inaccuracies in MCO overpayment reporting, including formatting errors and inconsistent classification of overpayments. Without standardized training on PIMR completion, these data quality issues are likely to persist, limiting DHCF's ability to effectively monitor overpayment recovery and ensure compliance with federal reporting requirements. Based on DHCF's response, we understand the agency does not intend to implement uniform training for MCOs on PIMR data completion and accordingly assumes the associated risks of continued data quality issues.

We consider this recommendation closed and unresolved.

Finding 7 – DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting

Federal regulation 42 CFR § 438.608(a)(2) requires MCOs, through its contract with the State, to report all overpayments identified or recovered to the state Medicaid agency. Additionally, MCO contracts require them to report overpayments and specify whether they are due to fraud, waste, or abuse. The Green Book states that management should use quality information that is appropriate, current, complete, accurate, accessible, and provided on a timely basis.[17]

Our audit found several inaccuracies in MCO overpayment reporting that limit DHCF's ability to effectively monitor these payments:

- One MCO's PIMRs had 1,870 transaction control numbers with file formatting that changed the last two digits to "00."
- Another MCO classified all overpayment recoveries as "waste" in FY 2023 without reporting any fraud or abuse.
- We found instances where TCNs had dates outside of FY 2023.

While DHCF developed the PIMR for MCOs to report overpayments and needed certification of data accuracy, the agency relied primarily on attestations rather than validation processes. DHCF did not have systematic procedures for auditing PIMR data quality or enforcing consistent reporting standards across all MCOs.

These data reporting inaccuracies relate to both of our audit objectives. Inconsistent overpayment classification and reporting could make it difficult for DHCF to identify potential fraud, waste, and abuse patterns that could be addressed to reduce costs. Without standardized reporting, the District may not be able to effectively track overpayment recovery performance across MCOs or identify opportunities for systemic improvements. Additionally, when overpayment issues are not properly classified or tracked, the District may overpay for managed care services. Furthermore, unaddressed fraud and abuse could lead to inappropriate service denials or access barriers for legitimate health care needs.

[17] GAO Green Book § 13.05.

Recommendation 7

We recommend that the Director, DHCF:

Establish regular data quality audits of PIMRs that address inconsistent TCN formatting, standardize fraud/waste/abuse classifications, and implement corrective actions for non-compliant MCO reporting to improve overpayment tracking and recovery.

Management Feedback:

DHCF disagrees with this recommendation. The agency characterizes the identified inaccuracies as largely immaterial and explains that the Excel formatting issue with transaction control numbers was a one-time error that was promptly corrected, that MCOs appropriately classified overpayments as "waste" since they do not make legal fraud determinations, and that out-of-period transaction control numbers in the PIMR are expected by design since their Program Integrity Division audit activities are retrospective. DHCF does not indicate any planned corrective actions, as they believe the issues identified were either immaterial or appropriate given their system design.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. While DHCF's response addresses some points, it does not fully align with CFR requirements and internal control standards. The lack of preventative controls, over-reliance on retrospective corrections, and acceptance of blanket "waste" classifications collectively reduce the reliability of overpayment reporting. Stronger oversight, preventative controls, and enhanced classification requirements are necessary to meet federal compliance and audit reliability standards.

We consider this recommendation closed and unresolved.

Program Integrity and Fraud Prevention

Effective program integrity measures are critical for controlling Medicaid costs and ensuring that limited resources are directed toward legitimate health care needs. Our audit identified opportunities for DHCF to strengthen its fraud detection, referral processes, and enrollment monitoring to better protect public funds.

Finding 8 – DHCF Can Strengthen Fraud Referral Processes to the MFCU

Federal regulation 42 CFR § 455.21(a)(1) requires state Medicaid agencies to refer all suspected provider fraud cases to their Medicaid Fraud Control Unit (MFCU). DHCF's Memorandum of Understanding (MOU) with the MFCU further outlines referral procedures and requirements.

In FY 2023, DHCF referred only one fraud case from an MCO to the MFCU, despite potential indicators of fraud in MCO operations. Notably, one MCO classified all overpayment recoveries as "waste" with no fraud classifications, raising questions about proper fraud identification. By contrast, DHCF made 145 referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between MCO and non-MCO sources.

DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars.

Recommendation 8

We recommend that the Director, DHCF:

Establish a structured referral framework for MCO-reported fraud consistent with 42 CFR §§ 455.15(a) and 455.21(a)(1) requirements to refer suspected fraud cases to the MFCU.

Management Feedback:

DHCF disagrees with this recommendation. The agency states that it has a written fraud referral policy and procedure, consistent with federal regulatory requirements (42 C.F.R. Sec. 455.12 et seq.), and that this framework includes a preliminary investigation process and payment suspension committee review to determine when referral to law enforcement is warranted. The agency notes that it conducted individualized trainings with each MCO in FY 2024 on properly classifying investigations and improving internal processes, which it reports have resulted in more fraud referrals in the current year. DHCF also states that the OIG's reference to 145 fraud cases in FY 2023 is incorrect, explaining that it initiated 31 preliminary investigations that year and referred seven cases to the Medicaid Fraud Control Unit. The agency further maintains that “waste” is a valid classification and states that OIG has not presented sufficient evidence to demonstrate that MCO classifications were improper. Separately, DHCF states that managed care network providers are subject to the same fraud oversight as all other enrolled providers.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. However, OIG's finding is not about the existence of policy but about the operating effectiveness and compliance of fraud referral practices. The combination of extremely low referrals from MCOs, what OIG determined to be misclassification of suspected fraud as waste (which DHCF disputes on the basis of insufficient evidence), reliance on internal discretion before referral to the MFCU, and inadequate monitoring controls show that DHCF has not provided reasonable assurance of compliance with 42 CFR § 455.21(a)(1). Accordingly, OIG maintains its recommendation that DHCF establish a structured, enforceable referral framework for MCO-reported fraud consistent with federal requirements and the standards of the GAO Green Book and Yellow Book. Based on DHCF's response, we understand the agency does not intend to implement additional structured referral framework enhancements and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Finding 9 – DHCF's Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs

The DC Healthcare Alliance Program and Medicaid are separate health care programs with distinct eligibility requirements. According to the MCO contracts, Alliance beneficiaries over the age of twenty-one are ineligible for Medicaid. The Alliance program is specifically designed for low-income District residents who do not qualify for Medicaid or Medicare and have no other health insurance. DHCF, as the administrator of both programs, is responsible for maintaining effective eligibility monitoring systems to prevent improper enrollment and duplicate payments.

Our audit found 18 of 60 Adult Healthcare Alliance beneficiaries who were simultaneously enrolled in Medicaid for periods ranging from two to 12 months.[18] This dual enrollment occurred despite contractual provisions explicitly saying that Alliance beneficiaries should not be eligible for Medicaid.[19] When beneficiaries are enrolled in both programs simultaneously, the District could make capitation payments to MCOs for the same individuals under both programs.

The District lacks an effective enrollment monitoring system to identify and prevent duplicate program enrollment. DHCF's current eligibility verification

[18] See the "What We Reviewed" section for additional methodological information.

[19] MCO Contracts § C.1.2.1.1.

processes do not include systematic cross-checks between programs to identify potential duplicate enrollments.

This inadequate monitoring directly impacts the District's ability to control Medicaid costs. The District may have made duplicate capitation payments for these 18 beneficiaries, paying both Medicaid and Alliance program costs for the same individuals. While DHCF officials stated such cases are rare, without systematic monitoring, the actual extent of duplicate enrollment and associated costs cannot be determined. Additionally, resources used for duplicate payments would reduce funds available for expanding services to other eligible beneficiaries.

Recommendation 9

We recommend that the Director, DHCF:

Independently monitor eligibility compliance by periodically auditing/reviewing enrollment data, ensuring that beneficiaries are only enrolled in programs for which they are eligible. For example, implement an automated cross-check system that verifies an applicant's enrollment status access both Medicaid and Alliance programs at the time of application and enrollment to prevent simultaneous participation in both programs.

Management Feedback:

DHCF disagrees with this recommendation. The agency questions the sample, methodology, and data fields the OIG used to conclude that 18 of 60 individuals had dual enrollment in the Alliance and Medicaid programs. DHCF explains that determining impermissible dual program enrollment requires verifying whether there are any "voided spans" during the enrollment period, as the eligibility and enrollment system can retroactively void enrollment in one program when dispositive information is received. For example, if an individual enrolled in the Alliance Program later receives citizenship information qualifying them for Medicaid, the system automatically voids the Alliance span and replaces it with a Medicaid span for the subject period. DHCF maintains that the OIG did not review the "voided span" data field, making it inaccurate to conclude that individuals had duplicate enrollment. The agency does not indicate any planned corrective actions, as they believe the OIG's methodology was flawed.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. However, in 2023, DHCF lacked an independent monitoring process to prevent beneficiaries from being enrolled in more than one plan. This omission increased the likelihood of overpayments, improper billing, and service coordination problems. System improvements made later cannot retroactively address the absence of this safeguard in the audit period. Based on DHCF's response, we understand the agency does not intend to implement independent eligibility monitoring enhancements and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Health Care Access and Service Delivery

A critical measure of the Managed Care system's effectiveness is whether beneficiaries can access health care services when they need them. Prior authorization processes can significantly impact the ability of beneficiaries to receive timely care. Our audit identified patterns in how MCOs handle prior authorization requests that directly affect health care access for District residents.

Finding 10 – Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access

Federal regulation 42 CFR § 438.210(a)(3)(ii) requires state Medicaid agencies to have mechanisms to ensure that MCOs do not "arbitrarily deny or reduce the amount, duration, or scope of required service[s] solely because of diagnosis, type of illness, or condition of the beneficiary."

During our audit period, we found that:

- The three MCOs denied 18,077 of the 38,958 (46 percent) prior authorization requests submitted by enrollees and providers. The District's 46 percent denial rate is significantly higher than the national average of 12.5 percent, which could create barriers to beneficiaries' access to health care services.[20]
- Enrollees and providers appealed 692 denial decisions.
- Of these appeals, 155 cases were overturned, 133 were withdrawn by the provider or enrollee, and 404 were upheld.

[20] US Department of Health and Human Services, Office of Inspector General, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*, OEI-09-19-00350, July 2023, https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

- The MCOs denied 12,962 prior authorization requests for services and drugs not approved on the fee schedules.

- DHCF did not review any of these denial decisions or overturned appeals during our audit period.

DHCF relied on MCOs and external vendors for oversight of prior authorization decisions, without implementing its own review mechanisms. While federal regulations did not require DHCF to conduct a full audit of all MCO prior authorization decisions, the DC MCOs' 46 percent denial rate, which is four times higher than the national average denial rate of 12.5 percent, indicates that further review is warranted.[21] The agency should have implemented oversight mechanisms such as statistical sampling of denials and systematic review of appealed cases to ensure MCOs are appropriately providing access to needed services. given

The high denial rate and lack of District oversight directly impact beneficiaries' access to health care services. Without District review of denial decisions, DHCF lacks reasonable assurance that MCOs are not inappropriately restricting beneficiaries' access to necessary health care services. The fact that 22 percent of appealed cases were overturned indicates that nearly one in four initial denials were incorrect. When beneficiaries are denied appropriate care, they may eventually require more expensive interventions for conditions that could have been treated earlier at a lower cost. Additionally, the District may be paying MCOs for health care services that beneficiaries are unable to access.

Recommendation 10

We recommend that the Director, DHCF:

Implement a process to request and review all prior authorization denials to verify MCO compliance with coverage requirements, identify inappropriate denial patterns, and ensure beneficiaries have appropriate access to needed services.[22]

[21] HHS, *High Rates of Prior Authorization Denials*.

[22] This recommendation aligns with the GAO's April 2024 report "MEDICAID: Managed Care Plans' Prior Authorization Decisions for Children Need Additional Oversight" (GAO-24-106532), which found that states were not reviewing representative samples of denials to assess appropriateness.

Management Feedback:

DHCF disagrees with the methodology underlying this finding but agrees to develop a process to review a representative sample of managed care prior authorization denials and appeals on a periodic basis. DHCF argues that the OIG's calculations are incorrect, stating that of the 19,327 "denials," 12,674 were for services categorically not covered under the DC State Plan for Medicaid, and 288 were either subsequently approved or withdrawn. DHCF calculates that excluding these cases yields a denial rate of 6,365 out of 38,958 requests, or 16% rather than the 50% rate cited in the audit report. DHCF agrees to strengthen health care access oversight by implementing a process to review a representative sample of denied and appealed cases to identify potential data-supported access barriers for covered services, with an estimated completion date of March 1, 2026.

Our notes:

We acknowledge DHCF's partial agreement to the recommendation and note that DHCF will develop an oversight process for prior authorizations. Based on the methodology stated in DHCF's response, OIG recalculated a denial rate of 46% when it excluded all non-covered transactions. As such, we updated the number in the report.

In 2023, DHCF did not review denials as part of its standard processes. In accordance with the audit objective related to access to care, the audit team requested data on beneficiary denials. DHCF did not monitor appeals; 155 appeals were overturned, indicating the District beneficiaries were entitled to benefits. DHCF could not provide documentation or other evidence to support that beneficiaries had access to care.

We consider this recommendation open and resolved, pending verification of implementation.

Recommendation 11

We recommend that the Director, DHCF:

Implement a systematic review of all appealed and overturned prior authorization cases to identify patterns, ensure proper corrective actions, and verify MCO compliance with appeal decisions.

Management Feedback:

See Management Feedback for Recommendation 10.

Our notes:

We acknowledge DHCF's partial agreement to the recommendation.

In 2023, DHCF did not review denials as part of its standard processes. DHCF did not monitor appeals; 155 appeals were overturned, indicating the District beneficiaries were entitled to benefits. DHCF could not provide documentation or other evidence to support that beneficiaries had access to care.

We consider this recommendation open and resolved, pending verification of implementation.

Contract Administration and Readiness

Finding 11 – DHCF Contract Administrators Did Not Complete Certification Requirements

Contract Administrator (CA) appointment delegation letters require DHCF officials nominated as CAs to complete seventeen classroom training hours to be qualified to monitor contractor performance and ensure technical requirements are met within the contract period. The Green Book states that personnel need to possess and maintain relevant knowledge, skills, and abilities to accomplish their assigned responsibilities, which are gained largely from professional experience, training, and certifications.[23]

Based on our review of DCHR employee training records, none of the DHCF contract administrators responsible for monitoring six contracts for and related to MCO administration completed the required seventeen classroom training hours during FY 2023. These contracts included the three Medicaid MCO contracts, the External Quality Review Organization broker contract, the enrollment broker contract, and the actuarial firm contract. DHCF officials stated that the required courses were not available in FY 2023. However,

[23] GAO Green Book § 4.02.

District officials stated they conducted training sessions every other week throughout FY 2023, though high demand created waiting lists.

The lack of proper CA certification and training relates to both of our audit objectives. First, inadequately trained CAs may have been less effective at monitoring MCO contract compliance, which may have allowed cost inefficiencies to go undetected. Any improper monitoring of "technical requirements under the contract … at the price or within the estimated cost stipulated in the contract" may create a risk of overpayment or waste.[24] Second, CAs serve as points of contact for MCOs and have critical oversight responsibilities for ensuring contractors meet their obligations to provide "timely and appropriate care" to beneficiaries.[25] Without proper training, CAs may have been less effective at identifying and addressing service delivery issues that affect beneficiary access to care, undermining the District's ability to effectively oversee and administer the contracts.

Recommendation 12

We recommend that the Director, DHCF:

Develop and implement a comprehensive training plan to ensure all Contract Administrators complete the required Office of Contracting and Procurement training courses within established timeframes.

Management Feedback:

DHCF disagrees with this finding. The agency states that the subject Contract Administrators were previously certified and were unable to complete recertification requirements only due to lack of availability of OCP training for recertification. DHCF was unable to comply during the period of review due to reasons outside of its purview. The agency explains that OCP exclusively administers Contract Administrator training and did not make the applicable training available for District employees during the period of review. Once training became available, all Contract Administrators promptly enrolled and have since completed their recertification.

[24] OCP Delegation Letters (on file).

[25] MCO Contracts § C.1.3.3.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. However, in FY 2023, DHCF contract administrators operated without the certifications required for effectively managing large, complex Medicaid contracts. This gap in qualifications weakened oversight capacity and created an elevated risk of contract mismanagement. Later certification does not change the deficiency in the audit year.

DHCF stated that it has taken remedial actions in FY 2024. We are marking this recommendation as open and resolved, pending verification of implementation.

Recommendation 13

We recommend that the Director, DHCF:

Establish an internal tracking system to monitor certification status and compliance with any other requirements for all staff serving as Contract Administrators for contracts for and related to MCO administration.

Management Feedback:

See Management Feedback for Recommendation 12.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. However, in FY 2023, DHCF contract administrators operated without the certifications required for effectively managing large, complex Medicaid contracts. This gap in qualifications weakened oversight capacity and created an elevated risk of contract mismanagement. Later certification does not change the deficiency in the audit year.

Based on DHCF's response, we understand the agency does not intend to establish an internal tracking system to monitor certification status and other requirements compliance and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Finding 12 – DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs

The MCO contracts signed at the start of FY 2023 require DHCF to conduct site visits as part of the readiness assessment that must be developed and certified for each MCO prior to enrolling any beneficiaries.[26] DHCF officials reported that

[26] MCO Contracts § H.11.6.3.1.

they did not conduct site visits to all MCOs, as required by contract. While the agency issued a readiness report for one MCO in March 2023 due to that MCO's nearly 3-year absence from the District's Managed Care program, it did not complete readiness assessments or conduct site visits for the other MCOs.

DHCF officials explained that the incumbent MCOs did not undergo readiness assessments due to their continued participation in the program. Officials also cited challenges from the COVID-19 Public Health Emergency in FY 2023, including limited staff capacity, resource constraints, and staffing changes that discouraged site visits.

This noncompliance with contractual requirements directly impacted both areas that were the subject of this audit. Without comprehensive readiness assessments and site visits, DHCF lacked verification that MCOs had the appropriate systems, staffing, and processes in place to effectively manage costs and prevent waste. More broadly, the Medicaid Managed Care program is specifically designed to ensure MCOs can provide "timely and appropriate care"[27] to beneficiaries. By not conducting these assessments, DHCF could not verify whether all MCOs were adequately prepared to deliver services and maintain appropriate provider networks. Finally, failing to follow contractually required oversight procedures undermines DHCF's accountability mechanisms and creates compliance risks for the Medicaid program.

Recommendation 14

We recommend that the Director, DHCF:

Develop and implement a documented site visit protocol for all MCOs, including a standardized assessment tool, staffing plan, and tracking mechanism to ensure contractually required readiness assessments are completed before each contract period begins, regardless of an MCO's incumbent status.

Management Feedback:

DHCF disagrees with this finding. The agency states that all readiness reviews were completed within required timeframes and in accordance with 42 CFR § 438.66(1)(2)(3)(4). During the audit period, only one MCO (Amerigroup) required a readiness review as it was newly procured and absent from the program for 3 years. DHCF states that Amerigroup's readiness review was completed in accordance with federal requirements, while the other MCOs (HSCSN, AmeriHealth, and MedStar) were not subject to additional mandatory readiness reviews as they were not newly contracted.

[27] OCP Delegation Letters (on file).

Our notes:

We acknowledge DHCF's disagreement with this recommendation. However, without in-person visits, there was a higher risk that MCOs began operations on a new contract period without meeting all readiness requirements.

Based on DHCF's response, we understand the agency does not intend to develop and implement a documented site visit protocol for all MCOs and a tracking mechanism to ensure readiness assessments are completed before each contract period begins and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Recommendation 15

We recommend that the Director, DHCF:

Establish policies and procedures that define when virtual assessments can substitute for in-person visits, specify technology requirements to ensure comparable information collection, and include documentation standards that demonstrate fulfillment of contractual obligations.

Management Feedback:

See Management Feedback for Recommendation 14.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. Based on DHCF's response, we understand the agency does not intend to establish policies and procedures defining virtual assessments, specifying technology requirements, and including documentation standards that demonstrate fulfillment of contractual obligations and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

Recommendation 16

We recommend that the Director, DHCF:

Develop a comprehensive MCO reassessment program that includes annual operational readiness reviews, quarterly performance monitoring, and targeted evaluations when significant changes occur in staffing, systems, or services to ensure continuous compliance with contract requirements and maintain service quality for Medicaid beneficiaries.

Management Feedback:

See Management Feedback for Recommendation 14.

Our notes:

We acknowledge DHCF's disagreement with this recommendation. Based on DHCF's response, we understand the agency does not intend to develop a comprehensive MCO reassessment program and accordingly assumes the associated risks.

We consider this recommendation closed and unresolved.

MANAGEMENT'S RESPONSE

On August 8, 2025, the Department of Health Care Finance (DHCF) provided its response to our draft audit report. DHCF disagreed with the majority of our findings and recommendations, indicating planned corrective actions for only two of the 16 recommendations. This limited commitment to corrective action leaves significant identified risks unaddressed.

In its response, the agency cited existing compliance measures, alternative interpretations of federal requirements, or the adequacy of current processes as reasons for not implementing the remaining recommendations. As a result, current practices remain largely unchanged despite identified opportunities to strengthen safeguards for District resources and resident welfare.

An effective control environment—consistent with *Standards for Internal Control in the Federal Government* (GAO Green Book)—requires timely remediation of identified weaknesses to address audit findings and reduce exposure to unmanaged risks.[28] By not

[28] U.S. Government Accountability Office. Standards for Internal Control in the Federal Government ("Green Book"). Washington, DC: GAO, 2014. https://www.gao.gov/greenbook. See p. 21 ("The control environment is the foundation for an effective internal control system"), and Principles 1–5, pp. 22 – 34, on integrity and ethical values, oversight, organizational structure, competence, and accountability.

implementing recommended corrective measures, DHCF leaves key risks in place, which can erode the reliability and effectiveness of oversight systems.

The control deficiencies identified pose ongoing risks to cost containment and beneficiary access to care. Without corrective measures, DHCF's internal control environment leaves the $8.8 billion awarded to the Medicaid Managed Care health care program vulnerable to mismanagement and improper use, underscoring the critical need for continued oversight.

CONCLUSION

Our audit of DHCF's oversight of the Medicaid Managed Care health care delivery system revealed both strengths and opportunities for improvement. DHCF established foundational frameworks for quality assessment, monitoring, and compliance, creating basic structures necessary for program oversight. However, the agency's implementation of these frameworks contains gaps that directly impact the District's ability to control costs and ensure beneficiary access to care.

The findings demonstrate that DHCF has not fully operationalized all the internal controls needed to verify that the Managed Care system is reducing costs as intended. Incomplete policies and procedures, insufficient overpayment monitoring, inadequate data validation, limited fraud referral mechanisms, and duplicate enrollments all represent missed opportunities for cost containment. Similarly, DHCF's limited oversight of prior authorization denials, inadequate contract administrator training, and incomplete MCO readiness assessments could create barriers to health care access for District residents.

By implementing the recommendations in this report, DHCF can strengthen its oversight capabilities through enhanced policies, improved data integrity measures, more robust monitoring systems, and strengthen staff capabilities through training. These improvements would enable the agency to more effectively fulfill its responsibility to ensure that the Managed Care health care delivery system achieves both objectives: reducing costs while increasing access to quality health care services for District Medicaid beneficiaries.

By addressing these findings, DHCF can better fulfill its mission to improve health outcomes through comprehensive, cost-effective, and quality healthcare services and ensure the creation of a more effective, accountable Medicaid Managed Care health care program that serves the needs of District residents while responsibly managing public resources.

APPENDIX 1. FINDINGS

Table of Findings

APPENDIX 2. RECOMMENDATIONS

Table of Recommendations

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	1	Develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.	**Open; Resolved**	Tracking implementation	4
DHCF	2	Modify the MCO contracts to specify the timeframes and documentation required for payment of overpayment recoveries to the District in situations where MCO retention is not permitted and establish procedures for refunding the federal share of these overpayments to CMS as required by federal regulations.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	5
DHCF	3	Implement a comprehensive data validation system that requires unique Transaction Control Numbers for all encounters across all systems, establishes clear standards for format and content, and ensures consistent tracking between encounter data and all reports to improve overpayment monitoring and cost recovery.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	6
DHCF	4	Independently audit the accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	6
DHCF	5	Establish a regular independent audit process for accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports, rather than relying solely on attestations, to verify completeness, identify potential overpayments, and improve cost control.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	6

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	6	Ensure MCOs receive uniform training and feedback about how to complete the PIMR data before submission to DHCF.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	6
DHCF	7	Establish regular data quality audits of Program Integrity Monthly Reports that address inconsistent Transaction Control Number formatting, standardize fraud/waste/abuse classifications, and implement corrective actions for non-compliant MCO reporting to improve overpayment tracking and recovery.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	7
DHCF	8	Establish a structured referral framework for MCO-reported fraud consistent with 42 CFR §§ 455.15(a) and 455.21(a)(1) requirements to refer suspected fraud cases to the MFCU.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	8
DHCF	9	Independently monitor eligibility compliance by periodically auditing/reviewing enrollment data, ensuring that beneficiaries are only enrolled in programs for which they are eligible. For example, implement an automated cross-check system that verifies an applicant's enrollment status access both Medicaid and Alliance programs at the time of application and enrollment to prevent simultaneous participation in both programs.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	9
DHCF	10	Implement a process to request and review all prior authorization denials to verify MCO compliance with coverage requirements, identify inappropriate denial patterns, and ensure beneficiaries have appropriate access to needed services.	**Open; Resolved**	Tracking implementation	10

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	11	Implement a systematic review of all appealed and overturned prior authorization cases to identify patterns, ensure proper corrective actions, and verify MCO compliance with appeal decisions.	**Open; Resolved**	Tracking implementation	10
DHCF	12	Develop and implement a comprehensive training plan to ensure all Contract Administrators complete the required Office of Contracting and Procurement training courses within established timeframes.	**Open; Resolved**	Tracking implementation	11
DHCF	13	Establish an internal tracking system to monitor certification status and compliance with any other requirements for all staff serving as Contract Administrators for contracts for and related to MCO administration.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	11
DHCF	14	Develop and implement a documented site visit protocol for all MCOs, including a standardized assessment tool, staffing plan, and tracking mechanism to ensure contractually required readiness assessments are completed before each contract period begins, regardless of an MCO's incumbent status.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	12
DHCF	15	Establish policies and procedures that define when virtual assessments can substitute for in-person visits, specify technology requirements to ensure comparable information collection, and include documentation standards that demonstrate fulfillment of contractual obligations.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	12

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	16	Develop a comprehensive MCO reassessment program that includes annual operational readiness reviews, quarterly performance monitoring, and targeted evaluations when significant changes occur in staffing, systems, or services to ensure continuous compliance with contract requirements and maintain service quality for Medicaid beneficiaries.	**Closed; Unresolved**	Agency will not implement corrective actions and assumes associated risks	12

APPENDIX 3. MANAGEMENT RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

To: Daniel W. Lucas, D.C. Inspector General, D.C. Office of the Inspector General

From: Melanie Williamson, Chief of Staff, D.C. Department of Health Care Finance

Date: August 8, 2025

Re: Draft OIG Report: Medicaid Managed Care Audit (OIG No. 23-1-07HT)

This memorandum responds to the DC Office of the Inspector General's July 10, 2025 Draft Audit Report, entitled "Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations." The audit period of review was Fiscal Year 2023 when the District was contracted with managed care organizations Amerigroup, Amerihealth, MedStar, and HSCSN. The Draft Report contains twelve findings, and sixteen corresponding recommendations. Findings 1-3 highlight the effective oversight frameworks that DHCF has established. Findings 4-12 contain substantive recommendations, and are addressed below. Through this document, DHCF responds to each finding and recommendation, specifying areas of agreement/disagreement, and the estimated date of completion for applicable corrective actions.

I. Oversight and Accountability

a. **Finding 4: Not all DHCF Division Policies and Procedures for Monitoring MCOs Were Complete.** The DC OIG recommends that DHCF develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.

   i. **DHCF Response**: DHCF disagrees in part with this finding.

      1. DHCF's managed care division does in fact has a well-established and documented compliance monitoring program in place, but broader policies and procedures across all divisions could further strengthen the managed care program.
      2. DHCF is reviewing the suite of activities that comprise its managed care compliance monitoring program, and identifying the corresponding policies and procedures that need to be strengthened.
      3. By March 1, 2026, DHCF will have completed the corresponoding updates and additions to its compliance monitoring program.

b. **Finding 5: MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies.** DC OIG recommends that DHCF modify its MCO contracts to comply with 42 C.F.R. Sec. 438.608(d)(3), by specifying the

timeframes and documentation required for payment of overpayment recoveries to the District, where MCO retention is not permitted.

i. **DHCF Response**: DHCF disagrees with this finding.

1. DHCF is already in compliance with 42 C.F.R. Sec. 438.608(d)(3). The applicable contract language states:

   C.5.33.1.6: "The Contractor shall submit *monthly* reports and a comprehensive *annual* report in a format determined by DHCF, on its recovery of overpayments, in accordance with 42 C.F.R. Sec. 438.608(d)(3)," and

   C.5.33.1.7: "The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments.

2. CMS confirmed DHCF's compliance with 42 C.F.R. 438.608(d) at page 9 of its FY 22 Focused Program Integrity Review of the D.C. Medicaid Program Report, available at *https://www.cms.gov/files/document/washington-dc-fy22-focused-pi-review-report.pdf*.

II. Data Management and Reporting

a. Finding 6: DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance.

i. **DHCF Response**: DHCF disagrees with this finding.

1. DC OIG states that "DHCF could not accurately determine whether MCOs reported all identified overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR" and that "without reliable overpayment data, DHCF cannot effectively verify MCOs are identifying and recovering all overpayments."
2. First, it is important to note that the PIMR is fundamentally not a "Financial Reconciliation Report." The function of the PIMR is to consolidate key program integrity activities to facilitate agency utilization review and investigatory priorities. Encounter data validation and reconciliation are conducted on an ongoing basis by the agency through multiple other functions and the PIMR report neither guides, nor is intended to supplant these activities. DHCF, along with its contracted Actuary, have extensively reviewed its data validation activities with the DC OIG.
3. It is incorrect to state that 7,081 transaction control numbers (TCN) were missing from the FY 23 PIMR, and 7,364 TCNs were

missing from the FY 24 PIMR. DHCF showed the DC OIG, in real time, all of the "missing" TCNs. The PIMR is a *retrospective* review, so the TCNs reviewed are for a *historical* period, and will not, by definition, align with *present* encounter data. The PIMR did not "fail" to include applicable TCNs. OIG initially presented DHCF with more than 11,000 TCNs it claimed were missing based on the FY2023 PIMRs. DHCF reviewed and identified all TCNs as being pulled directly from its own MMIS, so it is impossible for those claims to be missing from MMIS. DHCF met with the OIG and presented this data to the OIG, as well as sending OIG data files with all the TCNs showing that they were all present and accounted for in MMIS. DHCF has not been presented with the 7.364 TCNS allegedly missing from the FY24 PIMRs, but DHCF suspects that all those TCNs are from time periods outside of FY23, in which case they will not be found in the FY2023 claims data set that the OIG is running them up against. But they will still be found in MMIS because they come from MMIS.

b. Finding 7: DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting

i. **DHCF Response**: DHCF disagrees with this finding.

1. The DC OIG characterized the following as "inaccuracies" in MCO overpayment reporting that "limit DHCF's ability to effectively monitor these payments," which inflates the impact of largely immaterial data:
    - **a.** One MCO PIMR had TCNs with file formatting that changed the last two digits to 00;
        i. **DHCF Response**: This was a one-time formatting error, whereby Excel "autocorrected" the TCNs to end in 00. Microsoft Excel has a formatting error that occasionally converts all digits greater than 15 to 15 digits, with the remaining digits being replaced by zeroes. The 17 digit TCN number's last 2 digits were therefore converted to zeroes despite the MCO having uploaded the full TCN correctly. Once this issue was identified, DHCF worked with the MCO to timely update the data with the full TCN numbers. This is not a systemic issue.
    - **b.** Another MCO classified all overpayment recoveries as "Waste" and not "Fraud or Abuse;"
        i. **DHCF Response**: This is immaterial for two reasons:
        ii. First, the MCOs do not make the findings of "fraud" or "abuse." Findings of fraud and abuse is determined via a separate process by the Medicaid Fraud Control Unit (MFCU), following a preliminary investigation by DHCF.

iii. Second, in the period reviewed by DC OIG, DHCF considers all of the identified overpayments properly categorized as "waste." The draft OIG Report does not identify any specific overpayment recoveries that it believes are nonetheless misclassified, so DHCF is unable to provide a further substantive response to the alleged errors.

c. There were instances where (PIMR) TCNs had dates outside of FY23.

i. DHCF Response: Since DHCF Program Integrity division (DPI) audit activities are retrospective, there will always be TCNs in the PIMR that are outside of the present fiscal year. This is by design.

III. Program Integrity and Fraud Prevention

a. **Finding 8: DHCF Can Strengthen its Fraud Referral Processes to the MFCU.** The DC OG states that "DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars."

i. DHCF Response: DHCF disagrees with this finding.

1. DHCF has a written fraud referral policy and procedure that is based on, and consistent with, federal regulatory requirements. *See* 42 C.F.R. Sec. 455.12 *et. seq*. This document has previously been provided to the OIG. DPI has an investigations branch that conducts preliminary investigations, consistent with 42 C.F.R. Sec. 455.14, to determine if credible allegations of fraud exist, and the payment suspension committee then convenes, consistent with our written policy and federal regulations, to determine if referral to law enforcement is justified under 42. C.F.R. Sec. 455.23. This framework is structured and effective.
2. It is unclear from the DC OIG, how it suggests DHCF can improve its MCO fraud referral procedure. The fraud referral procedure is a stand-alone procedure, distinguished from other monitoring activities, such as overpayment review. The fraud referral procedure has been reviewed, in real time, with the MCOs during a dedicated meeting. The fraud referral procedure, which was provided to the DC OIG, includes:

a. Potential Provider Fraud and Abuse Referral Document Form;

b. Potential Provider Fraud and Abuse Referral Web Portal Form;

c. Assignment of a referral number from DHCF

3. Upon receipt of a MCO fraud referral, DHCF initiates its regulatorily required "preliminary investigation" to determine the credibility of the referral. If credible, then DHCF refers the matter to the MFCU. In addition, this finding fails to acknowledge activities undertaken by DHCF since FY2023 that are directly relevant to this finding. For example, OIG was informed of comprehensive trainings conducted by DHCF with each of the MCOs individually in FY24 that focused on properly classifying investigations as fraud/waste/abuse, instructed the MCOs on how to improve their internal investigations to identify additional fraud, and have resulted in significantly higher fraud referrals during this current FY. It is unclear to DHCF whether the activities taken since the review period OIG examined are sufficient to address OIG's concerns or, if they are not, how it failed to address those concerns.
4. The DC OIG's reference to the total number of fraud referrals in FY 23 is also incorrect, stating that "DHCF made 145 [fraud] referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between MCO and non-MCO sources. This is incorrect, in FY 23 DHCF initiated 31 preliminary investigations, and referred 7 credible allegations of fraud to the MFCU. The "145" fraud referrals cited by the DC OIG is incorrect. In FY23, DHCF-DPI had 131 open investigations, inclusive of cases that had been opened in prior years and had not been closed due to ongoing activities, ongoing law enforcement investigations, or other reasons. Of those 131 cases, 7 cases were referred to the MFCU after DHCF determined that, pursuant to 42 C.F.R. section 455.23, credible allegations of fraud existed. None of those cases were MCO initiated investigations.
5. Regarding the alleged misclassification of waste, crucially, the OIG has not presented any evidence of improper classifications by the MCOs beyond the fact that one MCO classified all items on the PIMR as waste. Waste is a distinct and valid classification. Absent evidence that the classifications at issue were improper, DHCF cannot agree with the claim that misclassifications were made.
6. Lastly, all managed care network providers are required by federal law to be concurrently enrolled with the State Medicaid Agency. This means that every single managed care network provider, is also enrolled with DHCF. When DHCF develops its investigatory strategic plan, all enrolled providers are subject to review-managed care network providers are not excluded. DHCF determines its investigative priorities based on consideration of several factors, including but not limited to, aberrant utilization trends, or provider types/categories of services federally identified as high risk. Managed care network providers are absolutely not

without oversight from DHCF- they are subject to,and not excluded from the scope of fraud investigations.

b. Finding 9: DHCF's Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs

ii. DHCF Response: DHCF disagrees with this finding.

1. It is unclear the sample, methodology, or data fields that were used by the DC OIG to conclude that "18/60" individuals had dual enrollment in the Alliance and Medicaid enrollment for periods ranging from two to twelve months. As was explained at length to the DC OIG, material to determining impermissible dual program enrollment, is to verify whether there are any "voided spans" during the subject enrollment period. Periods of apparent "dual enrollment, should be verified by checking if there is a corresponding "void span" in the District's Medicaid management Information System (MMIS), that retroactively voids enrollment in one of the two subject programs due to dispositive information received subsequent to initial enrollment. For example, if an individual is enrolled in the Alliance Program from July 2023-September 2024, and at any time during this enrollment period, DHCF receives citizenship information that qualifies them for Medicaid, then the eligibility and enrollment system sends an automatic update to the claims processing system that "voids" the entirety of the Alliance span, and replaces it with a Medicaid span for the subject period. During DHCF's multiple meetings with the DC OIG, it repeatedly explained that the "voided span" data field must be considered in order to validate any conclusion of duplicate enrollment. It does not appear that the DC OIG reviewed the "voided span" data at all. In the absence of this information, it is inaccurate to conclude that an individual had duplicate enrollment.

IV. Health Care Access and Service Delivery

a. Finding 10: Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access

i. DHCF Response: DHCF disagrees with the methodology underlying this finding. The DC OIG's calculations are incorrect. DHCF agrees to develop a process to review a representative sample of managed care prior authorization denials and appeals, on a periodic basis.

1. DC OIG states that in FY23, there were 19,327 denials out of 38,958 requests. However, of the 19,327 "denials," 12,674 were for services categorically not covered under the D.C. State Plan for Medicaid. There is no basis to request a prior authorization for a non-covered service. Prior authorizations are only available for denied covered services. Further, 288 "denials" were either subsequently approved, or the request was withdrawn. Therefore, the 12,674 requests for non-covered services, and 288 approved or withdrawn requests should also be excluded from the total

"denials." Properly excluding these cases 12,962 cases, yields a denial of 6,365 out of 38,958 requests, or a 16% denial rate, rather than the incorrect 50% rate asserted in the Draft Audit Report.

2. DHCF agrees to strengthen its health care access oversight by implementing a process to review, on a periodic basis, a representative sample of denied and appealed cases to identify potential, data supported access barriers for covered services. Estimated Completion Date: March 1, 2026.

b. Finding 11: DHCF Contract Administrators Did Not Complete Certification Requirements

i. **DHCF Response**: DHCF disagrees with this finding.

1. The subject Contract Administrators were previously certified and were unable to complete recertification requirements only due to lack of availability of OCP training for recertification. DHCF was unable to comply during the period of review due to reasons outside of its purview.

2. The D.C. Office of Contracts and Procurement (OCP) exclusively administers Contract Administrator (CA) training for applicable District employees. OCP did not make the applicable CA training available for District employees, during the period of review, which precluded timely completion of recertification.

3. Once the training became available, all CAs promptly enrolled and have since completed their recertification.

c. Finding 12: Finding 12 – DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs.

i. **DHCF Response**: DHCF disagrees with this finding.

1. All readiness reviews were completed within required timeframes and in accordance with 42 CFR § 438.66 (1)(2)(3)(4).

2. During the specific period of review in this audit, only 1 MCO, Amerigroup, which was newly procured and absent from the program for 3 years, required a readiness review.

3. Amerigroup's readiness review was completed in accordance with 42 CFR § 438.66 (1)(2)(3)(4). HSCSN, AmeriHealth, and MedStar were not subject to additional mandatory readiness reviews, as they were not newly contracted MCOs. The reviews had been completed prior to the period of review at issue in the audit.

REPORT WASTE, FRAUD, ABUSE, AND MISMANAGEMENT

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