Department of Health Care Finance
DHCF *(HT)*

MISSION

The mission of the Department of Health Care Finance is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia.

SUMMARY OF SERVICES

The Department of Health Care Finance (DHCF), an agency established in FY 2009, provides health care services to low-income children, adults, the elderly and persons with disabilities. Over 200,000 District of Columbia residents (nearly one third of all residents) receive health care services through DHCF's Medicaid and Alliance programs. DHCF strives to provide these services in the most appropriate and cost effective settings possible.

ACCOMPLISHMENTS

✓ Expanded Medicaid coverage to non-elderly childless adults from 134% to up to 200% of the Federal Poverty Level (FPL).

✓ DHCF received over $9 million in federal grants to support health care reform implementation in the District. Specifically, the District received:

- $1 million under the Affordable Care Act's (ACA) State Planning and Establishment Grants for Health Insurance Exchange planning;;
- $149,880 under the ACA's Consumer Assistance Program Grants; and
- $8,200,716 under the ACA's Level One Health Insurance Exchange Establishment grant.

✓ DHCF implemented an Administrative Services Organization to support public provider billing for Medicaid services.

OVERVIEW OF AGENCY PERFORMANCE
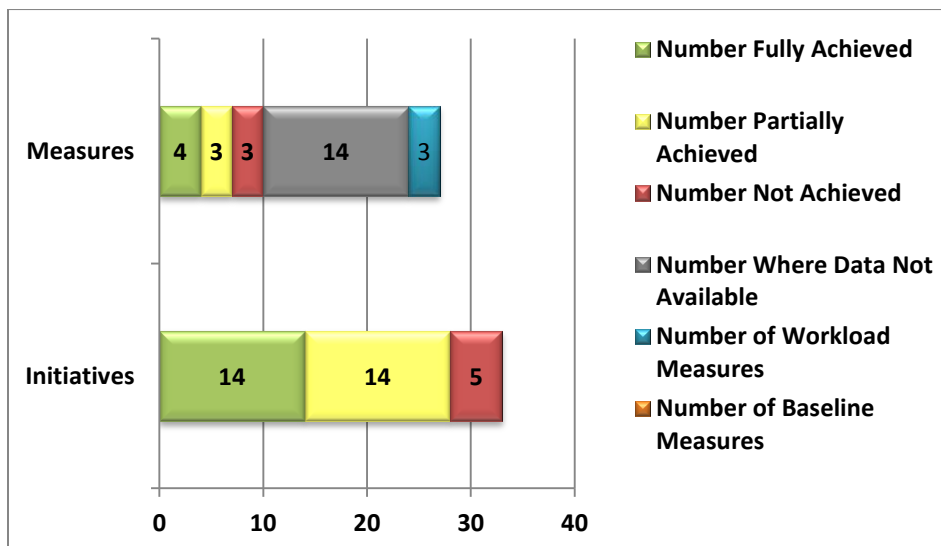
Performance Initiatives – Assessment Details

Performance Assessment Key:

🟢 Fully achieved   🟡 Partially achieved   🔴 Not achieved   ⚪ Data not reported

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Office of the Director

OBJECTIVE 1: Increase access to care for District residents.

🟢 **INITIATIVE 1.1: Coordinate with sister agencies on development and implementation of Health Care Reform initiatives.**

DHCF continues to coordinate with sister agencies on the development and implementation of Health Care Reform Initiatives. The Director of DHCF chairs the District's Health Reform Implementation Committee (HRIC), which is comprised of the Departments of Health, Mental Health, Human Services, Disability Services, and Insurance, Securities, and Banking. The HRIC is the primary vehicle for coordinating health reform implementation activities in the District. The HRIC is organized and operates through standing subcommittees: Eligibility and Medicaid Expansion; Insurance; and Health Delivery System. An additional sub-committee on Communications and an IT workgroup has also been established. The HRIC meets on a monthly basis and is tasked with making recommendations to the Mayor on implementation of the PPACA.

🟡 **INITIATIVE 1.2: Develop and implement outreach strategies.**

In FY2011, DHCF expanded and directed outreach to providers, beneficiaries, advocates and stakeholders. The use of social media has provided an immediate information resource. DHCF is present on Facebook, Twitter and LinkedIn. DHCF's has increased its output on the DHCF homepage to provide timely press releases, links to DHCF testimonies, DHCF reports and links to information on health care reform. Additional links have been added to the DHCF homepage which provides immediate access to information about the Office of the Ombudsman and the DC Medical Care Advisory Committee.

Specific outreach strategies undertaken include: launching a dedicated website for the Office of the Health Care Ombudsman and Bill Rights; hosting quarterly Managed Care Community Forums; and monthly EPD Waiver Provider meetings. DHCF organized and presented information on Health Care Reform at monthly public meetings under the auspices the Mayor's Health Reform Implementation Committee. DHCF disseminated flyers and postcards to incentivize beneficiary use and participation in preventive health services. DHCF worked with three firms to carry out comprehensive outreach, communications and social marketing to increase awareness of DHCF services.

OBJECTIVE 2: Design and implement health information exchange initiatives.

🟡 **INITIATIVE 2.1: Integrate and operate Patient Data Hub.**

In FY 2010 DHCF implemented the Patient Data Hub (PDH), funded through a Medicaid Transformation Grant from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The grant is intended to foster the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Through the initial contractor for the Patient Data Hub (PDH), DHCF has established the Patient Data Hub platform and has tested it and linked it to the Medicaid Management Information System (MMIS).

The initial contractor made the decision to phase out support for the technology platform used in the PDH. DHCF therefore had to determine how to leverage the current platform and enable it to interoperate with the DC RHIO and the planned DC HIE. DHCF Applied for a second 12 –month no-cost extension from CMS to be able to recruit another vendor who would do the refresh and implement a linkage to the DC RHIO; however, the no-cost extension was not approved. DHCF is reviewing its options regarding the disapproval. The PDH does not interoperate with the DC RHIO because the DC RHIO shut down in the fall of 2011.

● **INITIATIVE 2.2: Develop District-wide Health Information Exchange.**
Over the past year, the District has had the challenge of getting on track several initiatives including the DC HIE Development Program, the Electronic Health Records Incentive Program and the Health Insurance Exchange Program, all of which are being spearheaded by the Department of Health Care Finance. In response to this challenging opportunity, the DC HIE program management office (PMO) was established during the first quarter of FY2012. A Program Manager was hired and other PMO positions are being staffed on an interim basis by other Agency employees. The remainder of full-time program office positions is currently being recruited.

The District will develop the infrastructure, services, and a governance framework that will enable the implementation of the ONC National Health Information Network (NHIN) Direct specification as a secure method for point-to-point exchange of clinical and other patient information. The initial focus of the Direct-compliant DC HIE will be the implementation of core HIE services such as e-prescribing; structured lab reporting; and patient care summaries. These core services are consistent with the ONC PIN requirements and are coincident with HHS meaningful use (MU) requirements as well. DHCF has identified two key initial implementation steps and several near-term milestones and will continue its work on the HIE.

● **INITIATIVE 2.3: Implement Medicaid Electronic Health Record Incentive Payments Program.**
Under American Recovery and Reinvestment Act funding, states are awarded funds to manage a multi-year program providing incentive payments to Medicaid providers for adoption, implementation and meaningful use of certified electronic health records (EHRs). The program requires states to develop a State Medicaid HIT (Health Information Technology) Plan (SMHP) which sets out the baseline environment, the objectives for EHR adoption and the processes and policies by which incentive payment will be made. Development of the State Medicaid HIT Plan (SMHP) was completed and approved by CMS. This SMHP defines DHCF's approach to administering the Medicaid EHR incentive payments. For the District's SMHP, the document discloses DHCF's vision and process for implementing, administering and overseeing key aspects of the program and describes the Roadmap that will take DHCF from the present/prior to the EHR Incentive Program ('As-Is') to the DHCF's future HIT vision ('To-Be').

A technical and business process solution services vendor is being sought through a solicited bidding process to assist in developing the program solution. The selected vendor will develop an automated, web-based application tool and provide various operational support functions for the Medicaid EHR Incentive Program. The selected vendor will also manage day-to-day operations and will coordinate those operations with DHCF staff.

OBJECTIVE 3: Improve health outcomes for District residents.

🟡 **INITIATIVE 3.1: Improve birth and perinatal outcomes in the Medicaid program.**

2011 marks the third year in a multiyear initiative, called the Perinatal Collaborative, to improve the health of babies born to mothers in the Medicaid program. This initiative is a DHCF collaboration with Chartered Health Plan, Health Services for Children with Special Needs, Inc. (HSCSN), United Health Plan, George Washington University, the Department of Health, health care providers, and other experts in health care and health care quality improvement. Performance is calculated and reported annually, as the number of adverse outcomes per 1,000 pregnancies and infants. In FY 2011, the District's Managed Care Organizations (MCOs) individually undertook initiatives to track each pregnant woman with known risk factors for adverse outcomes and provide needed follow up and case management. The Collaborative maintained the improvement shown in Calendar year 2010, but did not show further improvement. The web resources to be developed during FY 2011 did not occur because of the very high vacancy rate in the Division of Quality and Health Outcomes for much of FY11.

🔴 **INITIATIVE 3.2: Launch a resource website for case managers and perinatal providers.**

As part of the Perinatal Collaborative to reduce adverse birth outcomes, DHCF anticipated launching a resource guide website for health plan case managers and other medical care providers. However, web resources to be developed during FY 2011 did not occur because of the very high vacancy rate in the Division of Quality and Health Outcomes for much of FY11.

🔴 **INITIATIVE 3.3: Reduce adverse outcomes for people with chronic illnesses.**

2011 marks the third year of a multiyear initiative, the Chronic Care Initiative, to improve the health of people with serious chronic illnesses. The goals of this collaborative are to reduce the rates of emergency room visits and hospital admissions by individuals with asthma, diabetes, high blood pressure, and congestive heart failure. Performance is calculated and reported annually, as the number of adverse chronic disease outcomes per 1,000 individuals with asthma, high blood pressure, diabetes and congestive heart failure. The Chronic Illness Collaborative did not achieve its goal in FY 11, due in large part to a high vacancy rate in the Division of Quality and Health Outcomes for much of FY11.

🟡 **INITIATIVE 3.4: Produce a Consumer Report Card to facilitate beneficiary choice in managed care.**

In FY 2009, DHCF developed a managed care report card, with reporting requirements for Medicaid managed care plans beginning in FY 2010. Foremost, the report card is intended to be a tool that adult Medicaid and Alliance beneficiaries and parents or guardians of children can use to help choose a managed care organization (MCO). Data on the report card includes information on: patient satisfaction; access to specialist doctors; how well patient care is managed; customer service; how well each plan met national quality standards; and how often each plan meets quality standards for specific health conditions. The 2010 report has been drafted and will be published in 2012.

🔴 **INITIATIVE 3.5: Implement a quality improvement strategy for nursing facilities.**

In FY 2010, DHCF developed a formal quality improvement strategy for nursing facility care.   Four strategies were outlined in this strategy and DHCF anticipated implementing the first three in FY 2011. The three strategies include: 1) initiate provider-specific feedback and dialogue between DHCF and individual nursing facilities regarding areas for improvement; 2) create a nursing facility report card; and 3) create a focused nursing home quality improvement initiative. However, due to

a high vacancy rate, the three strategies were not implemented. DHCF will move forward on implementation in 2012.

● **INITIATIVE 3.6: Create and implement a Patient Safety Program.**
In FY 2011, DHCF developed a draft patient safety program policy and procedure (P&P) for DHCF providers to improve health care outcomes for beneficiaries by identifying and reducing Patient Safety Events (PSEs) and specifying how to respond to adverse patient events that occur in all DHCF programs/services.

OBJECTIVE 4: Ensure limited resources are utilized appropriately.
● **INITIATIVE 4.1: Strengthen strategies to prevent provider fraud and abuse.**
In Fiscal Year 2011, DHCF fortified policies and procedures targeted at preventing fraud and abuse among Medicaid home health services providers. Specifically, DHCF published a proposed rule to strengthen the delivery of personal care aide (PCA) services delivered by home health care agencies. These rules proposed to require a preexisting relationship between beneficiaries and their primary care physicians or advanced practice registered nurses before a PCA prescription can be provided; setting standards for staffing agencies that contract with home health agencies for the delivery of PCA services; expanding the requirements governing National Provider Identification (NPI) numbers in conjunction with the new federal standards; and amending the notice requirement for discharges to comply with federal and District law governing advance notice. The final rules will be published in Fiscal Year 2012. In addition, DHCF consulted with the Department of Health in the development of proposed rules governing the licensing of home health agencies.

DHCF also changed the way in which PCA services are ordered to have them first prescribed by a physician using a standard form that requires the physician to give the diagnosis and functional limitations in Activities of Daily Living (ADL) necessitating the need for PCA services, and then assessed for the need by HHA.   DHCF also adopted a new assessment tool to be used to better determine exactly how many hours of PCA services a beneficiary requires. DHCF adopted a new care plan form for PCA services this past fiscal year. In addition, DHCF clarified policies and procedures governing the prior authorization process for PCA services requested in excess of 1040 hours per year. This revision means that there is a stronger clinical review of the prior authorization request process. Finally DHCF published a transmittal for home health providers and prescribers reminding them of existing policies and instructing them on new procedures (such as the use of a new prescriber form, assessment tool and care plan).

● **INITIATIVE 4.2: Conduct provider training on False Claims Act.**
The federal False Claims Act permits a person with knowledge of fraud against federal programs such as Medicaid to file a lawsuit against the entity that committed the fraud. If the action is successful, the plaintiff is rewarded with a percentage of the recovery. This training will reinforce DHCF's efforts to identify fraudulent billing before it occurs. Training was postponed in FY11 due to a high vacancy rate. DHCF will work with our law enforcement providers to develop training for the False Claims Act in Fiscal Year 2012 for DHCF staff and explore various avenues to train Medicaid providers.

● **INITIATIVE 4.4: Increase access to and appropriate use of medications via the Right Rx Initiative.**
Right Rx is a joint initiative of the District of Columbia Medicaid Pharmacy and Therapeutics (P&T) Committee and Medicaid Drug Utilization Review (DUR) Board that seeks to improve the usefulness of drug utilization review initiatives and to steer prescribing habits towards medications on the

District's Fee-for-Service Medicaid Preferred Drug List. The program was initiated in FY 2010 and seeks to ensure cost-effective pharmaceutical care for Medicaid beneficiaries. In FY 2011, the Right Rx Initiative provided electronic access to a list of preferred medications that do not require prior authorization. The Preferred Drug List, prior authorization forms, evidence-based guidelines, and dosing/class conversion assistance were made available online to ensure prescribers can access these resources quickly. The Preferred Drug List is also available via ePocrates[TM] medical software for free downloading to a prescriber's or pharmacist's Personal Digital Assistant (PDA). The two drug categories that have been covered initially are Long Acting Narcotic Analgesics and new oral Hepatitis C medications.

Outreach to major stakeholder organizations on the Right Rx Initiative included the Medicaid Care Advisory Committee (MCAC), District of Columbia Boards of Medicine and Pharmacy, District of Columbia Primary Care Association (DCPCA) and the Unity Health Care Clinics, chain and independent pharmacy associations. A portal for communication with DHCF program managers via the website for ongoing provider communication regarding prescription drugs is anticipated to be operational in FY2012.

- **INITIATIVE 4.5: Execute new Utilization Management Contract.**
  DHCF is still in the process of awarding a new Utilization Management contract. The RPF was released in November 2011 and DHCF expects to make an award in 2012. Through the utilization of concurrent, prospective, and retrospective reviews, the contractor will monitor the performance and quality of care offered by the District's Medicaid providers. Additionally, the contract will have a refined scope of work that will address fraud and abuse issues more extensively than in prior utilization management contracts. The Contractor will be certified by CMS as a Quality Improvement Organization (QIO), meaning that 75 percent of the contract cost can be federally funded.

Health Care Policy and Planning Administration

OBJECTIVE 5: Develop policies, plans and data to enable effective program administration and utilization of resources.

- **INITIATIVE 5.1: Improve eligibility policy and operations**.
  During FY 2011, DHCF continued to work with DHS's Economic Security Administration (ESA) to update and refine systems to accurately document beneficiary eligibility and ensure designations conform to State Plan and other relevant regulations and statutes. ESA is the entity that is responsible for determining eligibility for the District's medical assistance programs. One of the key priorities during FY 2011 was the development and implementation of new Alliance recertification rules. Changes to these rules ensured beneficiaries who are Medicaid eligible are enrolled in the Medicaid program, thus maximizing the District's use of Federal Medicaid funding. In addition, these new rules further ensure that all participants in the Alliance program have proof of District residency and participate in an in-person interview. Additionally, DHCF, in collaboration with the Social Security Administration (SSA), held an Optional States Supplemental Payment Program Training, a program administered and managed by DHCF for all participating District agencies. The training ensured agencies understanding of the program and enrollment processes to include SSA's and DHCF's roles.

● **INITIATIVE 5.2: Improve data collection, aggregation and analysis to better understand the populations served and inform policy decisions.**
The Division of Research and Rate-Setting Analysis, which grew from two to five members in FY11, effectively used the Medicaid Management Information System (OmniCaid) to conduct several analyses that informed program decisions. The analyses focused on a number of topics ranging from waiver programs to service utilization. In addition to these larger scale analyses, the Division has established itself as a resource for internal and external stakeholder questions regarding the populations served and data analysis.

● **INITIATIVE 5.3: Develop and implement a strategy for reimbursement of school-based health services provided by non-public schools.**
In FY 2011, DHCF collaborated with OSSE and DCPS to develop a reimbursement strategy to ensure the reimbursement of school-based health services provided to Medicaid-enrolled children in non-public schools that is in compliance with the new SPA. This collaboration will continue into FY12. The Health Care Policy and Research Administration continues to work closely with OSSE, DCPS and other agencies to provide training and technical assistance to ensure that correct Medicaid billing procedures are followed.

● **INITIATIVE 5.4: Maximize federal funding for substance abuse services for adults.**
During FY 2011, DHCF worked with the Department of Health's Addiction Prevention Recovery Administration (APRA) to develop a reimbursement strategy to allow Medicaid payment for substance abuse services provided to Medicaid enrolled adults. The new SPA establishes "Adult Substances Abuse Rehabilitative Services (ASARS), a new class of Medicaid reimbursable services intended to reduce or ameliorate substance abuse and substance dependence. Services provided under the SPA include assessment and diagnosis, clinical care coordination, crisis intervention, substance abuse counseling, medically managed intensive inpatient detoxification, medication management and medication assisted treatment. The ASARS SPA was submitted to the Centers for Medicare and Medicaid Services and is pending approval. In the meantime, an interagency task force has been working to prepare for implementation of the SPA. DHCF anticipates that the SPA will be approved and implemented in FY12.

OBJECTIVE 6: Support District-wide Health Reform Initiatives.
● **INITIATIVE 6.1: Maximize Federal Disproportionate Share Hospital (DSH) resources.**
DHCF received approval from the federal Centers for Medicare and Medicaid Services (CMS) in November 2011 for a waiver to expand Medicaid coverage to low-income District adults ages 19-64 above 133% to 200% of the federal poverty level. The waiver reallocates Disproportionate Share Hospital (DSH) funds from District hospitals to help improve health care coverage of District residents. The waiver allows the District to move a selected population out of the locally-funded Alliance program and into Medicaid, thereby improving beneficiaries' coverage and shifting spending form 100% local funds to 30% local funds/70% federal funds. The waiver was implemented in FY11.

● **INITIATIVE 6.2: Evaluate health care reform demonstration project opportunities.**
DHCF has evaluated various funding opportunities and demonstrations authorized by the Federal health reform legislation. During FY 2011, DHCF pursued and was awarded a CMS grant in the amount of $336,000 to fund planning activities for health homes in the District. In addition, DHCF submitted a proposal for the IMD Waiver demonstration. This application is still pending decision by CMS. DHCF also evaluated opportunities for funding for coordination of services for dual eligibles and for several programs designed to support rebalancing of long-term care program and services.

OBJECTIVE 7: Improve access to high quality services and improve resource management.

● **INITIATIVE 7.1: Implement a Redefined Personal Care Aide (PCA) Benefit.**
In January of 2011, DHCF revised the plan to implement a redefined Personal Care Aide (PCA) benefit. DHCF developed and implemented an initiative to reform the delivery of this benefit through use of more sensitive and specific methods, including physician authorization, adopting a new assessment tool, adopting a new care plan form, clarifying policies and procedures, and sending transmittals to health home providers and prescribers.

● **INITIATIVE 7.2: Submit and begin implementation of second Money Follows the Person operational protocol amendment.**
DHCF continued its work with the Department of Mental Health on a Money Follows the Person (MFP) Operational Protocol Amendment that includes people with mental health diagnoses/serious mental illness who will transition from nursing facilities, St. Elizabeth Hospital, and psychiatric residential treatment facilities (PRTFs) to smaller homes in the community. Submission of the amendment is pending the development of comprehensive community-based supports for youth transitioning from PRTFs. In an effort to model nationally recognized promising practices for transitioning youth from PRTFs and supporting them in the community, the Demonstration and DMH staff participated in national peer to peer "mental health workgroups" convened for MFP grantees and received DC-specific technical assistance from the National Technical Assistance Center for Children's Mental Health Georgetown University Center for Child and Human Development.

The MFP Demonstration researched the number of people residing in its pilot nursing home transition group who received a positive Preadmission Screening and Resident Review (PASRR) for mental illness. While the outcome indicated a low incidence of positive PASSR screens for mental health diagnoses, over the course of transitioning residents during FY 11, it was determined that the overwhelming majority of the residents who are participating in the MFP EPD pilot require community-based mental health supports once they leave the nursing home. MFP Transition Coordinators and nursing home social workers collaborate with DMH to coordinate and provide these community-based mental health supports.

● **INITIATIVE 7.3: Implement Participant-Directed Care.**
The District of Columbia, in the renewal of the 1915 (c) Elderly and Physically Disabled (EPD) waiver, plans to implement and operationalize participant-directed services. The new waiver was effective January 4, 2012.   The following participant-directed services are included in Waiver Year 2: participant-directed goods and services and participant-directed personal care—that beneficiaries who choose to participant direct may access. DHCF postponed the implementation of PDS to the new waiver period to provide the necessary time for planning and implementation.

● **INITIATIVE 7.4: Implement technology solutions to support the Office of the Health Care Ombudsman.**
During FY 2011, the Office of Healthcare Ombudsman began the process of implementing a technology strategy to support the Office's operation. The Office commenced using the available federal technology to input commercial and all other types of cases into its database. However, the Office was not able to integrate both the EXCEL data format with the HHS's format. The Office created a Healthcare Ombudsman's website that is accessible to the residents of the District of Columbia. The website is also positioned and accessible on the DHCF's website and the District's Health Reform website. In addition, the Office created a Healthcare Ombudsman's email address

that is accessible government-wide, and by community, and external stakeholders. The Office will continue to address policies, procedures, and other specific technology solutions. The Office of Healthcare Ombudsman will also continue to work with sister agencies, including the Office of the Chief Technology Office (OCTO) on planning and implementation of its technology strategic planning.

INITIATIVE 7.5: Establish formal relationships with Medicare Special Needs Plans (SNP) serving District residents dually enrolled in Medicare and Medicaid.

The District does not currently engage in any data sharing or capitation arrangement with Medicare Special Needs Plans (SNPs) serving the District Medicaid beneficiaries who are dually enrolled in Medicare and Medicaid. SNPs were established by the Centers for Medicare and Medicaid Services (CMS) as a managed care plan to serve special populations, with the goal of improving coordination and continuity of care. DHCF is actively exploring SNPs interested in serving District residents. A contract between DHCF and participating SNPs will ensure the plans are held accountable for service delivery and quality for District beneficiaries per CMS regulations, as well as ensure the District is in compliance with the CMS guidance that requires the contracts. This initiative will provide better coordination of care and enhanced benefits for District residents dually enrolled in Medicare and Medicaid.

INITIATIVE 7.6: Implement regulatory changes to improve the quality of services provided by home health care agencies.

In FY 11, DHCF published a proposed rule to strengthen the delivery of personal care aide (PCA) services delivered by home health care agencies. These rules proposed to require a preexisting relationship between beneficiaries and their primary care physicians or advanced practice registered nurses before a PCA prescription for services can be provided; setting standards for staffing agencies that contract with home health agencies for the delivery of PCA services; expanding the requirements governing National Provider Identification (NPI) numbers in conjunction with the new federal standards; and amending the notice requirement for discharges to comply with federal and District law governing advance notice. The final rules will be published in FY12. In addition, DHCF consulted with the Department of Health in the development of proposed rule governing licensed home health agencies.

INITIATIVE 7.7: Improve provider education on Health Check/EPSDT benefit.

HealthCheck is the program DHCF uses to provide the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit as mandated by the federal government. EPSDT encompasses the preventive care and screening health care services provided to children under the age of 21. Periodic provider training is required to ensure that HealthCheck providers are knowledgeable about the benefit, requirements, and recommendations of the DC periodicity schedule. In May 2011, with support and technical assistance from Georgetown University, DHCF and the MCOs launched a re-vamped and revised website to improve the HealthCheck training system. This system is monitored and updated regularly by Georgetown University, and now provides an on-line provider training module for pediatric providers to complete their EPSDT training requirements. Providers were informed through DHCF and MCO communications of this new resource.

OBJECTIVE 8: Improve the efficiency of program operations.

● **INITIATIVE 8.1: Certify the District's new Medicaid Management Information System (MMIS).**

In FY11, DHCF and ACS worked to complete the checklists required for certification. During this process, DHCF identified defects in the MMIS that had to be corrected to meet the CMS certification requirements. DHCF also worked with ACS to reprocess any claims that were incorrectly adjudicated because of these defects. CMS was on site in August for the certification review and the feedback at the exit conference was very favorable. CMS notified DHCF in December 2012 that the MMIS met the certification requirements.

● **INITIATIVE 8.2: Improve provider payment efficiency.**

In FY 2010, DHCF created a provider relations unit to help providers with issues related to claims submission or payment. The Division of Public and Private Provider Services works with other areas within DHCF and DC Government to implement new provider programs. During FY 2011, the Division continued to assist in facilitating paperless programs, such as electronic remittance advices and payment via electronic funds transfer (EFT). In FY11, DHCF increased the percentage of active providers receiving their payments electronically to 34%.

● **INITIATIVE 8.3: Implement an Administrative Services Organization (ASO).**

DHCF has contracted with an Administrative Services Organization (ASO) to create a system that will ensure claims are submitted accurately, timely, and with all supported documentation and appropriate validations to pass future audits. Currently, the ASO system is operational and accepting claims from DCPS and CFSA. During the month of September, the ASO has validated more than 7,000 claims for DCPS and nearly 600 claims for CFSA Healthy Horizons Clinic. The ASO team is currently working with OSSE on finalizing operational issues to ensure they can begin claiming for specialized transportation services. The ASO will begin working with additional agencies in FY12.

OBJECTIVE 9: Expand Access to High Quality Health Care.

● **INITIATIVE 9.1: Ensure access to a High Risk Pool for District Residents**

The Patient Protection and Affordable Care Act directs the federal Department of Health and Human Services (HHS) to fund high risk pools in every state. The high risk pool provides a coverage option for District residents who are uninsured and have a pre-existing health condition that has prevented them from obtaining health insurance coverage. After exploring the feasibility of a District-run program, DHCF informed HHS that it would join the 23 participating states utilizing the federal option. The program is administered by GEHA, a health insurance carrier under contract with the HHS. Coverage through the PCIP for District residents became available beginning October 1, 2010.

● **INITIATIVE 9.2: Conduct Planning Activities for Health Insurance Exchange Implementation**

In September 2010, DHCF was awarded a $999,999 grant to support the planning of the HIX under a State Cooperative Agreement with HHS. Using this grant funding, DHCF entered into a consulting contract with Mercer Government Human Services on April 14, 2011. Under this contract, Mercer conducted extensive planning and research around the nine core areas outlined in the HHS funding requirements. Since engaging Mercer, a series of HIX stakeholder and town hall meetings has been held throughout the District. These meetings provided an opportunity to engage stakeholders in meaningful outreach and dialogue, in order to represent their perspectives in the planning process. Stakeholders were also provided with an HIX survey that was accessible online and at DHCF, DHS and DISB.

In August of 2011 the District was awarded $8.2 million under the Level I Establishment Grant Program to further plan for the health insurance exchange. This grant will fund the requirements process for the Exchange IT system, as well as additional work related to the various functions of the Exchange.

Key Performance Indicators – Details

Performance Assessment Key:

⬤ Fully achieved   ⬤ Partially achieved   ⬤ Not achieved   ⬤ Data not reported   ⬤ Workload Measure

		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
⬤	1.1	Percent of District residents uninsured	6.2	6.2		6.2	100%	AGENCY MANAGEMENT PROGRAM
⬤	1.2	Number of District residents covered by Medicaid (Year End)	0	0		204,947		AGENCY MANAGEMENT PROGRAM
⬤	1.3	Number of District residents covered by Alliance (Year End)	0	0		23,711		AGENCY MANAGEMENT PROGRAM
⬤	3.1	QI Initiative 1: Adverse Perinatal Outcomes per 1,000 pregnancies and infants	0	220		Data not available		HEALTHCARE ACCOUNTABILITY
⬤	3.2	QI2: Adverse Chronic Disease Outcomes per 1,000 people with asthma, diabetes, hypertension and congestive heart failure	0	475		Data not available		HEALTHCARE ACCOUNTABILITY
⬤	3.3	HEDIS measure for childhood immunization	0	85		Data not available		HEALTHCARE ACCOUNTABILITY
⬤	3.4	HEDIS measure for timeliness of prenatal care	0	75		Data not available		HEALTHCARE ACCOUNTABILITY
⬤	3.5	Adults' access to preventive/ambulatory care services (adults aged 20-44, enrolled in health plans)	0	85		Data not available		HEALTHCARE ACCOUNTABILITY
⬤	4.1	Number of referrals to the Medicaid Fraud Control Unit (MFCU)	0	25		22	88%	HEALTHCARE ACCOUNTABILITY

		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
⚪	4.2	Total Recovered from provider audits (Local and Federal funds)	0	6.5		Data not available		HEALTHCARE ACCOUNTABILITY
🟢	4.3	Total recovered from Third Party Liability (TPL)	0	7		$7.10m	101.43%	HEALTHCARE ACCOUNTABILITY
🔵	6.1	Number of adults in new 1115 waiver	0	3,000		3,102		HEALTHCARE POLICY AND PLANNING
⚪	7.1	Number of participants in Elderly and Physically Disabled (EPD) Waiver (Year End)	0	2,250		3,940		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.2	Average number days to process EPD waiver application	0	30		Data not available		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.3	Number of participants in DD Waiver (Year End)	0	1,300		1,421		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.4	Number of beneficiaries in out-of-state nursing facilities	0	165		307		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.5	Number of beneficiaries in ICF/MRs	0	350		370		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.6	Number of individuals moved from institutions to community	0	100		24		HEALTHCARE DELIVERY MANAGEMENT
⚪	7.7	Percent Medicaid beneficiaries satisfied with their health plan	0	77		Data not available		HEALTHCARE DELIVERY MANAGEMENT
🟡	7.8	Number of consumers served by Ombudsman	0	4,400		3,313	75.30%	HEALTHCARE DELIVERY MANAGEMENT
🟡	7.9	Average number of days to resolve issues brought to Ombudsmans	0	2		2.5	80%	HEALTHCARE DELIVERY MANAGEMENT

		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
🟢	7.1	Reported complaints (including missed/late trips) on transportation broker services, per 1,000 trips	0	2.5		1.91	130.89%	HEALTHCARE DELIVERY MANAGEMENT
⚪	7.11	Percent of eligible children receiving any preventive dental services	0	42		Data not available		HEALTHCARE DELIVERY MANAGEMENT
🔴	7.12	Percentage of providers participating in HealthCheck/EPSDT Trainings	0	50		29	58%	HEALTHCARE DELIVERY MANAGEMENT
🔴	7.13	Number of individuals moved through MFP	0	140		24	17.14%	HEALTHCARE DELIVERY MANAGEMENT
🔴	8.1	Percent of providers paid electronically	0	75		34	45.33%	HEALTH CARE OPERATIONS
🟢	8.2	Average time to process Medicaid provider application	0	45		35	128.57%	HEALTH CARE OPERATIONS