



FY 2010 PERFORMANCE PLAN
Department of Health Care Finance

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), a newly created agency 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.

PERFORMANCE PLAN DIVISIONS

- Office of the Director
- Health Care Accountability Administration
- Health Care Delivery Management Administration
- Health Care Policy and Planning Administration
- Health Care Operations Administration

AGENCY WORKLOAD MEASURES

Measure	FY08 Actual	FY09 YTD
Number of District residents covered by Medicaid and Medicare (monthly average through August 2009)	145,199	151,816
Number of District residents covered by Alliance (monthly average through August 2009)	47,116	51,773



Office of the Director

SUMMARY OF SERVICES

The Executive Office provides executive management, policy direction, strategic and financial planning, public relations, and resource management. It controls and disseminates work assignments and coordinates agency operations to ensure the attainment of the agency's goals and objectives.

OBJECTIVE 1: Improve outreach and communications.

INITIATIVE 1.1: Expand outreach strategies and tools for providers and beneficiaries.

DHCF is developing and implementing outreach strategies for both providers and beneficiaries that use a variety of communication tools and vehicles. One example is the Provider Newsletter, which includes information such as updates on new regulations, processes, and federal requirements in the Medicaid program. In FY 2010, DHCF will develop a strategy to communicate with hard-to-reach populations and providers, such as sole practitioners, who may be interested in serving the Medicaid population. DHCF will disseminate a wide range of marketing materials, including flyers, brochures, posters, and other print-based media. Efforts will focus on increasing access to health coverage including assisting Medicare beneficiaries with their co-pays and deductibles, increasing provider participation in the Medicaid and Alliance programs, and increasing access to health services such as dental services, child well visits and transportation. In addition to media and print campaigns, DHCF will continue to use forums and town halls to reach as many constituents and providers as possible. DHCF anticipates the outreach campaign will begin in winter 2009.

OBJECTIVE 2: Expand access to high quality health care.

INITIATIVE 2.1: Implement Healthy DC.

The Healthy DC program was created as part of an effort to expand health insurance coverage to District residents. In FY 2010, DHCF will implement the Healthy DC program to reach uninsured District residents who do not qualify for Medicaid or the Alliance program and have incomes up to 400% of the federal poverty level (FPL), or up to \$88,000 for a family of four. The benefit package offered to members will include comprehensive primary, specialty, and inpatient care. Monthly premiums will be on a sliding-scale prioritizing affordability for uninsured residents who currently face prohibitively expensive or no options in the individual insurance market. DHCF anticipates the program will begin offering coverage in early 2010 and could serve up to 5,000 members by the end of the fiscal year.

OBJECTIVE 3: Design and implement health information exchange initiatives.

INITIATIVE 3.1: Implement Patient Data Hub.

In FY 2010 the Office of the Chief Information Officer (OCIO), within the Office of the Director, will embark on a variety of Health Information Technology (HIT) initiatives,



including the implementation of the Patient Data Hub (PDH) through the Medicaid Transformation Grant. The PDH, a 100% federally funded Transformation Grant pilot, comprises the technologies and components to enable real-time exchange of clinical and administrative medical data within the District. The PDH will first link government data sources (including Medicaid, immunization, lead registry and other databases) to provide a more complete profile of patients and their health care needs. The PDH will promote the adoption of Health Information Technology (HIT) within the District and improve public health policy decision making by making data more readily available. This will increase the quality of health care provided to and result in lower health care costs for District residents.

The PDH contract was awarded in May 2009. By the end of FY 2010, the Patient Data Hub will have linked all relevant District databases and also linked with the District’s Regional Health Information Organization.

INITIATIVE 3.2: Implement District-wide Health Information Exchange.

By December 2010, it is anticipated that the Office of the National Coordinator for Health Information Technology (HIT) at the Department of Health and Human Services will award the District at least \$5 million to facilitate the planning and implementation of a District-wide Health Information Exchange (HIE). An HIE is the electronic sharing of health-related information among organizations that adhere to nationally recognized standards along with the technology infrastructure and processes for sharing clinical, financial, and administrative health care information across care settings such as physician offices, hospitals, pharmacies, and payers.

This HIE will build off of the District’s Regional Health Information Organization (RHIO) and the Patient Data Hub (PDH). By sharing this health information, the District will realize better quality care for all its residents, reduce unnecessary or duplicative services or tests, and ensure patient safety by allowing any provider connected to the HIE to access important health information on their patient. In FY 2010, DHCF, in partnership with the Department of Health, will implement the HIE project.

KEY PERFORMANCE INDICATORS – Office of the Director

Measure	FY08 Actual	FY09 Projection	FY09 YTD	FY10 Projection	FY11 Projection	FY12 Projection
Objective 2						
Number of District residents covered by Healthy DC	N/A	N/A	N/A	5,000	5,000	5,000
Percent of District residents uninsured	10% ¹	N/A	TBD	9%	8%	7%

¹ According to Current Population Survey (CPS) data, 2008.



STANDARD CITYWIDE OPERATIONAL MEASURES

Measure	FY09 YTD
Contracts	
KPI: % of sole-source contracts	
KPI: Average time from requisition to purchase order for small (under \$100K) purchases	
KPI: # of ratifications	
KPI: % of invoices processed in 30 days or less	
Customer Service	
KPI: OUC customer service score	
Finance	
KPI: Variance between agency budget estimate and actual spending	
KPI: Overtime as percent of salary pay	
KPI: Travel/Conference spending per employee	
KPI: Operating expenditures "per capita" (adjusted: per client, per resident)	
People	
KPI: Ratio of non-supervisory staff to supervisory staff	
KPI: Vacancy Rate Total for Agency	
KPI: Admin leave and sick leave hours as percent of total hours worked	
KPI: Employee turnover rate	
KPI: % of workforce eligible to retire or will be within 2 years	
KPI: Average evaluation score for staff	
KPI: Operational support employees are percent of total employees	
Property	
KPI: Square feet of office space occupied per employee	
Risk	
KPI: # of worker comp and disability claims per 100 employees	



Health Care Accountability Administration

SUMMARY OF SERVICES

DHCF's Health Care Accountability Administration (HCAA) continuously improves the safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity of health care received by individuals enrolled in the health care programs administered by DHCF as defined by the Institute of Medicine's (IOM) standards.

OBJECTIVE 4: Improve health outcomes for District residents.

In recent years, the United States health care system has made strides toward improving health care quality. Here in the District, DHCF has developed several initiatives that focus on health outcomes and has created incentives for physicians to improve and monitor the quality of the care provided. In FY 2010, DHCF will continue to build upon existing quality improvement initiatives and as well as implement new initiatives.

INITIATIVE 4.1: Implement the Quality Improvement Collaborative in perinatal and chronic illness.

DHCF and various partners are embarking on a multiyear initiative to improve the health of babies born to mothers and the health of those with serious chronic illnesses. This initiative, through DHCF's Medicaid and Alliance programs, is in partnership with Chartered Health Plan, Health Right, Inc., Health Services for Children with Special Needs, Inc. (HSCSN), Unison Health Plan, George Washington University, the Department of Health, and other experts in health care and health care quality improvement.

The goals of this health care quality improvement collaboration are to reduce the rates of:

- Newborns with birth weight less than 2,500 grams;
- Newborns of 32 weeks or less gestational age;
- Pregnant women NOT tested for HIV prior to giving birth;
- Pregnancies ending in miscarriage or fetal loss (early or late);
- Deaths of infants in the first year of life; and
- Emergency room visits and hospital admissions by individuals diagnosed with asthma, diabetes, high blood pressure, and congestive heart failure.

As of late FY 2009, all four health plans (Chartered, Health Right, HSCSN and Unison) were calculating their Adverse Perinatal Outcomes Rates and Adverse Chronic Disease Outcome Rates based on the goals outlined above. Outcome rates will be calculated for each plan and a District-wide managed care rate will also be determined. This Collaborative will allow DHCF to focus managed care plans and their resources on two of the most pressing health issues facing the District – infant mortality and lack of appropriate care for those with chronic health conditions. DHCF will hold the plans accountable for achieving these goals through two avenues -- a Consumer Report Card (Initiative 4.2) and through financial incentives in pay-for performance initiatives (8.5).



INITIATIVE 4.2: Develop a Consumer Report Card to facilitate beneficiary choice in managed care.

DHCF is in the process of developing a managed care report card, with reporting requirements for plans beginning in FY 2010. Foremost, the report card is intended to be a tool that adult Medicaid and Alliance beneficiaries and parents or decision-making representatives of children can use to help them choose a managed care organization (MCO).

Secondarily, the report card will help inform advocates and others about key aspects of MCO performance. The report card will work in concert with DHCF's other quality improvement, pay-for-performance, and managed care initiatives. Key areas on which DHCF anticipates tracking performance (and grading on an A, B, C, D or F scale) with the report card include:

- Patient experience of care;
- Quality of data provided by the plan;
- Provider network adequacy and accessibility;
- Health education provided to enrollees;
- Patient care coordination;
- Activities to improve chronic care outcomes; and
- Activities to improve perinatal outcomes

The first managed care report card will be available as of winter 2009.

INITIATIVE 4.3: Implement quality improvements for chronic and long term care enrollees.

In FY 2010, DHCF will develop a global quality improvement strategy for home and community-based services. This will entail development of a set of performance measures that will cut across home and community-based services programs that provide services for DHCF's Medicaid Waivers for the elderly, individuals with physical disabilities and individuals with developmental disabilities. The measures will align with the Center for Medicare & Medicaid Services' (CMS) quality assurance framework and will include measures in the following domains:

- Participant access;
- Participant involvement;
- Provider capacity; and
- Provider capabilities.

For example, DHCF will improve the monitoring protocols for its home and community-based waiver programs by building a standardized set of monitoring strategies. Such strategies will include standardized data reports and beneficiary surveys. These monitoring strategies will be created and implemented in FY 2010, and will help improve the quality of care for beneficiaries.

INITIATIVE 4.4: Continue to Implement Nursing Facility Quality of Care Fund Projects.

In FY 2010 DHCF will continue to implement three Nursing Facility Quality of Care Fund projects using dedicated funding and in collaboration with the DC Office on Aging



(DCOA). Major projects DHCF anticipates implementing with DCOA over the end of FY 2009 and into FY 2010 include:

- 1) Nursing facility staff and resident satisfaction surveys (My Innerview);
- 2) On-Time Quality Improvement Long Term Care Initiative, which integrates health information technology into nursing home care and clinical practice; and
- 3) The development and maintenance of an on-line, real-time nursing facility bed database to track bed availability in the District.

A fourth project focused on geropsychology is also planned for FY 2010. Overall, more than \$6 million will be used from the Nursing Facility Quality of Care Fund in FY2010 to implement projects. Additional projects will be indentified and implemented, pending funding availability.

OBJECTIVE 5: Ensure limited resources are utilized appropriately.

To enable DHCF to continue to provide health quality health care to over 200,000 residents, the agency must use its limited resources efficiently and as prudently as possible. DHCF must ensure that its programs (Medicaid and the Alliance) are only used after other public or private coverage options are exhausted; that beneficiaries are District residents; that beneficiaries appropriately use health services; and that providers accurately and appropriately bill Medicaid and the Alliance for these health services. Improving the integrity of the eligibility process for Medicaid and Alliance beneficiaries, increasing fraud and abuse efforts and expanding recoupment work are several initiatives that DHCF is launching in FY 2010.

INITIATIVE 5.1: Ensure Alliance program is limited to District residents.

In order to preserve limited resources, DHCF must ensure that residents who enroll in the Medicaid or Alliance program do not have access to other public or private insurance, and also verify that they are indeed District residents. In late FY 2009/early FY 2010 the Department of Human Services (DHS) is implementing new policies regarding proof of residency for Alliance beneficiaries. DHCF is working closely with DHS on this implementation, and will be monitoring Alliance eligibility files to ensure that the residency requirements are met. DHCF anticipates that these residency changes will result in a 12 percent decrease (or about 6,800) in Alliance enrollees over FY 2010, due to lack of proof of District residency.

INITIATIVE 5.2: Limit Alliance coverage to District residents not eligible for other health insurance.

DHCF will also continue to work closely with DHS to implement new policies that do not allow residents who have Medicare or private insurance to enroll in the Alliance. For example, DHCF is working to ensure low-income Medicare beneficiaries receive Qualified Medicare Beneficiary benefits from Medicaid (which pays their cost-sharing and premiums); however these individuals will no longer be eligible for the Alliance program. DHCF anticipates that 723 individuals with other sources of health insurance will be disenrolled because of this initiative.

INITIATIVE 5.3: Transition coverage for Medicaid beneficiaries eligible for Medicare.



In FY 2010 DHCF will launch a new project aimed at its Medicaid beneficiaries who are also eligible for Medicare. In these cases, Medicare (which is 100 percent federally funded) will be the primary payer for these individuals and Medicaid will pay cost-sharing and provide access to benefits that Medicare does not cover. DHCF will first identify the individuals that appear to be eligible, and then reach out and help facilitate their enrollment into Medicare. DHCF anticipates that 375 Medicaid beneficiaries are also eligible but not enrolled in Medicare and projects savings of \$3 million annually when this initiative is fully implemented.

INITIATIVE 5.4: Increase referrals to the Medicaid Fraud Control Unit.

In FY 2010, DHCF aims to increase fraud prevention simultaneous with fraud detection. DHCF will continue to increase detections of potential fraud cases and referrals to the District Office of Inspector General's Medicaid Fraud Control Unit (MFCU). In FY 2008, DHCF submitted 7 referrals to the MFCU. In FY 2009, DHCF executed a new memorandum of understanding with the MFCU, and redesigned how DHCF's Investigations unit conducts the preliminary investigations of potential fraud required under federal law. These changes have resulted in the referral of 20 cases of potential fraud referred to the MFCU in FY 2009 to date – nearly triple the prior year's amount. In FY 2010, DHCF aims to refer 25 cases to the MFCU. DHCF is also revising the standard package of information given to the MFCU at the time of referral to enable quicker referrals of cases of potential fraud.

INITIATIVE 5.5: Implement strategies to prevent provider fraud and abuse.

DHCF will also focus on prevention efforts related to fraud and abuse. In FY 2010, DHCF will implement a number of changes to its provider enrollment processes (including strengthening provider requirements) and claims payment system to deny payments up front and *prevent* occurrence of fraud. This "cost avoidance" approach to fraud prevention is preferable to the "pay and chase" detection of fraud after it has occurred. In the pay-and-chase approach, attempts to recover money are sometimes not successful if the provider flees the country (as has recently happened) or the corporation goes bankrupt.

INITIATIVE 5.6: Increase recoupment of incorrect or fraudulent provider payments.

Beginning in 2010, DHCF will follow the example of many other state Medicaid agencies and extrapolate the findings of audits regarding overpayment to providers due to fraud or abuse, including poor billing practices. This will enable the Medicaid program to recover larger amounts of payments made for erroneous claims. DHCF will apply the detected error rate found in the sample of claims and apply it to all claims once the error rate reaches a predetermined threshold (e.g., 25% of claims are incorrect). In FY 2010, DHCF anticipates recovering \$7.5 million from providers due to these changes.

INITIATIVE 5.7: Implement proper utilization controls for home health benefits.

Currently, the District's Medicaid program allows for 1040 hours of Personal Care Aide (PCA) services per beneficiary per year. After 1040 hours (which translates to 6 months of full-time PCA services provided at 40 hours per week), prior authorization is required for additional hours of PCA services. However, a recent review of PCA utilization



revealed that many beneficiaries exceed the 1040 hour limit without a prior authorization. DHCF will make program oversight changes that will ensure appropriate utilization of PCA services. The project team has completed an analysis of PCA utilization, developed a methodology for ensuring that prior authorizations are required for beneficiaries requiring more than 1040 hours of PCA services, and is working with DHCF's Health Care Operations Administration to finalize the necessary systems changes. In addition, DHCF will begin recouping payments made for unauthorized PCA services over 1040 hours. In FY 2010, DHCF projects that these initiatives will save over \$4.2 million dollars.

KEY PERFORMANCE INDICATORS – Health Care Accountability Administration

Measure	FY08 Actual	FY09 Projection	FY09 YTD	FY10 Projection	FY11 Projection	FY12 Projection
Objective 4						
Quality Improvement Initiative 1: Adverse Perinatal Outcomes ²	TBD	N/A	TBD	TBD	TBD	TBD
Quality Improvement Initiative 2: Adverse Chronic Disease Outcomes ³	TBD	N/A	TBD	TBD	TBD	TBD
HEDIS measure for childhood immunization ⁴	81.2%	82%	72.9%	83%	85%	87%
HEDIS measure for timeliness of prenatal care ⁵	70%	75%	68.0%	78%	80%	85%
Adults' access to preventive/ambulatory care services (adults aged 20-44, enrolled in health plans) ⁶	78%	80%	77.7%	83%	85%	87%
Objective 5						
Number of referrals to	7	N/A	21	25	25	25

² This measure aggregates the following metrics: newborns with birth weight less than 2,500 grams; newborns of 32 weeks or less gestational age; pregnant women NOT tested for HIV prior to giving birth; and pregnancies ending in miscarriage or fetal loss (early or late); and deaths of infants in the first year of life.

³ This measure aggregates emergency room visits and hospital admissions by individuals diagnosed with asthma, diabetes, high blood pressure, and congestive heart failure

⁴ HEDIS (Healthcare Effectiveness Data and Information Set) measure on the percent of children enrolled in managed care who received age-appropriate immunizations by their second birthday.

⁵ HEDIS measure on the percent of deliveries to women enrolled in Medicaid managed care for which the woman received a prenatal care visit in either their first trimester or within 42 days of enrolling in the managed care organization.

⁶ The percent of Medicaid managed care enrollees aged 20-44 who had an ambulatory care or preventive care visit (as opposed to an emergency or hospital visit) during the year.



the Medicaid Fraud Control Unit (MFCU)						
Total recovered from provider audits (Local and Federal Funds)	\$700,000	N/A	\$2.6 million	\$7.5 million	\$7.5 million	\$7.5 million
Total recovered from Third Party Liability (TPL)	\$4.4 million	N/A	\$7.8 million ⁷	\$8.5 million	\$9 million	\$9.5 million

⁷ Represents TPL collections from October 2008 through June 2009.



Health Care Policy and Planning Administration

SUMMARY OF SERVICES

The Health Care Policy and Planning Administration (HCPPA) has responsibility for maintaining the Medicaid and CHIP (Children's Health Insurance Program) State Plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs. The HCPPA also develops policy for the administration of the Alliance and other health care programs for publicly funded enrollees. These programs are administered or monitored by DHCF based on sound analysis of the local and national health care environments and reimbursement policies and strategies. Finally, the HCPPA ensures coordination and consistency among health care and reimbursement policies developed by the various administrations within DCHF.

OBJECTIVE 6: Develop policies, plans and data to enable effective program administration and utilization of resources.

INITIATIVE 6.1: Better align federal reimbursement at Child and Family Services Agency.

DHCF is collaborating with the Child and Family Services Agency (CFSA) to restructure how Medicaid reimbursable services are provided and billed for a targeted population -- abused and neglected children. This effort is large in scope and includes identifying and implementing how best to coordinate and provide care for the target population. This effort stems from the large disallowances CFSA incurred from previous years regarding Medicaid billing. In FY 2010, DHCF will provide detailed technical assistance and training regarding proper Targeted Case Management (TCM) claims, implement a review process of CFSA claims, and develop new strategies on reimbursement for behavioral health services for abused and neglected children. In FY 2010, DHCF also plans to assist CFSA to begin claiming Medicaid reimbursement in three focus areas: TCM, purchased services, and for CFSA's internal clinic.

INITIATIVE 6.2: Improve billing practices at the District of Columbia Public Schools to improve access to health services.

In FY 2010, DHCF will continue its work with District of Columbia Public Schools (DCPS), Office of the State Superintendent of Education (OSSE) and charter schools to improve access to and maximize federal funding for school health services. DHCF will first work to further improve billing practices at DCPS in light of the recent audits of past years that revealed a lack of proper documentation needed to claim Federal Medicaid reimbursement. In FY 2010, DHCF will implement new payment methodologies to assist in proper billing. In addition, DHCF will work with the Department of Health and DCPS on linking data bases regarding health professionals' licenses to improve that area of documentation for proper billing. DHCF will also be conducting on-going, on-site reviews of DCPS' claims to assess their compliance with Federal and District laws and regulations.

INITIATIVE 6.3: Obtain Federal funding for current school services eligible for Medicaid.



In FY 2010 DHCF will work with the District of Columbia Public Schools (DCPS) and the Office of the State Superintendent of Education (OSSE) on billing for services in the schools that are now eligible for Medicaid reimbursement. These newly eligible services are:

- Behavioral support;
- Skilled nursing services;
- Personal care services;
- Mental health and counseling;
- Orientation and mobility; and
- Nutrition.

DHCF will work with DCPS and OSSE on setting rates and appropriate billing structure to ensure that the District receives the maximum federal reimbursement available. DHCF will provide trainings to DCPS and OSSE on the Medicaid requirements in order to ensure proper claiming and also implement system changes to ensure timely payment to the schools. These services are currently funded with 100% Local Funds.

INITIATIVE 6.4: Obtain Federal Funding for DCPS Early Stages Program.

DHCF is collaborating with DCPS' Early Stages program so that they can begin billing Medicaid in FY 2010 for health related services, as provided under IDEA (Individuals with Disabilities Education Act), to this preschool aged population. This will help DCPS identify as early as possible any potential development delays with children before they enter school. DHCF is also working with DCPS to facilitate the co-location of dental services with the Early Stages program, with a target start date of April 2010. DHCF will work with DCPS to identify existing Medicaid dental providers that will serve children participating in the Early Stages program. Since DCPS will partner with private providers and co-locate the services, the dental providers will be able to work independently and bill for Medicaid services as part of their existing Medicaid and MCO (managed care organization) provider agreements. This arrangement will increase access to services by bringing existing Medicaid providers directly to children in need of care.

INITIATIVE 6.5: Increase technical assistance provided to OSSE and charter schools.

In FY 2010 DHCF will provide increased technical assistances to the Office of the State Superintendent of Education (OSSE) and charter schools in the District. Currently, there are 27 charter schools enrolled in the Medicaid program as providers, however only 8 billed for Medicaid services during the past school year (2008-2009). DHCF's goal is to assist the remaining 19 schools to begin billing Medicaid and also add 5 new charter schools for a total of 32 schools by the end of FY 2010.

INITIATIVE 6.6: Maximize Federal Disproportionate Share Hospital (DSH) resources.

DHCF is developing an 1115 waiver that will be submitted to the federal government for approval. This waiver will reallocate Disproportionate Share Hospital (DSH) funds from District hospitals to help improve health care coverage of District residents. The waiver will also ensure that those hospitals serving a disproportionate share of Medicaid,



Alliance and uninsured District patients receive appropriate DSH funding by changing the formula that calculates the amount of funding a hospital receives. The waiver will allow the District to move selected populations out of the Alliance and into Medicaid using a portion of the District's DSH allocation, thereby improving coverage and shifting spending from 100 percent local funds to spending eligible for Federal match. In FY 2010, DHCF anticipates that over 11,000 Alliance beneficiaries will be moved to the Medicaid program resulting in over \$14 million in savings.

INITIATIVE 6.7: Better understand and assess the District's uninsured population. DHCF is working with the Urban Institute to conduct the 2009 District of Columbia Household Survey on Health Insurance Status. The survey will gather information about health insurance coverage, demographic and economic information, and access to and use of health care by District residents. Results from the survey will assist the Department in its roll-out of the new Healthy DC program as well as provide a more accurate landscape of the health insurance status of District residents. The survey will conclude on November 30, 2009, with final results available in February 2010. Throughout FY 2010, DHCF will use this data to assist in Healthy DC implementation and administration of the Medicaid and Alliance programs.

OBJECTIVE 7: Promote access to care by ensuring sound and competitive provider reimbursement methodologies and rates.

Beneficiary access to health care services depends upon the availability of high quality providers participating in DHCF programs. Understanding that provider participation hinges in large part on reimbursement rates, in FY 2009, DHCF completed an analysis of physician reimbursement and then significantly increased fees. These rates have been integrated into the managed care contracts this contract year. In FY 2010, DHCF will develop and implement new rates in at least three major areas: Intermediate Care Facilities (ICFs), Psychiatric Residential Treatment Facilities (PRTFs) for children, and prescription drugs.

INITIATIVE 7.1: Implement new rate for Intermediate Care Facilities.

The current Medicaid reimbursement system for Intermediate Care Facilities (ICFs) was implemented beginning in FY 1997 and, with the exception of implementing one-to-one services, has not been updated since. The proposed new methodology moves away from an inflexible and inefficient cost-based rate setting methodology that is based on provider costs to a more flexible methodology based on the needs of Medicaid beneficiaries. The new methodology will ensure that the reimbursement rates to ICFs meet the economic and efficiency standards set by the Medicaid program and are at a level that will maintain and attract new providers. This proposed reimbursement methodology will be implemented beginning in FY 2010 and includes a number of innovative components, such as supplemental payments to providers for implementing quality of care initiatives for consumers with developmental disabilities.

INITIATIVE 7.2: Implement new rate for Psychiatric Residential Treatment Facilities (PRTFs)

In FY 2010, DHCF will implement a new rate for Psychiatric Residential Treatment Facilities (PRTFs). This increase will both encourage provider participation and save



local dollars by maximizing federal Medicaid reimbursement. This rate change establishes a new service for children under the age of 22 in a provider type identified as psychiatric residential treatment facilities (PRTFs). This also establishes a methodology to reimburse PRTFs that will increase rates, thereby encouraging provider participation. PRTFs located in the District will be reimbursed at the Maryland Medicaid rate; out-of-District PRTFs that participate in their state Medicaid programs will be reimbursed at their state Medicaid rate; and out-of-District PRTFs that do not participate in their state Medicaid programs will be paid at their lowest self-pay rate.

INITIATIVE 7.3: Implement new rate for Prescription Drugs.

In FY 2010, DHCF will also implement a new rate for Maximum Allowable Costs (MAC) for prescription drugs. The new MAC rate allows the District to apply a ceiling to the amount it will reimburse for multi-source, generic drugs covered by Medicaid. This is a widely-used payment mechanism designed to standardize the reimbursement rates for these drugs, thus encouraging pharmacies to dispense lower priced drugs and save Medicaid dollars.

INITIATIVE 7.4: Increasing provider participation in the Medicaid program.

Historically, Medicaid programs have had major challenges in getting providers to participate due to low reimbursement rates, high administrative burden, and other perceived hassles. DHCF intends to increase provider participation in its program in FY 2010. DHCF has already raised provider rates to match Medicare rates (only 11 other states have done so), and is improving its administrative processes, including streamlining provider enrollment and allowing for claims payment and tracking via the web. In FY 2010, DHCF intends to conduct an outreach campaign to inform providers of these changes and to encourage them to become Medicaid providers.

KEY PERFORMANCE INDICATORS – Health Care Policy and Planning Administration

Measure	FY08 Actual	FY09 Projection	FY09 YTD	FY10 Projection	FY11 Projection	FY12 Projection
Objective 6						
Number of charter schools billing Medicaid	8	N/A	25	32	40	45
Objective 7						
Number of physicians active in Medicaid program	TBD	N/A	TBD	TBD	TBD	TBD



Health Care Delivery Management Administration

SUMMARY OF SERVICES

The Health Care Delivery Management Administration is responsible for managing selected services provided to District residents, including:

- Chronic and long-term care services;
- Home and community-based services to adults enrolled in Medicaid program;
- Medicaid 1115 Waiver for Childless Adults ages 50-64;
- Managed Care Contracts for the Medicaid and Alliance programs;
- Ombudsman and the Health Care Bill of Rights Office;
- HealthCheck (EPSDT); and
- Oversight of preventive and acute care, including the CHIP (Children's Health Insurance Program).

OBJECTIVE 8: Improve access to high quality services and reduce institutionalization.

INITIATIVE 8.1: Develop enhanced services for chronic and long-term care enrollees.

During FY 2010, new health services will be added to DHCF's Elderly and Physical Disabled (EPD) waiver. The EPD Waiver is a home and community-based program that helps keep residents in their home and community to receive services, instead of having to be in an institution. The new services to be added include adult day care, supported employment, and other services aimed at helping people stay out or move out of institutional settings such as nursing facilities. These new services will improve health outcomes and quality of life for beneficiaries. As of late 2009, approximately 2100 District residents were participating in the EPD Waiver.

INITIATIVE 8.2: Reduce the number of beneficiaries in institutional-based settings.

Money Follows the Person (MFP) is an Federal grant initiative aimed at transitioning people out of facilities (such as nursing homes) and into home and community-based settings (HCBS). HCBS are primarily settings covered under the District's HCBS waivers (the Elderly and Physically Disabled, or EPD Waiver, and the DD Waiver for individuals with developmental disabilities). MFP is an important initiative for the District because it provides funds and resources to expand DHCF's HCBS capacity and reduces reliance on facility-based services. Facility-based services, on average, are more costly than home and community-based services and people greatly prefer to receive long-term care services in their homes and communities. To foster home and community-based service capacity growth, MFP provides an enhanced federal match (88.8%) for 12 months after individuals transition from a institutional facility and free technical assistance (e.g., consulting services) through the Centers for Medicare and Medicaid Services on developing transition systems, services and growing HCBS capacity. In FY 2010, DHCF plans to move 75 beneficiaries from institutions into the community. The priority population served by MFP in FY 2010 will be individuals with developmental disabilities.



INITIATIVE 8.3: Implement Participant Directed Care.

Participant directed care is a model that allows individuals to have greater control over the hiring of direct care staff. This model allows individuals greater say in both how care is delivered as well as control over the budget for the services and other supports they receive (i.e., assistive technology, special training such use of Metro, etc.).

Participant directed care allows the beneficiary to have the greatest choice and control over their own health care decisions. Participant directed care is a national best practice in long-term care that every other state in the nation has adopted. Additionally, research has shown that consumer directed programs are slightly less costly than standard home and community-based programs and that direct service staffing shortages are far less significant in consumer directed programs. DHCF will amend the Waiver serving the elderly and individuals with physical disabilities (EPD Waiver) to implement this program, and anticipates serving about 250 beneficiaries when it is fully implemented early in 2011.

INITIATIVE 8.4: Increase the capacity of the Office of the Ombudsman.

In FY 2009, DHCF began operation of the Office of the Ombudsman. The office represents the interests of District residents, providing services for those eligible for and/or receiving District benefits and those receiving services from private insurance companies. The Ombudsman receives, tracks, trends and resolves complaints as well as conducts outreach and education on health coverage issues. In the first four months of operations, the top areas of complaints included: eligibility for programs; access to health services; questions on insurance coverage; access to prescription drugs; reimbursement for health services; and quality of care concerns.

Throughout FY 2010, the Office will implement a toll-free line, increase staffing and develop a website to increase the capacity of the Office. In FY 2010, the Office will also conduct targeted education campaigns on increasing health coverage, especially for Healthy DC and for Medicare beneficiaries to receive financial assistance with their out-of-pocket expenses. In four months of service in FY 2009, the Office served 723 consumers (about 181 cases per month). DHCF intends to double these efforts with new resources and projects, and plans to serve about 350 consumers a month (or about 4,200 consumers total) in FY 2010.

INITIATIVE 8.5: Implement pay-for-performance to improve quality in health services.

In FY 2009, pay-for-performance initiatives were included in District's contracts with the Medicaid managed care plans that serve over 150,000 District residents. The current pay for performance contracts award high performance in four areas: clinical care; general access to services; adult and pediatric access to care; and administrative performance. The health plans are financially rewarded for performance that meets or exceeds national Medicaid benchmarks (at the 25%, 50%, and 75% threshold with higher percentages resulting in additional points) or demonstrates improvement over time.

Specific examples of measures eligible for rewards include: timeliness of prenatal and postpartum care, controlling high blood pressure, diabetes care, and use of appropriate



medications to treat asthma. In FY 2010, DHCF will begin to use financial incentives with the managed care plans to encourage efforts regarding improving health outcomes. DHCF will withhold 1% of the Medicaid managed care capitation payments to health plans each month during the current contract year. In summer/fall 2010 (following validation of the performance data) each health plan's scores will be compared against Medicaid national averages. The funds will be distributed based on relative success compared to national Medicaid benchmarks.

KEY PERFORMANCE INDICATORS – Health Care Delivery Management Administration

Measure	FY08 Actual	FY09 Projection	FY09 YTD	FY10 Projection	FY11 Projection	FY12 Projection
Objective 8						
Number of participants in Elderly and Physically Disabled (EPD) Waiver	1,953	2,050	2,147	2,175	2,250	2,325
Average number days to process EPD Waiver application ⁸	Greater than 60 days	45 days	45 days (estimate)	30 days	30 days	30 days
Number of participants in DD Waiver	900	1100	1200	1300	1300	1300
Number of beneficiaries in out-of-state nursing facilities	200	185	178	170	165	160
Number of beneficiaries in ICF/MRs	470	420	390	370	350	340
Number of individuals moved from institutions to community	Unknow	N/A	TBD	75	100	120
Percent Medicaid beneficiaries satisfied with their health plan ⁹	71%	N/A	73%	75%	77%	79%
Number of consumers served by Ombudsman	N/A	N/A	723	4,200	4,400	4,600

⁸ Measured by average time between DHCF receipt of a complete EPD Waiver application and approval/denial of the application.

⁹ Data from *The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey*.



Average number of days to resolve issues brought to Ombudsman	N/A	N/A	2.5 ¹⁰	2.5	2.0	2.0
Total percent of eligible children receiving any preventive dental services	29%	N/A	TBD	35%	42%	50%

¹⁰ Note: Issues reported in FY 2009 are simple cases that do not require external interventions.



Health Care Operations Administration

SUMMARY OF SERVICES

The Health Care Operations Administration is responsible for the administration of programs that pertain to the payment of claims, management of the fiscal agent contract, management of the administrative contracts, management of the payment systems, provider enrollment, and other provider requirements.

OBJECTIVE 9: Improve the efficiency of program operations.

INITIATIVE 9.1: Improve Payment Processes for Providers

The Health Care Operations Administration will focus on improving the overall payment process, specifically improving the timeliness and accuracy of payments to providers. This will be accomplished with implementation of DHCF's new Medicaid Management Information System (MMIS) in FY 2010. This new MMIS will give our providers access to new functionality via a secured web portal. For example, instead of paper processes, providers will be able to do the following via DHCF's website:

- Submit requests for prior authorizations;
- Verify beneficiary eligibility;
- File claims electronically; and
- Check claims status.

This new functionality will give providers a tool to better manage claims submission and validation. In addition, the new system is more configurable than the current MMIS system, allowing DHCF more flexibility to implement programs and initiatives that increase timely payment and improve services for providers.

INITIATIVE 9.2: Create a Provider Relations Unit.

In FY 2010, DHCF will roll out a Provider Relations Unit which will allow for better response to the needs of public and private providers. In particular, the unit will serve those providers who need more help on issues related to claims submission or payment. The unit will work with other areas within DHCF and DC Government to implement new provider programs such as the new initiative regarding Psychiatric Residential Treatment Programs.

This unit will also work to increase provider enrollment in DC Medicaid by decreasing the time and amount of paperwork needed to become a Medicaid provider. Currently, some applications can take over a year to approve. In FY 2010, the Provider Relations Unit will approve applications in 30 to 90 days. The Unit will also assist in facilitating paperless programs like electronic remittance advices and payment via electronic funds transfer (EFT). Currently, only 25% of active providers receive their payments electronically. Issuing these paper checks can lead to delays in payment, higher processing and staff costs, and lost checks. In FY 2010, DHCF's goal is to have 50% of providers (about 400 active providers) paid electronically.

INITIATIVE 9.3: Implement an Administrative Services Organization (ASO).



Several audits of previous years Medicaid claims from the Child and Family Services Agency (CFSA) and the District of Columbia Public Schools (DCPS) resulted in disallowances because these agencies were not able to provide documentation to support the claims or they billed for services that were not allowable under Medicaid law. To help prevent these disallowances in future audits, DHCF will contract with an Administrative Services Organization (ASO) to provide claims submission and reconciliation support for DHCF's sister agencies (including CFSA, DCPS, the Department of Mental Health, the Office of the State Superintendent of Education, the Department of Disability Services, the Department of Health, the District Department of the Environment, the Department of Youth Rehabilitation Services and Fire and Emergency Medical Services). The selected vendor will create a system and be held financial accountable to ensure that claims are submitted accurately, timely, and with all supported documentation and appropriate validations to pass future audits. The contract will be awarded in the beginning of FY 2010. Implementation will begin immediately thereafter and transition throughout the year.

KEY PERFORMANCE INDICATORS – Health Care Operations Administration

Measure	FY08 Actual	FY09 Projection	FY09 YTD	FY10 Projection	FY11 Projection	FY12 Projection
Objective 9						
Average time to process Medicaid provider application	--	N/A	--	60 days	45 days	45 days
Percent of providers paid electronically	--	N/A	25%	50%	75%	100%
Reported complaints (including missed/late trips) on transportation broker services, per 1,000 trips	4.5 per 1,000 trips	3 per 1,000 trips	1.48 per 1,000 trips	2.5 per 1,000 trips	2.5 per 1,000 trips	2 per 1,000 trips