FY 2011 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), 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.

PERFORMANCE PLAN DIVISIONS
- Health Care Accountability Administration
- Health Care Policy and Planning Administration
- Health Care Delivery Management Administration
- Health Care Operations Administration
- Office of Health Care Innovation
- Office of the Director

AGENCY WORKLOAD MEASURES

Measure	FY2009 Actual	FY2010 Actual[1]
Number of District residents covered by Medicaid and Medicare (Year End)	156,786	198,845
Number of District residents covered by Alliance (Year End)	55,048	26,228

[1] As of July 2010

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 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. 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); and deaths of infants in the first year of life. This initiative is a DHCF collaboration with Chartered Health Plan, Health Services for Children with Special Needs, Inc. (HSCSN), Unison 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. The calendar year 2008 baseline rate was 327 and the calendar year 2009 measure was 231. The calendar year 2010 measure will be available in July 2011.[2] In FY 2011, the District's Managed Care Organizations (MCOs) will individually undertake initiatives to track each pregnant woman with known risk factors for adverse outcomes and provide needed follow up and case management. As discussed in Initiative 3.2, these efforts will be supported by web resources also to be developed during FY 2011.

INITIATIVE 3.2: Launch a resource website for case managers and perinatal providers.
As part of the Perinatal Collaborative to reduce adverse birth outcomes, in FY 2011 DHCF will launch a resource guide website for health plan case managers and other medical care providers. For case managers across health plans, the website will improve access to up-to-date information on resources to meet members' medical, psychological and social needs. Resources will include information on services to meet psychosocial risk factors (such as alcohol or other substance misuse, domestic violence, and mental health problems), as well as services to support healthy babies, such as breast feeding.

[2] Reporting this measure six months after the close of the calendar year allows for a six months lag in health care claims submission, consistent with national standards for the calculation and reporting of such quality measures. No national or other comparisons are available because no one else is measuring perinatal outcomes in this way. In this quality improvement initiative the District's Medicaid managed care program is comparing itself to itself over time to gauge achievements in continuous quality improvement.

The site will clearly make the connection between psychosocial needs and health, and link case managers to services that are available to the mother. The services will include those based in the District, services available from national organizations, and services through virtual communities on the web. The resource website will be launched by September 2011, and utilization will be monitored to measure its effectiveness.

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 calendar year 2008 baseline rate was 340 and the calendar year 2009 measure was 490. The calendar year 2010 measure will be available in July 2011. To improve outcomes, in FY 2011 DHCF will develop a strategy to provide illness self management resources that people with asthma, diabetes, high blood pressure, and congestive heart failure can use to achieve better health while living with these illnesses. Illness self management resources include programs lead by health care professionals and people successfully living with chronic illnesses to show others how they too can successfully manage these permanent illnesses. As a result, DHCF expects to see significant reductions in the rates of emergency department and acute hospitalization utilization for 2011 among the targeted population.

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). By August 2011, DHCF will calculate and report the scores for each health plan using data from FY 2010. The report card will work in concert with DHCF's other quality improvement, pay-for-performance, and managed care initiatives. 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.

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 the first three will be implemented in FY 2011. Specifically, during the next fiscal year DHCF will: 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. Provider-specific feedback and dialogue will begin in January 2011 and will be ongoing. The nursing facility report

card and home quality improvement initiative will be designed based on best practices of other states and will be created by September 2011. Data for the report card and the quality improvement initiative will come from multiple sources including: the Centers for Medicare and Medicaid Services (CMS)'data (including the Minimum Data Set, Nursing Home Compare and Special Focus Facility Initiative); DHCF's Quality Improvement Organization's (QIO) reports on specific instances of poor quality of care; the Department of Health's Health Regulation and Licensing Administration's standard health inspection surveys and complaint investigations; and the District's Long Term Care Ombudsman. Areas in which to focus quality improvement efforts will be selected in consultation with providers and other stakeholders, with high priority areas including pressure ulcers, falls, and loss of ability to perform Activities of Daily Living (ADLs).

INITIATIVE 3.6: Create and implement a Patient Safety Program.
In FY 2011, DHCF will develop and implement a patient safety strategy 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. This initiative will entail the adoption of measurement, evaluation and reporting framework for PSEs which include Serious Reportable Events (an event that results in death or loss of body part, disability or loss of bodily function) and Sentinel Events (unexpected occurrence involving death or serious physical or psychological injury or the risk thereof). The DHCF patient safety framework will align with national patient safety standards (e.g. the National Quality Forum, the Joint Commission on Accreditation of Health Care Organizations, the U.S. Agency for Healthcare Research and Quality, and the Center for Medicare and Medicaid Services) and the patient safety work of other District agencies (e.g. the Department of Disability Services, the Department of Health and the Department of Mental Health). During FY 2011, DHCF will conduct analyses of PSE reports to identify systemic trends, issues and concerns, and provide technical assistance to and disseminate information on best patient safety practices and tools to providers to help them establish operational systems that prevent and mitigate harm caused by PSEs. The DHCF will publish an annual report on the Patient Safety Program by the end of September 2011.

OBJECTIVE 4: Ensure limited resources are utilized appropriately.

INITIATIVE 4.1: Strengthen strategies to prevent provider fraud and abuse.
In FY 2011, DHCF will fortify policies and procedures targeted at preventing fraud and abuse among Medicaid home health services providers. This initiative is in response to significant increases in expenditures within home health (in the District and nationwide) in recent years, some of which may be inappropriate and/or fraudulent. This initiative will include strengthening home health regulations, improving the home health provider application and enrollment processes, and developing and initiating a formal strategy for quality improvement in home health that incorporates increased coordinated and collaboration with other District oversight agencies. This will be completed by September 30, 2011. This activity will reinforce DHCF's intent to deny erroneous payments up front

and prevent the occurrence of fraud. This "cost avoidance" approach to fraud prevention is preferable to the “pay and chase" detection of fraud after it has occurred.

INITIATIVE 4.2: Conduct provider training on False Claims Act.
As another aspect of DHCF’s efforts to prevent fraud and abuse, during FY 2011 DHCF will provide False Claims Act training for approximately 75-100 DHCF employees who process or review Medicaid claims. This same training will also be required of Medicaid providers who bill more than $5 million annually. 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 education will reinforce DHCF’s efforts to identify fraudulent billing before it occurs. DHCF has begun work with a contractor to develop this training and anticipates training will begin in late 2010.

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 will provide 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 will also be available online to ensure prescribers can access these resources quickly. The three drug categories that will be covered initially are Long Acting Narcotic Analgesics, Hepatitis C medications, and Hemophilia clotting factors. The above changes will go into effect by December 30, 2010, with outreach to major stakeholder organizations such as 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. Performance will be assessed through monthly drug utilization review reports to view the shift of market share toward medications on the preferred drug list, as well as reporting associated cost savings. A portal for communication with DHCF program managers via the website for ongoing provider communication regarding prescription drugs will also be made available in FY 2011.

INITIATIVE 4.5: Execute new Utilization Management Contract.
DHCF will award a new Utilization Management contract during FY 2011. 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. This contract will be awarded by May 2011.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Accountability Administration

Measure	FY2009 Actual	FY2010 Target	FY2010 Actual	FY2011 Projection	FY2012 Projection	FY2013 Projection
Quality Improvement Initiative 1: Adverse Perinatal Outcomes per 1,000 pregnancies and infants[3]	231	less than 230	TBD	less than 220	less than 210	less than 200
Quality Improvement Initiative 2: Adverse Chronic Disease Outcomes per 1,000 people with asthma, diabetes, hypertension and congestive heart failure[4]	490	less than 490	TBD	less than 475	less than 450	less than 425
HEDIS measure for childhood immunization[5]	82%	83%	TBD	85%	87%	87%
HEDIS measure for timeliness of prenatal care[6]	65%	70%	TBD	75%	80%	82%
Adults' access to preventive/ambulatory care services (adults aged 20-44, enrolled in health plans)[7]	75%	80%	TBD	85%	87%	90 %
Number of referrals to the Medicaid Fraud Control Unit (MFCU)	21	25	TBD	25	25	25
Total recovered from provider audits (Local and Federal Funds)	$1.3 million	$7.5 million	TBD	$6.5 million	$6.5 million	$6.5 million
Total recovered from Third Party Liability (TPL)	$4.3 million	$6.5 million	TBD	$7 million	$7.5 million	7 million

[3] 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.
[4] This measure aggregates emergency room visits and hospital admissions by individuals diagnosed with asthma, diabetes, high blood pressure, and congestive heart failure
[5] 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.
[6] 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.
[7] 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.

Health Care Policy and Planning Administration

SUMMARY OF SERVICES

The Health Care Policy and Planning Administration (HCPPA) is responsible 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 and reports on demonstration projects such as 1115 waivers and coordinates 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 DHCF.

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 2010, DHCF will continue to work with the Income Maintenance Administration (IMA) at the Department of Human Services to update and refine systems to accurately document beneficiary eligibility and ensure designations conform to State Plan and other relevant regulations and statutes. (IMA is the entity that determines eligibility for the District's medical assistance programs). A key priority during FY 2011 will be the development and implementation of new Alliance recertification rules. Changes to these rules will ensure that beneficiaries who are Medicaid eligible are enrolled in the Medicaid program, thus maximizing the District's use of local funds in the Federally-matched Medicaid program. In addition, these new rules will further ensure that all participants in the Alliance program have proof of District residency. Implementation will include finalizing rules, planning with IMA regarding necessary changes to service center operations, and communicating these changes with beneficiaries, providers and other affected stakeholders. DHCF anticipates implementing these new rules during the first quarter of FY 2011.

INITIATIVE 5.2: Improve data collection, aggregation and analysis to better understand the populations served and inform policy decisions.
The updated Medicaid Management Information System (Omnicaid) and evolving Patient Data Hub resources will improve DHCF's ability to track beneficiaries' health indicators and health services use. With this new level of data and the addition of key staff to the Data Analytics and Reimbursement unit within the Health Care Policy and Planning Administration, DHCF will be able to conduct analysis in-house that was previously outsourced. Efforts during FY 2011 will focus on describing attributes of and service use by the Medicaid program's fee for service population, a high-cost, relatively unmanaged group. The ability to effectively collect and analyze patient data will enable DHCF to make well informed decisions on the types of services that should be covered, and improve quality of care provided through District agencies. Further, by

building the data collection capabilities in-house, DHCF will reduce the need to outsource this service.

INITIATIVE 5.3: Develop and implement a strategy for reimbursement of school-based health services provided by non-public schools.
In FY 2010, DHCF received federal approval of and implemented the school-based health services state plan amendment (SPA). This SPA changes the reimbursement methodology for school-based health services and also allows for reimbursement of additional services including behavioral support, skilled nursing services, personal care services, mental health and counseling, orientation and mobility, and nutrition. In FY 2011, DHCF will collaborate with the Office of the State Superintendent of Education (OSSE) and the District of Columbia Public Schools (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. The new strategy will lay out the proper way for billing for services to lower the risk of disallowance. The Health Care Policy and Planning Administration's Office of the Provider Liaison will 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 will collaborate 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. Currently, the Medicaid program reimburses for methadone treatment for adults but does not pay for other substance abuse services such as counseling and intensive outpatient services. The development and approval of a SPA for adult substance abuse services will allow Medicaid reimbursement of services currently funded by local dollars through APRA. DHCF anticipates that this SPA will be completed and submitted to the federal Centers for Medicare and Medicaid Services (CM) by February 2011 with implementation to occur later in FY 2011.

OBJECTIVE 6: Support District-wide Health Reform Initiatives.

INITIATIVE 6.1: Maximize Federal Disproportionate Share Hospital (DSH) resources.
During FY 2011, DHCF will finalize and implement the 1115 Medicaid waiver to expand Medicaid coverage to low-income District adults ages 19 to 64 above 133% to 200% of the federal poverty level. This waiver will be fully implemented following Federal 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 allow the District to move a selected population out of the locally-funded Alliance and into Medicaid, thereby improving beneficiaries' coverage and shifting spending from 100% local funds to 30% local funds/70% federal funds. DHCF projects that this waiver

will allow the movement of approximately 3,000-4,000 individuals from the Alliance program to the Medicaid program as of November 1, 2010.

INITIATIVE 6.2: Evaluate health care reform demonstration project opportunities. As a part of Federal health care reform, beginning January 1, 2012, states have the option to participate in several new Medicaid demonstration projects. In FY 2011 DHCF will evaluate and identify the potential demonstration projects so the agency and the District are prepared to participate in calendar year 2012. Specific projects to be evaluated include: bundled payments for episodes of care; provision of global capitated payments to safety-net hospitals; allowing pediatric providers to organize as accountable care organizations; and provision of Medicaid payments to institutions of mental disease for adult enrollees.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Policy and Planning Administration

Measure	FY2009 Actual	FY2010 Target	FY2010 Actual	FY2011 Projection	FY2012 Projection	FY2013 Projection
Number of adults in new 1115 waiver	Not Available	Not Available	Not Available	3,000	3,000	3,000

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; Managed Care Contracts for the Medicaid and Alliance programs; Ombudsman and the Health Care Bill of Rights Office (Ombudsman); HealthCheck (EPSDT); and Oversight of preventive and acute care, including the CHIP (Children's Health Insurance Program).

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

INITIATIVE 7.1: Implement a Redefined Personal Care Aide (PCA) Benefit. During FY 2011, DHCF will implement a redefined Personal Care Aide (PCA) benefit that better targets a benefit to its original intent (e.g., to serve as a rehabilitative, relatively short-term benefit rather than an ongoing long-term care service). Services provided by Personal Care Aides include assistance with dressing, bathing, eating, mobility, etc. Building on FY 2010 efforts, DHCF will continue to prior authorize PCA services but will implement a new limit of up to 520 hours per year. Additionally, approvals will be made in two hour increments up to eight hours per day, and a new assessment tool will be designed to achieve greater granularity and better tailor prior approvals to beneficiary needs. With supporting medical documentation, up to an additional two hundred hours may be approved in 50 hour increments; DHCF will develop a request format for such submissions. The total of up to 720 hours of PCA

benefits annually parallels the Medicare benefit for the same service. Concurrent with requests for hours over 520 hours, DHCF also will develop a referral process to the Section 1915(c) Home and Community-Based Services Waiver for Elders and Persons with Disabilities. For beneficiaries with long-term care service needs, the coordination provided by this Waiver program may be more appropriate. In FY 2011, DHCF projects that this initiative will save approximately $17.3 million.

INITIATIVE 7.2: Submit and begin implementation of second Money Follows the Person operational protocol amendment.
Building on FY 2010 efforts, in FY 2011 DHCF will submit to the Centers for Medicare and Medicaid Services (CMS) a second Money Follows the Person (MFP) Operational Protocol Amendment targeted to persons with severe mental illness who currently reside in nursing homes. MFP is a federally funded Medicaid initiative that provides District residents who live in long-term-care facilities with options for safe transitions to homes in the community with the supports they need to thrive in-home. As part of this initiative DHCF will research the number of people residing in nursing homes who meet a Preadmission Screening and Resident Review (PASRR) under MFP for mental illness. DHCF will also develop an Operational Protocol Amendment, including housing resources, to facilitate movement of these individuals into the community. In FY 2011, in partnership with the Department of Mental Health, DHCF will transition at least 35 people with mental illness out of nursing homes and into the community.

INITIATIVE 7.3: Implement Participant-Directed Care.
In FY 2011, DHCF will implement participant-directed care in its Medicaid Waiver programs for Elderly Individuals and Individuals with Physical Disabilities (the EPD Waiver) and Individuals with Development Disabilities (the DD Waiver). Participant-directed care is a model that allows individuals to have greater control over the hiring of direct care staff, including greater say in both how care is delivered as well as control over the budget for the services and other supports they receive. Participant-directed care is a national best practice in long-term care that every other state in the nation has adopted. 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 EPD Waiver to implement this program. Key implementation steps will begin in October 2010 and will include: a) selecting and readiness review of a Fiscal Management Services (FMS) entity; b) initiating a training curriculum for direct care workers delivering participant-directed care; and c) testing and finalizing Medicaid Management Information Systems (MMIS) changes to accommodate participant direction and the FMS. Enrollment will then begin and is expected in winter of 2011, enrollment during FY 2011 is estimated to be 35-40 individuals. In addition, during FY 2011, DHCF will work with the Department on Disability Services to amend the DD Waiver to include participant direction, with the expectation that services will be available in this waiver as of FY 2012.

INITIATIVE 7.4: Implement technology solutions to support the Office of the Health Care Ombudsman.
Building upon the infrastructure that was created in FY 2010, during FY 2011 the Office of the Ombudsman will develop and implement a technology strategy to support the Office's operations. The goal of these efforts is to improve monitoring and program effectiveness that will have benefits across agencies beyond DHCF. For example, with these improvements the Office will be better able to track the number of complaints regarding major providers such as managed care organizations and home health agencies. The strategy will include policies, procedures, and specific technology solutions. The technology component will include the creation of a website and the selection and implementation of a complaint tracking system. These changes will build upon FY 2010 efforts that included implementing a toll-free line and expanding staffing. The Office of the Ombudsman office will work with sister agencies, including the Office of the Chief Technology Officer (OCTO) on planning and implementation.

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. By October 2010, DHCF will establish a data sharing agreement for the SNPs interested in developing a relationship with the District of Columbia. During FY 2011, the District will explore relationships and develop and disseminate a Request for Proposals to enter into a contractual relationship with 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 partnership with the Department of Health, Health Regulation and Licensing Administration (HRLA), DHCF will develop and implement new regulatory and licensure requirements to ensure higher quality services for Medicaid beneficiaries using home health care agencies. DHCF will implement new requirements in its rules to raise quality expectations and enhance DHCF's capacity to oversee home health care agency operations. DHCF also will work with HRLA to ensure that changes in licensure requirements are reflective of DHCF's rule changes. DHCF's new requirements will be implemented by June 2011.

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

In FY 2011, DHCF will work with the Managed Care Organizations (MCOs) to streamline and improve the HealthCheck training system in an effort to increase provider participation, maximize utility and improve outcomes for children covered by Medicaid. HealthCheck is the program DHCF uses to provide the Early, 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. During FY 2011, DHCF will create and disseminate a new HealthCheck/ EPSDT Provider manual, and enhance the provider training process for EPSDT service providers. Training will focus on enabling providers to gain a better understanding of electronic health records and how to access tools to improve the care provided to children. Throughout the year there will be multiple in-person trainings offered to providers and DHCF will also explore ways technology can enhance training, both in-person, and through the HealthCheck provider website, and webinars.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Delivery Management Administration

Measure	FY2009 Actual	FY2010 Target	FY2010 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
Number of participants in Elderly and Physically Disabled (EPD) Waiver (Year End)	2,181	2,175	2,245	2,250	2,325	2,350
Average number days to process EPD Waiver application[8]	45 days (estimate)	30 days	30	30 days	30 days	30 days
Number of participants in DD Waiver (Year End)	1,327	1,300	1,382	1,300	1,300	1,310
Number of beneficiaries in out-of-state nursing facilities	178	170	186	165	160	155
Number of beneficiaries in ICF/MRs	390	370	402	350	340	330
Number of individuals moved from institutions to community	Not Available	75	60	100	120	130
Percent Medicaid beneficiaries satisfied with their health plan[9]	73%	75%	TBD	77%	79%	80%
Number of consumers served by Ombudsman	723	4,200	TBD	4,400	4,600	4,700

[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.

Measure	FY2009 Actual	FY2010 Target	FY2010 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
Average number of days to resolve issues brought to Ombudsman	2.5[10]	2.5	TBD	2.0	2.0	2.0
Percent of eligible children receiving any preventive dental services	Not Available	35%	TBD	42%	50%	55%
Reported complaints (including missed/late trips) on transportation broker services, per 1,000 trips	1.48 per 1,000 trips	2.5 per 1,000 trips	TBD	2.5 per 1,000 trips	2 per 1,000 trips	2 per 1,000 trips
Percentage of providers participating HealthCheck/EPSDT Trainings	Not Available	Not Available	TBD	50%	55%	70%
Number of individuals moved through MFP	Not Available	120	TBD	140	145	150

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 8: Improve the efficiency of program operations.

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

DHCF's new Medicaid Management Information System (MMIS) was implemented on December 21, 2009. The MMIS is the system that processes claims for Medicaid fee for service beneficiaries and pays monthly capitation payments to the managed care plans operating in the Medicaid and Alliance programs. It also stores the medical assistance program eligibility information from the Income Maintenance Administration (IMA) at the Department of Human Services and enrollment information for providers participating in the DC Medicaid program. To complete the implementation process, the system must be certified by the Centers for Medicare and Medicaid Services (CMS). This certification increases the federal funding for the operations of the MMIS from 50 to 75% of total cost, thus reducing local fund expenditures. During FY 2011, DHCF will work with Affiliated Computer Systems (ACS), the District's fiscal agent, and CMS to have the system certified. As a part of the certification process, DHCF employees will attend multiple training sessions, gather data per CMS requirements and participate in

[10] Note: Issues reported in FY 2009 were simple cases that did not require external interventions.

mock review sessions. The certification should be completed by February 2011. Once the system is certified the federal funding percentage will increase and be retroactive to the date of MMIS implementation.

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. In addition, the Provider Relations Unit works with other areas within DHCF and DC Government to implement new provider programs. During FY 2011, the Unit will continue to assist in facilitating paperless programs, such as electronic remittance advices and payment via electronic funds transfer (EFT). Currently, only 25% of active providers receive their payments electronically but this represents approximately 60% of the actual dollars paid. Most of our pharmacies, hospitals, nursing homes and other facility providers are paid 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 was to have 50% of providers (about 400 active providers) paid electronically. For FY 2011 the goal is to have 600 providers (or approximately 75% of active providers) paid electronically.

INITIATIVE 8.3: 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 could not provide documentation to support the claims submitted or they billed for services that were not allowable under Medicaid law. To help prevent these disallowances in future audits, DHCF has contracted with an Administrative Services Organization (ASO) to provide claims submission and reconciliation support for DHCF's sister agencies. These sister agencies include CFSA, DCPS, the Department of Mental Health (DMH), the Office of the State Superintendent of Education (OSSE), the Department of Disability Services (DDS), the Department of Health (DOH), the District Department of the Environment (DDOE), the Department of Youth Rehabilitation Services (DYRS) and Fire and Emergency Medical Services (FEMS). The selected vendor will create a system and be held financially accountable to ensure that claims are submitted accurately, timely, and with all supported documentation and appropriate validations to pass future audits. The contract was awarded in the 4th quarter in FY 2010 to PCG. Implementation began in late FY 2010 and will transition throughout the year. The ASO will be operational for DCPS and OSSE/Public Charter Schools in January 2011 and for CFSA in February 2011

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Operations Administration

Measure	FY2009 Actual	FY2010 Target	FY2010 Actual	FY2011 Projection	FY2012 Projection	FY2013 Projection
Percent of providers paid electronically	25%	50%	TBD	75%	100%	100%
Average time to process Medicaid provider application	Not Available	Not Available	60 days	45 days	45 days	45 days

Office of Health Care Innovation

SUMMARY OF SERVICES

The Office of Health Care Innovation (OHCI) is responsible for the administration of new health care initiatives that utilize private market insurance, including employer sponsored base coverage for publicly funded enrollees. OHCI will also be a lead on implementation of health care reform initiatives, such as the health insurance exchange.

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. High Risk Pool coverage in the District will be provided with approximately $9 million until 2014, when state health exchanges will commence. The high risk pool will provide 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. DHCF will work in partnership with HHS to promote high risk pool coverage to eligible DC residents as part of its overall outreach strategy for raising awareness of health coverage in DC. This will include advertisements, links on consumer websites, promotional materials, and targeted outreach to providers and case-managers.

INITIATIVE 9.2: Conduct Planning Activities for Health Insurance Exchange Implementation

The Patient Protection and Affordable Care Act enables states to establish a Health Insurance Exchange through which uninsured residents may purchase insurance and receive subsidies depending on income. The U.S. Department of Health and Human Services (HHS) is providing $1 million grants to states and the District to conduct planning purposes during FY 2011. The District will use these funds to coordinate background research, capacity, systems, and infrastructure assessments, and preliminary budget forecasting. Quarterly and Final reports will be developed and submitted to HHS, and will form recommendations to guide the District's plans for implementation of an Exchange by the 2014 federal deadline.

Office of the Director

SUMMARY OF SERVICES
The Office of the Director 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: Increase access to care for District residents.

INITIATIVE 1.1: Coordinate with sister agencies on development and implementation of Health Care Reform initiatives.
Beginning in FY 2010 and continuing throughout FY 2011, DHCF will coordinate with sister agencies and city leadership to develop and implement health care reform initiatives. DHCF co-chairs the District's Health Reform Implementation Committee (HRIC) with the Department of Insurance, Securities and Banking (DISB) and will serve a leadership role in city-wide committees focused on policy, planning and communications. Within DHCF, health care reform initiatives will be conducted across administrations, with coordination responsibilities housed in the Director's Office. Implementation of key initiatives (including state plan amendments, grants application submission and implementation, etc.) will be housed within divisions of DHCF. Key health reform related goals and responsibilities for the Director's Office during FY 2011 include: conducting public forums; analyzing the development of the health insurance exchange; overseeing the necessary regulatory changes; and providing information to providers and payers. These activities will continue throughout FY 2011.

INITIATIVE 1.2: Develop and implement outreach strategies.
During FY 2011, DHCF will develop an organization-wide communication strategy for all DHCF initiatives, including health care reform, health information exchange, beneficiaries, providers and key stakeholders. DHCF will contract with outside vendors in October 2010, to assist with the development of a communications strategy and to conduct outreach initiatives. Specific projects DHCF will implement in FY 2011 include: developing and implementing outreach programs targeted at increasing the enrollment and service use in adolescent populations; convening stakeholders for city-wide initiatives such as health information technology; and conducting forums targeted at providers to increase the number of physicians participating in Medicaid. DHCF will award at least three task orders, focused on strategy development for the agency, beneficiary outreach and provider outreach activities. Outreach activities will be active by November 2010.

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. The PDH is a pilot implementation of technologies designed to enable real-time exchange of clinical and administrative medical data within the District, with better access to data informing clinical and program management decisions. In FY 2011, DHCF will focus on the using the PDH to share clinical data from hospitals and clinics, and use PDH data to improve DHCF operations. Specifically, by the end of FY 2011 the PDH will be built out to include interfaces with the DC Regional Health Information Organization (DC RHIO) for hospital and clinic data and Children's National Medical Center for pediatric data.

INITIATIVE 2.2: Develop District-wide Health Information Exchange.
In January 2010, the Office of the National Coordinator for Health Information Technology (ONC) at the US Department of Health and Human Services awarded the District $5.1 million to facilitate the planning and implementation of a District-wide Health Information Exchange (HIE). HIE is the electronic sharing of health-related clinical, financial, and administrative health care information across care settings (such as physician offices, hospitals, pharmacies, and payers). The grant requires DHCF to conduct planning initiatives in FY 2010 and begin development in FY 2011. DHCF will focus FY 2011 initiatives on developing five key infrastructure components: governance; architecture; technical infrastructure; business and technical operations; and legal/policy. In FY 2011, DHCF will develop a roll out plan for HIE in the District, establish a governance mechanism for the provision of HIE services, and develop and deploy core HIE services. Services to be established during FY 2010 include: a baseline HIE architecture, implementation of core HIE services such as e-prescribing; structured lab reporting; and continuity of care reporting. These HIE components be operational at the end of FY 2011.

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. This development of the SMHP is currently underway. During FY 2011, DHCF will develop and manage processes for verifying and authorizing incentive payments to eligible Medicaid providers (including physicians, nurse practitioners, certified nurse midwives, dentists, physician assistants, acute care hospitals, and children's hospitals) who have successfully adopted certified EHRs and initiated their meaningful use. Payments will be phased over multiple years, with an initial payment for adoption, implementation and/or upgrade of an EHR to meet certification requirements.

Subsequent payments will be tied to meaningful use of the EHR for functions such as e-prescribing, health information exchange and submission of clinical quality measures. Over six years, eligible providers may receive as much as $63,750 each in incentive payments. Incentive payments will begin during FY 2011.

PROPOSED KEY PERFORMANCE INDICATORS – Office of the Director

Measure	FY2009 Actual	FY2010 Target	FY2010 Actual	FY2011 Projection	FY2012 Projection	FY2013 Projection
Percent of District residents uninsured	6.2%	6.2%[11]	6.2%	6.2%	6 %	6%

[11] *Health Insurance Coverage in the District of Columbia, Estimates from the 2009 DC Health Insurance Survey*, The Urban Institute, April 2010.