FY 2012 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, an agency that was established in FY 2009, provides health care services to low-income children, adults, elderly, and persons with disabilities. Over 200,000 District of Columbia residents (one-third of all residents) receive health care services through DHCFs 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 Policy and Research Administration
- Health Care Delivery Management Administration
- Health Care Operations Administration
- Health Care Reform and Innovation Administration

AGENCY WORKLOAD MEASURES

Measure	FY2009 Actual	FY2010 Actual	FY2011 Actual[1]
Number of District residents covered by Medicaid (Year End)	156,786	196,070	204,947
Number of District residents covered by Alliance (Year End)	55,048	25,608	23,711

[1] As of August 2011

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. Additionally, this division includes the Office of the Health Care Ombudsman and Bill of Rights, which ensures the safety and well-being of District residents and their health care services through advocacy, education, and community outreach.

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 2012, DHCF will coordinate with sister agencies and city leadership to develop and implement health care reform initiatives. DHCF chairs the District's Health Reform Implementation Committee (HRIC) 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 oversight responsibilities housed in the Director's Office (coordination activities will be housed in the Health Care Reform and Innovation Administration). Implementation of key initiatives (including state plan amendments, grants application submission and implementation, etc.) will be housed within divisions of DHCF. The HRIC meets monthly and will continue operating throughout FY 2012 and until 2014.

INITIATIVE 1.2: Implement technology solutions to support the Office of the Health Care Ombudsman.

Building upon the infrastructure that was previously created, during FY 2012, 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 earlier 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.

OBJECTIVE 2: Develop and implement a comprehensive health information technology (HIT) plan.

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 2012, DHCF will complete the development and implementation of the PDH to exchange Medicaid claims information to improve health information sharing and improve health outcomes.

INITIATIVE 2.2: Develop and implement the "Direct" solution.
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). DHCF will develop and implement the Direct solution to be used by providers who are not connected to the HIE to provide them with a vehicle to meet the "meaningful use" definition. Meaningful use means providers need to show they're using certified HER technology in ways that can be measured significantly in quality and in quantity. The Direct solution will be implemented in FY2012.

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 Medicaid HER Incentive Program provides incentive payments to eligible professionals and eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified HER technology. The 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. Eligible hospitals may receive a minimum payment of $2 million and will have a six year window to meet eligibility criteria.

PROPOSED KEY PERFORMANCE INDICATORS – Office of the Director

Measure	FY2009 Actual	FY2010 Actual	FY2011 Target	FY2011 Actual	FY2012 Projection	FY2013 Projection
Percent of District residents uninsured	6.2%	6.2%	6.2%	6.2%[2]	6 %	6%
Number of consumers served by Ombudsman	723	3,727	3,900	3,313	3,500	3,600
Percentage of closed/ resolved cases among OHCOBR consumers	NA	90%	90%	98%	92%	94%

[2] Please note that the same percent uninsured is used for FY11 actual to prior years. The 6.2% is from the DC Health Insurance Survey. A more recent survey has not been completed.

Health Care Policy and Research Administration

SUMMARY OF SERVICES

The Health Care Policy and Research Administration maintains the Medicaid and CHIP state plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; develops policy for the Health Care Alliance program and other publicly funded health care programs that are administered or monitored by DHCF based on sound analysis of local and national health care and reimbursement policies and strategies; and ensures coordination and consistency among health care and reimbursement policies developed by the various divisions within DHCF. The division also designs and conducts research and evaluations of health care programs.

OBJECTIVE 3: Develop policies, plans and data to enable effective program administration and utilization of resources.

INITIATIVE 3.1: Streamline and improve eligibility policy and operations.

During FY 2012, DHCF will collaborate with the Economic Security Administration (formerly the Income Services Administration) at the Department of Human Services to implement eligibility changes as mandated by the Affordable Care Act. DHCF will embark on an ambitious but mandated complete redesign and retooling of Medicaid eligibility rules and processes as a result of health care reform. Eligibility categories will be consolidated, a new income standard based on IRS rules will be implemented, and all eligibility determinations will be integrated into a new, automated, streamlined eligibility portal. To support this major redesign, DHCF, with ESA, will submit a funding request to CMS to support the design, development and implementation of a new, automated eligibility system that will be integrated into the DC Health Care Exchange and will support eligibility determinations for all health and human service programs and a new, integrated case management system. Implementation will begin in FY 2012.

INITIATIVE 3.2: Improve data collection, aggregation and analysis to better understand the populations served and inform policy decisions.

The updated eligibility system and Medicaid Management Information System (Omnicaid) 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 Research Administration, DHCF is able to conduct analysis in-house that was previously outsourced. DHCF will review and analyze Medicaid and Alliance program utilization and program data to inform policy, program and budget issues.

INITIATIVE 3.3: 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 2012, 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 identify the proper way for billing for services to lower the risk of disallowance.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Policy and Research Administration

Measure	FY2010 Actual	FY2011 Target	FY2011 Actual*	FY2012 Projection	FY2013 Projection
Number of adults in 1115 childless adults waiver	Not Available	3,000	3,102	3,698	4,245

*As of August 2011

Health Care Delivery Management Administration

SUMMARY OF SERVICES

The Health Care Delivery Management Administration (HCDMA) ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, CHIP and Alliance programs. HCDMA accomplishes this through informed benefit design; use of prospective, concurrent and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers.

OBJECTIVE 4: Improve access to high quality services and improve resource management.

INITIATIVE 4.1: Develop and Issue a RFP for Long Term Care Support Services

During FY 2012, DHCF will develop and issue a request for proposals (RFP) to help manage the Personal Care Aide (PCA) benefit. Services provided by Personal Care Aides include assistance with dressing, bathing, eating, mobility, etc. At present, some of the services above are being provided by home health agencies that also deliver the personal care aide and EPD waiver services. The goals of this procurement are to:

1) Eliminate any conflicts of interest that may exist when an agency that is assessing the need for and authorizing the quantity of service to be delivered is the same agency that will receive financial compensation for delivering the services;

2) Improve program integrity and reduce fraud, waste, and abuse.

DHCF anticipates that this initiative will reduce fraud, waste and abuse in the program, result in more appropriate utilization of PCA services and produce significant cost savings.

INITIATIVE 4.2: Develop and Submit the ID/DD Waiver Application.

The current ID/DD waiver expires in November 2012; however, the DHCF must submit a new waiver proposal in the spring of 2012. In FY2012, DHCF, in collaboration with DDS, will develop and submit the ID/DD waiver application to the federal Centers for Medicare and Medicaid Services (CMS).

INITIATIVE 4.3: 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. During

August 2010, DHCF discussed with one of the District's current Medicaid managed care organizations (MCOs), United Healthcare Community Plan (formerly Unison), an opportunity to contract with their Medicare Advantage Health Plan (MA Plan). The Medicare Information Patient Provider Act (MIPPA) requires that carriers also have a MIPPA contract with the jurisdiction in which they do business, for the exchange of member information. Execution of the contract did not occur prior to conclusion of FY11.

In September 2011, United Healthcare's MA Plan presented DHCF with a proposed agreement to offer the MA Health Plan to dual eligibles residing in the District of Columbia. The District will provide the MA Health Plan with information on fee-for-service Medicaid provider participation. This initiative will provide better coordination of care and enhanced benefits for District residents dually enrolled in Medicare and Medicaid. Currently, the agreement has been submitted to the Office of Contracting and Procurement (OCP) for approval and completion.

INITIATIVE 4.4: 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.

INITIATIVE 4.5: Develop a Fee-for-Service member handbook.

In FY 2012, DHCF will develop and publish a Medicaid Fee for Service (FFS) member handbook. The handbook will provide Medicaid beneficiaries with important information regarding available benefits, how to access care, and key contact information. The handbook will be made available to all Medicaid FFS members.

INITIATIVE 4.6: 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. The program was initiated in FY 2010 and seeks to ensure cost-effective pharmaceutical care for Medicaid beneficiaries. In FY 2011 the Right Rx Initiative provided electronic access to a list of preferred medications that do not require prior authorization. The Preferred Drug List, prior authorization forms, evidence-based guidelines, and dosing/class conversion assistance were made available online to ensure prescribers can access these resources quickly. The initial drug category featured was Long Acting Narcotic Analgesics. The above changes were implemented accompanied by outreach to major stakeholder organizations such as the Medicaid Care Advisory Committee, District

of Columbia Boards of Medicine and Pharmacy, District of Columbia Primary Care Association (DCPCA) and the Unity Health Care Clinics. Performance has been assessed through monthly drug utilization review reports to view the shift of market share toward medications on the preferred drug list, as well as tracking associated cost savings. A portal for communication with DHCF program managers via the website for ongoing provider communication regarding prescription drugs was made available in FY 2011. During FY12, the Right Rx Initiative program will focus on promoting appropriate utilization and managing rising cost within several therapeutic categories, including Hepatitis C oral medications and Hemophilia clotting factor products. Increased use of the bi-monthly published Medicaid Providers Bulletin to highlight clinical practice standards updates and streamlined prior authorization procedures for these medications also is planned. The proposed use of the bi-monthly Medicaid Providers bulletin is intended to target some of the new high cost medications that have more specific prescribing and dosing requirements that demand strict prior authorization protocols. However, the bulletin might also be used to present comparative utilization data for providers on various therapeutic classes of medications. Most of the commonly dispensed drugs are already being dispensed generically.

OBJECTIVE 5: Improve health outcomes for District residents.

INITIATIVE 5.1: Improve birth and perinatal outcomes in the Medicaid program.
2012 marks the fourth 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 DHCF collaboration with Chartered Health Plan, Health Services for Children with Special Needs, Inc. (HSCSN), United Health Plan, 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 and 2010 measures were 231. The calendar year 2011 measure will be available in July 2012.[3] 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.

INITIATIVE 5.2: Launch a resource website for case managers and perinatal providers.

[3] 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.

As part of the Perinatal Collaborative to reduce adverse birth outcomes, in FY 2012 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. 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 2012, and utilization will be monitored to measure its effectiveness.

INITIATIVE 5.3: Reduce adverse outcomes for people with chronic illnesses.
2012 marks the fourth 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 performance to-date has been:

2008 baseline rate: 340 adverse outcomes / 1,000 individuals
2009 measure was: 490 adverse outcomes / 1,000 individuals
2010 measure was: 388 adverse outcomes / 1,000 individuals

The calendar year 2011 measure will be available in July 2012.

To improve outcomes, in FY 2012 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 2012 among the targeted population.

INITIATIVE 5.4: Execute new Utilization Management Contract.
DHCF will award a new Utilization Management contract during FY 2012. Through the utilization of concurrent, prospective, and retrospective reviews, the contractor will monitor the performance and quality of care offered by the District's Medicaid providers. Additionally, the contract will have a refined scope of work that will address fraud and abuse issues more extensively than in prior utilization management contracts. The Contractor will be certified by CMS as a Quality Improvement Organization (QIO), meaning that 75 percent of the contract cost can be federally funded. This contract will be awarded by September 30, 2012.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Delivery Management Administration

Measure	FY2010 Target	FY2010 Actual	FY2011 Target	FY2011 Actual	FY2012 Projection	FY2013 Projection
Percent of Medicaid beneficiaries in nursing facilities residing in out-of-state nursing facilities		TBD	10.3 %	NA[4]	9 %	8 %
Number of beneficiaries in ICF/MRs	370	402	350	NA[5]	340	330
Percent Medicaid beneficiaries satisfied with their health plan[6]	75%	TBD	77%	TBD[7]	79%	80%
Percent of eligible children receiving any preventive dental services	35%	37%	42%	TBD	50%	55%
Reported complaints (including missed/late trips) on transportation broker services, per 1,000 trips	2.5 per 1,000 trips	1.2 per 1,000 trips	2.5 per 1,000 trips	1.9 per 1,000 trips	2 per 1,000 trips	2 per 1,000 trips
Number of individuals moved from institutions to the community through Money Follows the Person program	60	32	24	24	60	60
Quality Improvement Initiative 1: Adverse Perinatal Outcomes per 1,000 pregnancies and infants8	less than 230	231	less than 220	TBD	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 failure9	less than 388	388	less than 373	TBD	less than 342	less than 342
HEDIS measure for childhood immunization10	83%	82%	85%	TBD	87%	87%
HEDIS measure for timeliness of prenatal care11	70%	65%	75%	TBD	80%	82%

[4] These data are forthcoming.
[5] These data are forthcoming.
[6] Data from *The Consumer Assessment of Healthcare Providers and Systems (CAHPS)* Health Plan Survey.
[7] FY11Actual data is not available until Fall 2012 because data is based on HEDIS measures. The Quality Improvement initiatives are calculated on the same reporting cycle as HEDIS and are generally available 9 months after the CY.
[8] 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.
[9] This measure aggregates emergency room visits and hospital admissions by individuals diagnosed with asthma, diabetes, high blood pressure, and congestive heart failure
[10] 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.

Measure	FY2010 Target	FY2010 Actual	FY2011 Target	FY2011 Actual	FY2012 Projection	FY2013 Projection
Adults' access to preventive/ambulatory care services (adults aged 20-44, enrolled in health plans)12	80%	78%	835%	TBD	85%	88 %

[11] 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.

[12] 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 Operations Administration

SUMMARY OF SERVICES

The Health Care Operations Administration ensures the division of programs that pertain to the payment of claims; management of the fiscal agent contract, management of the administrative contracts, management of the systems and provider enrollment and requirements. The office provides contract management of the Pharmacy Benefits Manager, and the MMIS Fiscal Intermediary contract as well as additional administrative contracts.

OBJECTIVE 6: Improve the efficiency of program operations.

INITIATIVE 6.1: 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 2012, 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 2011, DHCF's goal was to have 600 providers (or approximately 75% of active providers) paid electronically; in FY2012, DHCFs goal is to have 90% of active providers paid electronically.

INITIATIVE 6.2: Establish Inter-Departmental Committee on Public Providers and Medicaid Billing.

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). DHCF will establish a committee on public providers and Medicaid billing to inform and involve the public partners on Medicaid and the ASO.

INITIATIVE 6.3: Implement health care reform initiatives.

The Patient Protection and Affordable Care Act requires state to implement several Medicaid-related initiatives. Specifically, DHCF will implement initiatives related to

prescription drug rebates, recovery audit contractors, and health care acquired conditions in FY2012.

OBJECTIVE 7: Strengthen program integrity.

INITIATIVE 7.1: Strengthen strategies to prevent provider fraud and abuse.
In FY 2012, 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. DHCF will also implement edits required by CMS such as National Correct Coding Initiative (NCCI), Medical Unlikely Edits (MUE) and other Utilization Review edits into the MMIS. 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 7.2: Establish Multi-Disciplinary Compliance Team.
A lack of knowledge, ineffective / incomplete implementation of policies and procedures, insufficient documentation and inadequate oversight are reasons for inefficient operations. Therefore, the overarching focus must include educating stakeholders and DHCF employees on Medicaid rules and regulations to improve compliance. DHCF will establish an internal multi-disciplinary compliance team that will engage in on-going promotion of compliance issues related to program integrity, HIPAA, and other key areas.

PROPOSED KEY PERFORMANCE INDICATORS – Health Care Operations Administration

Measure	FY2010 Actual	FY2011 Projection	FY2011 Actual	FY2012 Projection	FY2013 Projection
Percent of providers paid electronically	31%	75%	34%	45%	45%
Average time to process Medicaid provider application	60 days	45 days	35 days	35 days	35 days
Number of referrals to the Medicaid Fraud Control Unit (MFCU)	TBD	25	22	25	25
Total recovered from provider audits (Local and Federal Funds)	TBD	$6.5 million	TBD[13]	$6.5 million	$6.5 million
Total recovered from Third Party Liability (TPL)	TBD	$7 million	$7.1 million	$6 million	$6 million

[13] FY11 Actual data for "total recovered from audits" is TBD because cases are still in the administrative appeal process.

Office of Health Care Reform and Innovation

SUMMARY OF SERVICES

The Health Care Reform and Innovation Administration identifies validates and disseminates information about new health care models and payment approaches to serve Medicaid beneficiaries seeking to enhance the quality of health and health care and reducing cost through improvement. Creates and tests new models in clinical care, integrated care and community health, and creates and tests innovative payment and service delivery models, building collaborative learning networks to facilitate the collection and analysis of innovation, as well as the implementation of effective practices, and developing necessary technology to support this activity.

OBJECTIVE 8: Implement health care reform.

INITIATIVE 8.1: Ensure stakeholder engagement in planning efforts

Stakeholder engagement is a key component an inclusive and transparent health reform implementation process. The ACA requires states to consult with a variety of stakeholders during the planning, establishment, and development of ongoing operations of the HIX. The participating and buy-in of stakeholders is essential to successful program implementation and long-term sustainability of the current health reform initiatives. DHCF will develop and implement a communications plan in FY2012 to ensure stakeholder engagement in the health reform planning efforts.

INITIATIVE 8.2: Secure funding for the 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 planning, establishment, and implementation funds through grants to states and the District for health insurance exchanges. The District was awarded a planning grant and Level I grant, totally over $9 million. The District will apply for Level II funding in FY2012 to secure funding to implement the District health insurance exchange. The Exchange must be implemented by 2014.

INITIATIVE 8.3: 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. DHCF will evaluate and identify the potential demonstration projects so the agency and the District are prepared to participate when demonstration opportunities are available. 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.