Department of Health Care Finance
DHCF *(HT)*

MISSION

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

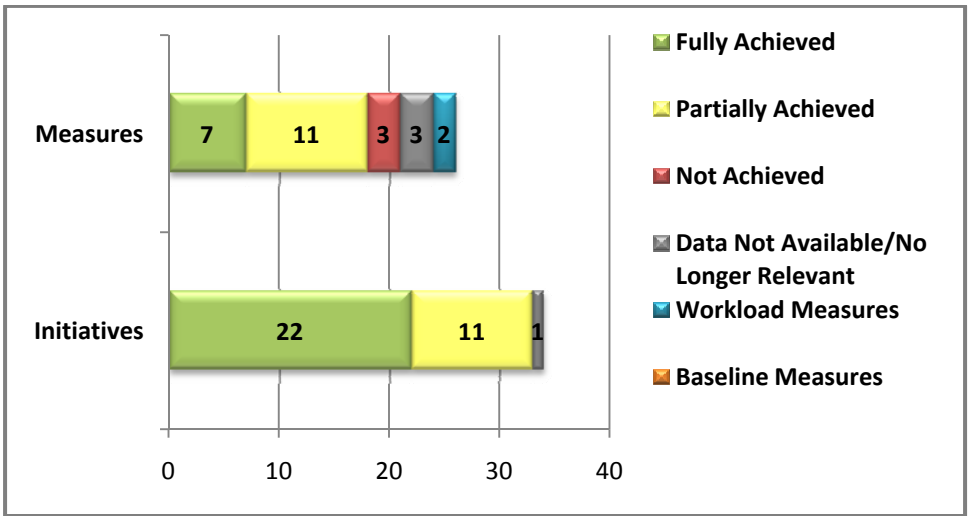
SUMMARY OF SERVICES

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

ACCOMPLISHMENTS

- ✓ Led the District to becoming the 2nd lowest in the nation in percent of uninsured residents, with only 6.2% of all District residents and 3.2% of District children lacking health insurance coverage in 2010.
- ✓ Became the second jurisdiction in the nation to implement the Medicaid expansion under the Patient Protection and Affordable Care Act (federal health reform), providing more expansive health insurance coverage to 30,000+ low-income District residents and saving District taxpayers millions of dollars annually.
- ✓ Significantly improved management of the Medicaid program and operations, resulting in the program's first improvement from material weakness status since 2006 in the District's Comprehensive Annual Financial Report.

OVERVIEW OF AGENCY PERFORMANCE



Performance Initiatives – Assessment Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

OFFICE OF THE DIRECTOR

OBJECTIVE 1: Improve outreach and communications.

INITIATIVE 1.1: Expand outreach strategies and tools for providers and beneficiaries.
In FY 2010, DHCF expanded and directed outreach activities to providers, beneficiaries, advocates and stakeholders. DHCF disseminates a provider newsletter to supply physicians and other providers with information that will improve billing and patient-care processes. Beyond DHCF's bi-monthly provider town hall meetings, specific outreach strategies undertaken include: The Office of the Health Care Ombudsman and Bill Rights has attended or presented to more than 10 organizations including a Health Fair over 14,000 residents; quarterly Managed Care Community Forums; and monthly EPD (Elderly and Physical Disabilities) Waiver Provider Town Hall. In addition, DHCF completed a procurement at the end of FY 2010 that resulted in the award of contracts to multiple firms for comprehensive outreach, communications and social marketing to increase awareness of DHCF services.

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 developed initial plans to establish a new coverage option for individuals ineligible for Medicaid or Alliance with incomes up to 400% of the federal poverty level (FPL). Significant budget pressures across the city and growing enrollment in other public assistance programs caused readjustments in Healthy DC planning and policy. While DHCF did not launch the Healthy DC program in FY 2010, the agency preserved eligibility and enhanced existing coverage - despite declining rends in other jurisdictions – through implementing changes to the Medicaid program and utilizing Healthy DC funds. As a result, DHCF was ensured continued coverage to roughly 225,000 DC residents as of the end of FY 2010, 14,000 more people than at the beginning of FY 2010.

OBJECTIVE 3: Design and implement health information exchange initiatives.

INITIATIVE 3.1: Implement Patient Data Hub.

The Patient Data Hub (PDH) is a multi-year 100% federally funded Transformation Grant pilot that comprises the technologies and components to enable real-time exchange of clinical and administrative medical data within the District. The PDH links government data sources (including Medicaid, immunization, lead registry and other databases) to provide a more complete profile of patients and their health care needs. Following the award of a contract for the PDH in May 2009 to MedPlus, Inc., implementation activities carried out in FY 2010 included software configuration and development of customizations to address requirements and specifications, installation and testing of software, user training, and loading Medicaid claims and encounter data. During FY 2010, an initial technical design also was developed for the interface between the PDH and the DC Regional Health Information Organization (DC RHIO) for exchange of clinical information for Medicaid recipients. Detailed implementation work on this interface is pending execution of a modification to the MedPlus contract early in FY 2011.

INITIATIVE 3.2: Implement District-wide Health Information Exchange

In FY 2010, DHCF received a Health Information Exchange (HIE) Cooperative Agreement Grant from the Office of the National Coordinator for Health Information Technology (ONC) at the Department of Health and Human Services (DHHS). The $5.18 million grant will facilitate the planning and implementation of a District-wide HIE. As part of the grant requirement for an initial planning phase, the District received funding authorization of $518,971 for development of an HIE Strategic Plan and an HIE Operational Plan, both of which were submitted to ONC in August 2010. DHCF has begun a review process with ONC that will continue into FY 2010. Under the requirements of the HIE grant, DHCF, in conjunction with the Department of Health (DOH) and the Office of the Chief Technology Officer (OCTO), convened an HIE Steering Committee consisting of representatives from health associations, interest groups and other District agencies. A grant management working group was also put into place to oversee required grant activities. DHCF also worked with the DC Primary Care Association (DCPCA) to position the DC RHIO (Regional Health Information Organization) as the technical baseline for the District's HIE strategy. DHCF HIE planning efforts also addressed several additional implementation requirements, including planning for a governance structure, planning for a sustainability model , identifying enhancements to security and privacy policies to incorporate recent HIPAA changes, connecting the Medicaid Patient Data Hub to the RHIO to link Medicaid clinical and claims data, and achieving coordination with other federal programs and states. This initiative has been fully implemented.

HEALTH CARE ACCOUNTABILITY ADMINISTRATION

OBJECTIVE 4: Improve health outcomes for District residents.

INITIATIVE 4.1: Implement the Quality Improvement Collaborative in perinatal and chronic illness. In FY 2010, two Collaboratives, one focused on Perinatal health, and one on Chronic Illness, were created to improve health outcomes in these areas. Detailed specifications for measuring both perinatal and chronic disease outcomes were created and deployed to calculate a baseline 2008 outcomes measures and assess the first year (2009) performance. The Perinatal Collaborative also developed and implemented a Global Authorization Assessment Form (GAAP) which screens for known pregnancy risks. Use of the GAAP created a comprehensive and uniform process for Medicaid providers to help ensure that pregnancies associated with risk factors receive appropriate case management and follow-up. A prototype website was also created that will identify psychosocial and health resources for mothers to help them have healthy pregnancies and healthy babies. The rate of adverse perinatal outcomes dropped from 327 adverse outcomes in 2008 to 231

adverse outcomes in 2009, based on fiscal year 2008 and fiscal year 2009 data, although this improvement may have been due to improved measurement. The Chronic Illness Outcomes Collaborative was also convened and identified illness self management and care coordination strategies as priority strategies for improving health outcomes. DHCF Also developed a directory of illness self management resources in the District. Finally, DHCF also implemented pay for performance (see Initiative 8.5) and a Consumer Report Card (see Initiative 4.2) for the District's contracted health plan to improve performance in these areas.

- **INITIATIVE 4.2: Develop a Consumer Report Card to facilitate beneficiary choice in managed care.** In FY 2010, DHCF developed a report card that Medicaid and Alliance beneficiaries, or parents or decision-making representatives of children in Medicaid or the Alliance, can use to help select a managed care organization (MCO). The report card was also developed to inform advocates and others about key aspects of MCO performance. The report aggregates data from national standardized quality data sets and summarizes performance in the areas of: 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; activities to improve perinatal outcomes; and specific performance on high profile health issues (i.e. lead screening). The first and baseline managed care report card was completed in 2009 and available to stakeholders in 2010; the second report card will be available by the end of calendar year 2010.

- **INITIATIVE 4.3: Implement quality improvements for chronic and long term care enrollees.** In FY 2010, DHCF developed and began implementing the DC Medicaid Nursing Home Quality Measurement & Improvement Initiative. Built upon the analyses of data from various sources, this initiative uses approaches that have been shown to collectively change the way care is delivered to meet both resident preferences and health needs. The ultimate goal is better health outcomes for nursing home residents. The initiative contains four phases: 1) provider-specific feedback & dialogue; 2) quality improvement collaborative(s); 3) public disclosure of nursing home performance in caring for DC Medicaid residents; and 4) incentives for nursing homes to achieve significant quality improvements. Similarly, a quality improvement strategy for home health care has been drafted as have a strategy, monitoring protocols and processes for home- and community-based services for the Developmental Disabilities (DD) waiver. Additionally, DHCF has completed a new quality strategy for the Elderly and Physically Disabled (EPD) waiver, with technical assistance provided through the Centers for Medicare and Medicaid Services, which will be included in the upcoming waiver renewal process.

- **INITIATIVE 4.4: Continue to Implement Nursing Facility Quality of Care Fund Projects.** The Nursing Home Quality of Care Fund was established to support investments that increase the quality of care provided to Medicaid beneficiaries in nursing homes. DHCF has partnered with the DC Office on Aging, which administers the program through a series of quality improvement grants. Some accomplishments in FY 2010 include the development of: 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) An on-line, real-time nursing facility bed database to track bed availability in the District. After careful review, the project focused on geropsychology that was considered for FY 2010 was not deemed appropriate for implementation at this time.

OBJECTIVE 5: Ensure limited resources are utilized appropriately.

- **INITIATIVE 5.1: Ensure Alliance program is limited to District residents.**
In FY 2009, DHCF published Emergency and Final rules clarifying and standardizing the process through which applicants prove District residency when applying for the Alliance. This included the adoption of a Proof of DC Residency form for any individual without traditional residency documentation (such as a license, utility bill, lease, etc.). The form provides a uniform process and set of data during the eligibility determination process. Building on this, in FY 2010, DHCF worked with the Department of Human Services (DHS) to implement the rule for all new applicants, including ongoing outreach and education to community-based organization and providers to ensure appropriate use of the Proof of DC Residency Form. Through the course of FY 2010, the Proof of DC Residency form was been successfully adopted by applicants and organizations that assist residents in applying for benefits. The result of this action did not result in an overall decrease in enrollment; however that is likely due to the continued recession-driven enrollment growth in the program offsetting any downward trends.

- **INITIATIVE 5.2: Limit Alliance coverage to District residents not eligible for other health insurance.**
In FY 2009, DHCF published Emergency and Final rules limiting Alliance coverage to DC residents who cannot access other types of insurance, such as Medicaid, Medicare, or commercial health insurance. This initiative is one of the solutions established to enable DHCF and the District to maximize resources and eliminate redundancies, and close the budget gap. During the last quarter of FY 2009, DHCF worked closely with the Department of Human Services (DHS), Income Maintenance Administration (IMA) to notify and terminate all Alliance members with other forms of insurance. In FY 2010, DHCF provided more detailed guidance to IMA to ensure that all new applicants for the Alliance are screened for alternate insurance. DHCF also began utilizing its Third-Party Insurance (TPL) vendor to run period data matches of the Alliance membership, which identifies members that may have alternate sources of coverage. This information is provided to IMA for additional verification and possible termination.

- **INITIATIVE 5.3: Transition coverage for Medicaid beneficiaries eligible for Medicare.**
In FY 2010, DHCF conducted a review of Medicaid claims data to estimate the number of Medicaid beneficiaries who are likely eligible for Medicare coverage, but are not yet enrolled. DHCF identified an experienced contractor who can assist these individuals to enroll in Medicare and developed contract language to secure their services. The contract to perform this function was executed in October 2010. Actual enrollment of Medicaid beneficiaries into Medicare will begin in 2011.

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

The Medicaid Fraud Control Unit (MFCU) is the prosecutorial entity within the Office of the Inspector General (OIG) which pursues actions against fraudulent Medicaid providers. DHCF refers suspected cases of fraud to the MFCU for investigation and adjudication. In FY 2010, DHCF formalized and standardized policies and procedures related to provider fraud, including: 1) Identifying suspected provider fraud; 2) Investigating, referring, and resolving suspected provider fraud; 3) Receiving, processing and efficiently handling calls to the DC Medicaid fraud hotline; and 4) Cooperating with the DC Medicaid Fraud Control Unit. In addition, DHCF revised the standard package of information given to the MFCU at the time of referral to enable quicker referrals of cases of potential fraud. As a result, in FY 2010 DHCF increased the number of cases of suspected fraud identified and referred to the MFCU to 25, up from 21 in FY 2009.

- **INITIATIVE 5.5: Implement strategies to prevent provider fraud and abuse.**
In FY 2010, DHCF continued work on its provider enrollment reform initiative targeting providers of durable medical equipment/medical supplies, orthotics, and prosthetics (DME/POS). DME/POS providers have been the subject of increased federal scrutiny for health care fraud and abuse. As a result of these efforts, DHCF terminated 25 DME/POS providers in FY 2010 because they either failed to meet requirements for Medicaid providers or failed to responds to requirements to re-enroll. Termination of these providers does not limit beneficiary's ability to access services, but rather ensures access to higher quality providers and enables DHCF to maximize its available resources by eliminating overpayments and fraudulent payments.

- **INITIATIVE 5.6: Increase recoupment of incorrect or fraudulent provider payments.**
In FY 2010, DHCF published a proposed rule on extrapolation that would change the process by which DHCF can recoup incorrect or fraudulent payments. The rule enables the Medicaid program to calculate the rate of wrongful billing by a provider by drawing a statistically valid and methodologically sound sample of their claims. The error rate found in the sample will be used as the error rate for the entire population of claims from which the sample was drawn and represents. This will be used to determine the amount providers are to repay to the District of Columbia. DHCF already has regulatory authority to extrapolate (apply) the results of a sample of claims to all similar types of claims for certain types of providers; i.e., providers of personal care, mental health care, and certain long term care waiver services. The rule would extend this authority to apply to all Medicaid services and their providers. Although the rule has not been finalized, DHCF substantially increased financial recoveries from providers in FY 2010 as a result of intensified efforts focused on high risk provider types. While awaiting the final rule the Office of Utilization Management (OUM) improved work processes and focused on home health claims, which DHCF already had extrapolation authority. In 2010, OUM recovered $5.6 million – more than four-fold increase from the $1.3 million recovered in 2009. This improvement highlights the benefit of using the extrapolation method for recoveries on all provider claims.

- **INITIATIVE 5.7: Implement proper utilization controls for home health benefits.**
In July 2010, DHCF transferred the Personal Care Aide (PCA) prior authorization process to the District's Quality Improvement Organization (QIO), Delmarva Foundation, to ensure more consistent monitoring. DHCF also began drafting policies and procedures to be implemented in FY 2011 to establish a cap on the number of hours of PCA that can be provided per year and to require authorization for these services. In addition, DHCF began drafting more rigorous regulations for PCA services that contain a number of safeguards that will enable more effective abuse prevention and monitoring. Post payment reviews of claims submitted and paid for home health benefits was also a priority for Office of Utilization Management for FY 2010 and accounted for the majority of the $5.6 million recovered by DHCF in 2010.

HEALTH CARE POLICY AND PLANNING ADMINISTRATION

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.**
During FY 2010, DHCF and CFSA collaborated to develop and submit to the Centers for Medicare and Medicaid Services (CMS) a Medicaid State Plan Amendment (SPA) for targeted case management (TCM). The SPA will allow reimbursement for TCM services provided by CFSA's nurse care managers, increasing the potential amount of federal funds received by CFSA. The SPA aligns

the District's Medicaid policy on TCM with current federal rules and regulations. Additionally, DHCF and CFSA collaborated to ensure federal reimbursement for services provided by CFSA's Healthy Horizons clinic. DHCF conducted at least two public provider reviews of the Healthy Horizons clinic, and as a result, DHCF issued two reports highlighting compliance with rules and regulations.

- **INITIATIVE 6.2: Improve billing practices at the District of Columbia Public Schools to improve access to health services.**
DHCF submitted and received approval for a State Plan Amendment (SPA) for school-based health services in September 2009 for an FY 2010 implementation. This SPA provides a new reimbursement methodology for school-based health services provided by school-based health services providers that aligns with federal policy, and protects against disallowances. In collaboration with the Office of the State Superintendent for Education (OSSE), the District of Columbia Public Schools (DCPS), and the Charter Schools, DHCF implemented the SPA during the course of FY 2010.

- **INITIATIVE 6.3: Obtain Federal funding for current school services eligible for Medicaid.**
As part of the implementation process for the school-based health services State Plan Amendment (SPA) (See Initiative 6.2), DHCF set rates for all approved school-based health services, employing a cost-based reimbursement methodology. Newly eligible services are: behavioral support; skilled nursing; personal care; mental health and counseling; orientation and mobility; and nutrition services. This included creating a cost report template and instructions and implementing a random moment time study (RMTS) – a first for the program. Finally, DHCF sponsored trainings for the District of Columbia Public Schools (DCPS) and Charter Schools on the new reimbursement methodology, the cost reporting process, and the RMTS.

- **INITIATIVE 6.4: Obtain Federal Funding for DCPS Early Stages Program.**
The school-based health services State Plan Amendment (SPA) included a provision for the Early Stages program at for the District of Columbia Public Schools (DCPS). The Early Stages Center is a free, comprehensive diagnostic testing facility that evaluates children 3-to-5-years-old for developmental delays and identifies the services that will help them succeed as they enter school. In FY 2010, DHCF worked to implement dental services at the Early Stages program location, including identifying Medicaid enrolled dentists to link to DCPS. In FY 2010, DCPS drafted an RFP for the dental services. By the close of FY 2010, services have not yet commenced, however, DHCF and DCPS continue to collaborate on the project and move towards implementation.

- **INITIATIVE 6.5: Increase technical assistance provided to OSSE and charter schools.**
In FY 2010, DHCF conducted 27 charter school site visits to explain the Medicaid provider enrollment process, Medicaid billing, and the school-based health services program. By the end of FY 2010, 29 charter schools were enrolled in the Medicaid program.

- **INITIATIVE 6.6: Maximize Federal Disproportionate Share Hospital (DSH) resources.**
Since 2002, the District has had a waiver that reallocates Disproportionate Share Hospital (DSH) funds from District hospitals to help improve health care coverage of District residents ages 50-64. The waiver allowed the District to move eligible individuals 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. The enactment of health care reform allowed the transition of eligible individuals with incomes up to 133% of the Federal Poverty Level (FPL) out of the Alliance and into Medicaid. This transition, involving approximately 32,000

people, was effective July 1, 2010. As a result, DHCF has closed out the 50-64 waiver, and has submitted a new 1115 waiver application to allow Medicaid coverage for eligible individuals with incomes over 133% up to 200% of FPL (approximately 3,000 individuals). Approval of this new waiver occurred in November 2010 with an implementation date of December 1, 2010. Simultaneously, a DSH state plan amendment (SPA) was submitted to Centers for Medicare and Medicaid Services and was approved in October 2010. The SPA will ensure that hospitals serving a disproportionate share of Medicaid, Alliance and uninsured District patients receive appropriate DSH funding by updating the formula that calculates the amount of funding a hospital receives.

- **INITIATIVE 6.7: Better understand and assess the District's uninsured population.**
  In April, 2010, DHCF released the findings of the 2009 District of Columbia Household Survey on Health Insurance Status. The survey was based on information from over 4700 households. The report included information on health insurance coverage, demographic and economic information, and access to and use of health care by District residents. Highlights include an overall rate of uninsured of 6.2%, much lower than the comparable national rate of 15.4% and the second lowest in the country. Beyond the April 2010 report, the survey data will serve as a resource for DHCF to conduct further analyses to guide administration of the Medicaid and Alliance programs and inform strategies to implement health care reform.

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

- **INITIATIVE 7.1: Implement new rate for Intermediate Care Facilities.**
  DHCF submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to update the Medicaid reimbursement methodology for Intermediate Care Facilities (ICFs) in August 2010 and is awaiting approval. The previous methodology was implemented beginning in FY 1997 and, with the exception of implementing one-to-one services, had not been updated since. The new methodology, developed with significant collaboration and stakeholder input, 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 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. The new methodology also 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 (PRFTs)**
  This State Plan Amendment (SPA) for a new Psychiatric Residential Treatment Facility (PRTF) rate was approved effective April 2009 and implemented in 2010. The SPA established a new service for children under the age of 22 in a provider type identified as PRTFs. It also established a methodology to reimburse PRTFs at increased rates, thereby encouraging provider participation. PRTFs located in the District are reimbursed at the Maryland Medicaid rate; out-of-District PRTFs that participate in their state Medicaid programs are reimbursed at their state Medicaid rate; and out-of-District PRTFs that do not participate in their state Medicaid programs are paid at their lowest self-pay rate.

- **INITIATIVE 7.3: Implement new rate for Prescription Drugs.**
  The Maximum Allowable Cost (MAC) state plan amendment was approved by the Centers for

Medicare and Medicaid Services (CMS) in April 2010. The SPA 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: Increase provider participation in the Medicaid program.

In FY 2010 DHCF raised physician rates to match Medicare rates (only 11 other states have done so) with a goal of increasing physician participation in the Medicaid program. During FY 2010, DHCF also improved its administrative processes, including streamlining provider enrollment and allowing for claims payment and tracking via the web. In addition, rates have been raised for facilities such as PRTFs (outlined in Initiative 6.3). DHCF's Health Care Policy and Planning Administration also worked closely with charter schools in the District to help them enroll as Medicaid providers. All of these efforts contributed to increased provider participation.

HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION

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

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

While DHCF planned to add additional services to its Elderly and Physically Disabled (EPD Waiver) during FY 2010, as a result of federal input and changes, DHCF halted these efforts and redefined its overarching EPD strategy. The federal Centers for Medicare and Medicaid Services (CMS) recommended that the District take a broader approach to its EPD Waiver rather than simply adding new services. Specifically, CMS recommended that the District redefine case management and restructure the waiver to offer 24-hour support, which required more time than anticipated including collaborating with advocates on case management. The second change that affected this initiative was the passage of federal health reform legislation created new home and community-based services options that merited consideration in the context of a broader EPD strategy. In response, in FY 2010, DHCF convened an internal working group to develop an enhanced EPD waiver, focused on: 1) A Comprehensive EPD Waiver, to offer 24-hour support with development of such service definitions is underway; and 2) an EPD Supports Program, intended to provide services to people who do not require 24-hour support and who have strong circles of family support (the format of this program is contingent upon CMS guidance which DHCF is currently pursuing through technical assistance calls with CMS).

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

In FY 2010, the District assisted 60 individuals with intellectual and/or developmental disabilities (ID/DD) move out of facilities and into intermediate care facilities for persons with developmental disabilities (ICFs/DD). DHCF achieved these transitions through its partnership with the Department on Disability Services (DDS). DHCF funds a Money Follows the Person (MFP) staff person at DDS and assists in transitions as well as identification of housing for people moving out of ICFs/DD and into the community under this program (a Federal grant initiative aimed at transitioned people out of facilities and into home and community-based settings). Transitions moved more slowly than anticipated due to challenges associated with identifying affordable, accessible housing and longer lead time than anticipated for transition planning (i.e., identifying supports providers, community-based health care providers, etc.).

INITIATIVE 8.3: Implement Participant Directed Care.

In July 2010, with regular input and guidance from an advocacy Advisory Work Group, DHCF

developed and informally submitted a Participant Direction waiver amendment to the federal Centers for Medicare and Medicaid Services (CMS). Participant direction gives the individual consumer more control over the type and amount of care they receive. CMS provided feedback and DHCF completed changes based on those comments. Additionally, DHCF has developed draft regulations to implement Participant Direction, released a Request for Proposals (RFP) for a contractor to serve the Fiscal Management Services (FMS) entity for the effort, and prepared a financial analysis for legal sufficiency, and secured OCFO sign-off on the effort. The waiver amendment and regulations will be submitted to the Council and the City Administrator's office, respectfully. Additionally, DHCF has begun systems modifications to accommodate Participant Direction. While DHCF anticipates an on-time implementation in FY 2011, the Department reduced the projected enrollment to 25 for the initial year, based on expert technical assistance from CMS-contracted analysts and CMS as national trends indicate slow up-take in Participant Directed programs. Finally, the Department on Disability Services (DDS) was included in the work discussed above in anticipation of adding Participant Direction to the ID/DD waiver in FY 2012.

- **INITIATIVE 8.4: Increase the capacity of the Office of the Ombudsman.**
  As part of efforts to expand the capacity of the Office of the Ombudsman within the District-wide budget and hiring constraints, the Office of the Ombudsman hired three student interns. The interns worked full time during the summer months and part-time during the year. By utilizing the internship program, DHCF was able to maximize its limited resources and provide career and professional training for District-based college students. In addition, the office hired one additional full-time staff person to service beneficiary needs. The addition of human capital enabled the Ombudsman's office to increase the number of residents served to 1603, above the 723 consumers served in FY 2009.

- **INITIATIVE 8.5: Implement pay-for-performance to improve quality in health services.**
  DHCF has implemented pay for performance for all of the District's contracted health plans. By withholding one percent of their capitation payments, DHCF incentivizes the health plans to improve the quality of health care provided to beneficiaries on specific Healthcare Effectiveness Data and Information Set HEDIS and administrative performance measures. The health plans can receive these funds based on a calculation of their improvement in meeting quality of care and administrative performance goals. DHCF anticipates disbursing the first year's incentive payments during the first quarter of FY 2011.

HEALTH CARE OPERATIONS ADMINISTRATION

OBJECTIVE 9: Improve the efficiency of program operations.

- **INITIATIVE 9.1: Improve Payment Processes for Providers**
  Omnicaid, the new Medicaid Management Information System (MMIS), was successfully implemented on December 21, 2009. As a result, providers are now submitting prior authorization requests and uploading required documentation, verifying beneficiary information and checking claim status using the web portal. In addition, some smaller provider offices also use the web portal to submit claims electronically. A time study completed to compare the time taken to verify eligibility using the web portal and DHCF's Interactive Voice Response system (IVR) showed that it takes half the time to verify eligibility online. This implementation has had a favorable response from provider groups. DHCF's ability to respond to inquiries from providers and beneficiaries has also improved in Omnicaid. Users are now presented with windows based screens that use 'point and click' functionality to navigate from one tab to another. The system allows access to additional

information to explain eligibility changes, claim adjudication logic and payment information. As DHCF continues to identify areas of potential fraud or abuse, the agency is now able to add limits that would cause a claim to suspend for review. In addition, DHCF Is now able to , after doing the necessary review, release pended claim en masse or in the event of a configuration error do mass adjustments without providers needing to resubmit claims.

- **INITIATIVE 9.2: Create a Provider Relations Unit.**
In FY 2010, DHCF rolled out a Provider Relations Unit to improve the District's response to the needs of public and private providers. During FY 2010, the unit researched an average of 1,000 claims per month related to submission and payment issues. Furthermore, the unit worked with other areas within DHCF and DC Government to implement new provider programs such as the new initiative regarding Psychiatric Residential Treatment Facilities (PRTF). This unit has also worked to decrease the time and amount of paperwork needed to become a Medicaid provider. In FY 2010, the Unit approved applications within an average of 14 days, compared with approximately 60 days during FY 2009. The average number of days for a variety of DHCF providers is as follows: Durable Medical Equipment (DME) Providers – 25 days (due to a required site visit); Pharmacy – 15 days; Hospital, Dialysis and Lab – 13 days; and other providers – 14 days. Applications are in progress for EPD Waiver, Charter School, PRTF and Freestanding Mental Health Clinics so averages are not available. The unit also assisted in facilitating the electronic funds transfer (EFT) program. During FY 2009, only 25% of active providers received an electronic payment. During FY 2010, 32% of providers were paid electronically which made up for a majority of the dollars paid out. The Provider Relations Unit is also on the verge of rolling out a campaign to increase the number of providers enrolled in the EFT program, consisting of a letter conveying the merits of participating in the EFT program as well as a revised EFT/District vendor application which will allow for an easier enrollment process.

- **INITIATIVE 9.3: Implement an Administrative Services Organization (ASO).**
DHCF selected Public Consulting Group (PCG) as the vendor for the District's Administrative Services Organization in October 2009. DHCF chose PCG because of its experience working with District agencies including District of Columbia Public Schools (DCPS) and their submission that met the District's needs by presenting a sound solution which involves qualitative and quantitative analyses of the claims to ensure accurate submission and payment. Due to circumstances beyond the control of DHCF, the contract was not approved until mid-September 2010. Once the contract was approved, a kick-off meeting was held between DHCF and PCG to discuss the plan for implementing the ASO for DHCF's sister agencies. The vendor will begin working with DCPS, the Office of the State Superintendent of Education (OSSE) and Child and Family Services Agency (CFSA) in October 2010.

Key Performance Indicators – Details

Performance Assessment Key:

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

	Measure Name	FY2009 YE Actual	FY2010 YE Target	FY2010 YE Actual	FY2010 YE Rating	Budget Program
	HEALTH CARE ACCOUNTABILITY ADMINISTRATION					
1.1	HEDIS measure for childhood immunization[1]	72.9	83			QUALITY AND PROGRAM INTEGRITY
1.2	HEDIS Measure for prenatal care[2]	68	78			QUALITY AND PROGRAM INTEGRITY
1.3	Adults' access to preventive/ambulatory care services (adults aged 20-44, enrolled in health plans)[3]	77.7	83			QUALITY AND PROGRAM INTEGRITY
1.4	Quality Improvement Initiative 1: Adverse Perinatal Outcomes[4]	231	226	231	97.84%	HEALTHCARE ADMIN SUPPORT
1.5	Quality Improvement Initiative 2: Adverse Chronic Disease Outcomes[5]	490	480	490	97.96%	HEALTHCARE ADMIN SUPPORT
2.1	Number of Referrals to Medicaid Fraud Control unit (MFCU)	21	25	25	100%	QUALITY AND PROGRAM INTEGRITY
2.2	Total Recovered from Provider Audits (Local and Federal Funds, Millions of Dollars)	1.3	7.5	$5.60	74.66%	

[1] Data unavailable until July 2011.
[2] Data unavailable until July 2011.
[3] Data unavailable until July 2011.
[4] Data unavailable until July 2011. The increase in reported adverse outcomes from FY 2008 to FY 2009 is due to, in FY 2009, health plans beginning to utilize data to determine whether a woman had been tested for HIV/AIDS; this data was not utilized in FY 2008.
[5] Data unavailable until July 2011. The increase in reported adverse outcomes from FY 2008 to FY 2009 is due to, in FY 2009 health plans beginning to pull diagnosis codes to identify adverse outcomes from all billing lines available, not simply the first line in data.

	2.3	Total Recovered from Third Party Liability (Millions of Dollars)	7.8	8.5	$5.80	68.24%	
	HEALTH CARE POLICY AND PLANNING ADMINISTRATION						
	1.1	Number of Chartered Schools Billing Medicaid	25	32	29	90.63%	PUBLIC PROVIDER LIAISON
	2.1	Number of Physicians Active in Medicaid Program	0	4600	4992	108.52%	POLICY UNIT
	HEALTH CARE DELIVERY MANAGEMENT ADMINISTRATION						
	1.1	Percent of eligible children receiving preventive dental services	0	35	47	134.29%	CHILDREN & FAMILY
	1.2	Number of Participants in Elderly and Physically Disabled Waiver	2181	2175	2201	108.52%	DISABILITIES AND AGING
	1.3	Average Number of Days to Process EPD Waiver Application	45	30	35	85.71%	DISABILITIES AND AGING
	1.4	Number of Participants in Developmental Disabilities Waiver	1327	1300	1345	96.65%	DISABILITIES AND AGING
	1.5	Number of Beneficiaries in Out-of-State Nursing Homes	178	170	190	89.47%	DISABILITIES AND AGING
	1.6	Number of Beneficiaries in ICF/MRs	390	370	402	92.04%	DISABILITIES AND AGING
	1.7	Number of Individuals Moved from Institutions to Community	0	75	60	80%	DISABILITIES AND AGING
	1.8	Percent of Medicaid Beneficiaries Satisfied with their Health Plan	73	75	67	89.33%	
	1.9	Number of Consumers Served by the Ombudsman	723	4200	3742	89.10%	CHILDREN & FAMILY
	1.10	Average Number of Days to Resolve Issues Brought to Ombudsman	2.5	2.5	2.87	87.10%	
	HEALTH CARE OPERATIONS ADMINISTRATION						

1.1	Average time to process Medicaid provider application (number of days)	0	60	22	272.73%	HEALTHCARE OPERATIONS
1.2	Percent of Providers Paid Electronically	25	50	31	62%	HEALTHCARE OPERATIONS
1.3	Transportation Broker Complaints (including missed/late trips) per 1,000 trips	1.48	2.5	1.57	159.24%	HEALTHCARE OPERATIONS
AGENCY MANAGEMENT						
1.1	Percentage of District Residents Uninsured[6]	0	9	6.2	145.16%	
	Number of District residents covered by Medicaid and Medicare (monthly average through August)	151,816		172,170[7]		
	Number of District residents covered by Alliance (monthly average through August)	51,773		50,140[7]		

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

[7] The monthly average number of District residents covered by Medicaid and Medicare increases substantially due to the transition in July 2010 of 30,000+ residents from the Alliance program to the Medicaid program as a result of federal health care reform. Similarly, while the average number of District residents covered by the Alliance is approximately 50,000, following this transition (in July and August 2010) there were slightly more than 25,000 residents covered by the Alliance program.