Department of Health Care Finance
DHCF *(HT0)*

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

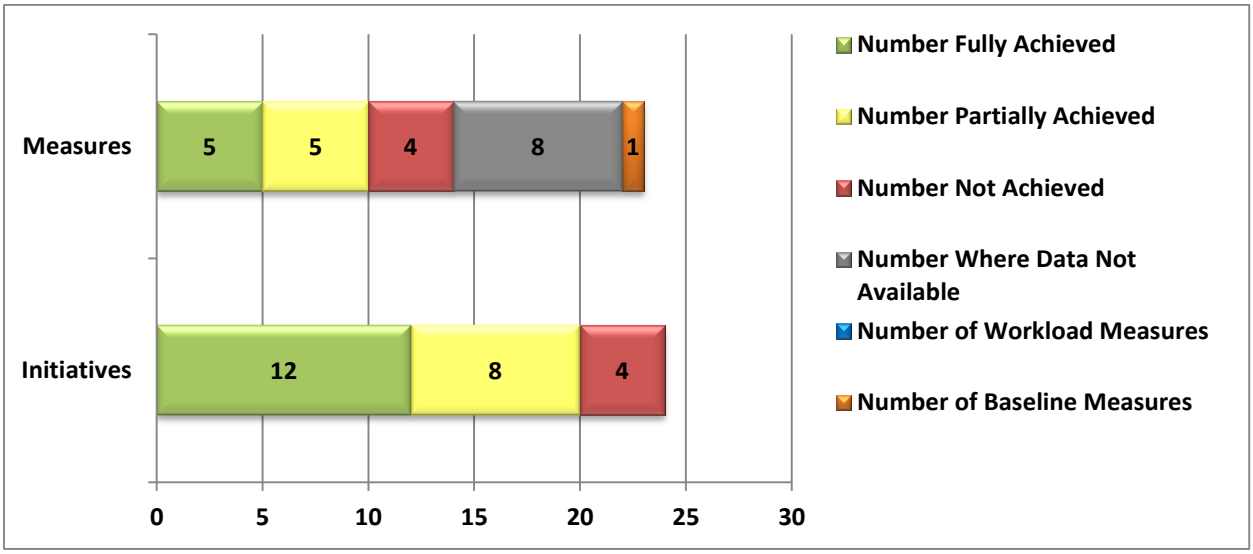
The Department of Health Care Finance provides health care services to low-income children, adults, elderly and persons with disabilities. Over 200,000 District of Columbia residents (one-third of all residents) receive health care services through DHCFs Medicaid and Alliance programs. DHCF strives to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

ACCOMPLISHMENTS

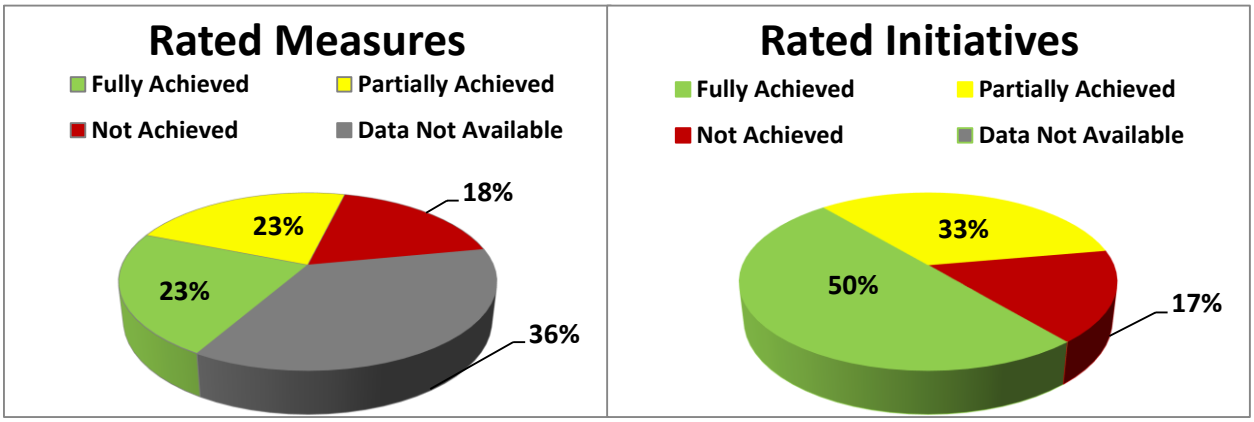
- ✓ Developed quality outcome measures and established a baseline for MCOs.
- ✓ Developed state-of-the art data analysis system.
- ✓ Implemented conflict-free assessment for PCAs to reduce fraud, waste and abuse.

OVERALL OF AGENCY PERFORMANCE

TOTAL MEASURES AND INITIATIVES



RATED MEASURES AND INITIATIVES



Note: Workload and Baseline Measurements are not included

Default KPI Rating:	
>= 100%	Fully Achieved
75 - 99.99%	Partially Achieved
< 75%	Not Achieved

Performance Initiatives – Assessment Details

Performance Assessment Key:

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

Agency Management

OBJECTIVE 1: Increase access to care for District residents.

INITIATIVE 1.1: Increase public awareness of services offered by the Ombudsman Office within the non-English speaking community.

Fully Achieved. The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) did supplement its current contract and contracted with a vendor to provide additional brochures and a media campaign targeting most of the prevalent languages spoken in the District of Columbia. A television ad was created, produced and various TV spots were purchased. The Office of Health Care Ombudsman's TV ad is airing on twelve (12) TV stations to include: AEN, APL, ENT, FAM, FOOD Network, FX, HLN, HGT, LIFE, OWN, TLC and TVL. The ad will be shown on the above-mentioned television stations until November 16, 2014. The Office of Health Care Ombudsman and Bill of Rights has worked collaboratively with the DC Health Care Exchange via twenty (20) Outreach/Education events of which our office shared exhibit tables and provided hand-outs explaining the purchase of health insurance through the exchange. OHCOBR also referred consumers interested in obtaining health insurance to the DC Health Link. We have been guest speakers at six (6) Outreach/Education events where representatives spoke about the new health exchange, services provided by the Office of Health Care Ombudsman and Bill of Rights; and Medicare's Savings Program (Qualified Medicare Beneficiary-QMB).

INITIATIVE 1.2: Establish the Office of Rates, Reimbursement, and Financial Analysis.

Fully Achieved. DHCF established the ORRFA on October 1, 2013 and began recruiting for all ORRFA positions at that time. All positions have been recruited and all positions are filled with the exception of one position.

OBJECTIVE 2: Develop policies, plans and data to enable effective program administration and utilization of resources.

INITIATIVE 2.1: Streamline and improve eligibility policy and operations.

Fully Achieved. DHCF, in collaboration with ESA, implemented the new Medicaid eligibility methodologies, effective October 1, 2013. Medicaid Eligibility rules correlating to the ACA-mandated changes to eligibility categories and income criteria have been published as a proposed rulemaking on November 7, 2014. Final rulemaking status should occur within the next thirty to sixty days. DHCF has developed eligibility policies and procedures for the new ACA-mandated changes.

INITIATIVE 2.2: Conduct policy and regulatory work necessary to authorize and implement new reimbursement methodologies for all hospital services, both inpatient and outpatient.

Fully Achieved. Five State Plan Amendments were drafted and submitted to CMS requesting the authority to update the reimbursement methodologies for Inpatient Hospital, Outpatient Hospital, Specialty Hospital, Sub-Acute Services in Specialty Hospitals, and Cost Reporting, Auditing, Records Maintenance and Appeals for Hospital Services. These SPAs are currently under review by CMS.

INITIATIVE 2.3: Increase sister agency personnel and public awareness of Medicaid's regulatory obligations, services, utilization, costs and changes related to the Affordable Care Act.
Fully Achieved. DHCF produced seven data snapshots in FY14, which are available on the DHCF website. The snapshots highlighted several topics related to beneficiary demographics, program utilization and costs, including identification of HIV seropositive beneficiaries, Mental Health Rehabilitation Services (MHRS) utilization, and costs and utilization of prenatal care services and pregnancy outcomes among teens in the District.

INITIATIVE 2.4: Complete State Plan Amendments and MOUs needed to implement Medicaid eligibility changes as mandated by the ACA.
Partially Achieved. All State Plan Amendments were submitted and approved by CMS. MOUs have been drafted and executed between DHCF, the DC Health Benefits Exchange, and the Department of Human Services (DHS). DHCF is working under a pre-existing MOU with Office of Administrative Hearings. DHCF is currently working on revisions to this MOU.

INITIATIVE 2.5: Implement the 1115 Childless Adults Waiver renewal application.
Fully Achieved. DHCF received approval from CMS to continue the waiver through December 2015 and implemented the waiver accordingly.

OBJECTIVE 3: Improve access to high quality services and improve resource management.

INITIATIVE 3.1: Develop utilization and cost reports of managed care activity and performance.
Fully Achieved. The MCO Quarterly Reports have been implemented and are distributed for public review through the DHCF website. The first report, Quarter 1 Performance Review was distributed in February 2014 and represents the review period of July 2013 to September 2013. The Quarter 2 report was distributed in June 2014 and represents October 2013 to December 2013. The most recent report for the review period of January 2014 to March 2014 was released in October 2014. The reports are presented to Stakeholders, including but not limited to the Chair of the Committee on Health, Medicaid providers and the Managed Care Organizations (MCOs). The report is also presented and discussed during the Medical Care Advisory Committee (MCAC).

INITIATIVE 3.2: Establish a Managed Care Advisory Council.
Not Achieved. A meeting was convened with the MCOs and the Child and Adolescent Supplemental Security Income Program (CASSIP) in November 2013 to discuss interest and feasibility of implementing the Council. During the same period, additional outreach was conducted to several providers within the health plans' networks (e.g., Pediatricians, OB/GYNs and Family Medicine), to gauge further feedback. Both the MCOs and providers expressed interest and willingness to participate, however all expressed concern about duplicate efforts with the Health Care Ombudsman Advisory Council. DHCF concluded that it was best to work within the established Ombudsman Advisory Council rather than establish a new council and moved forward accordingly.

INITIATIVE 3.3: Increase Medicaid providers' knowledge of EPSDT services.
Partially Achieved. The District continues to focus on improving compliance with the requirements for provider training. A summary of the requirements is included in DHCF's bi-monthly notifications to all providers. According to the latest reports from DHCFs vendor, Georgetown, the current percentage of overall EPSDT/HealthCheck providers who have taken the training is 64% (488 out of 758). DHCF also monitors compliance within each MCO provider

network - AmeriHealth (66%); HSCSN (71%); MedStar Family Choice (60%) and Trusted (72%). Additionally, three out of the four largest providers have a compliance rate of over 75%. DHCF is refining the provider list to ensure those providers on the list actually provide services to children. This effort will result in a more accurate provider list and a more accurate picture of the number of providers who need training and are serving children.

INITIATIVE 3.4: Expand the Pharmacy Network for the Healthcare Alliance Program.

Fully Achieved. The Alliance Pharmacy benefit was moved to the 25 DC Provider Pharmacy Network on October 1, 2013. This program allows the Alliance beneficiaries to have access to a larger pool of pharmacies with extended hours and days of operation. The transition of this service has given DHCF insight into expenditures and utilization of prescriptions and drugs for the Alliance population.

INITIATIVE 3.5: Implement Conflict Free Assessment for PCA Services.

Fully Achieved. The Long Term Care Supports Services (LTCSS) contract was awarded on July 16, 2013 (FY13). The contractor began conducting conflict free assessments on November 20, 2013 for new requests (defined as not receiving PCA services within the past 90 days) only in an effort to allow DHCF, the home care providers, and the contractor an opportunity to become familiar with the process and address all unforeseen concerns especially since the contractor was not involved in the piloting of the new LTC Assessment Tool. Initial assessment of existing beneficiaries was projected to start in April 2014; however, as a result of the FBI raid, DHCF fast-tracked the initial assessment for this group at the end of February, 2014. Although there have been a number of challenges, the new conflict-free assessment process has allowed for a more comprehensive review of a beneficiary's need for PCA services as the tool evaluates beneficiaries on more than just functional limitations and considers skilled care needs and cognitive / behavioral support needs as well. As of October 21, 2014, approximately 3,218 beneficiaries have been assessed and approximately 1,800 existing beneficiaries need an initial assessment. The deadline for this phased-in process (as per the new PCA regulation) has been extended to February 28, 2015. The current number of beneficiaries in the program has dropped by almost 2,000, a reflection of potential elimination of fraud, waste, and abuse and subsequent cost savings.

INITIATIVE 3.6: Improve Elderly and Persons with Physical Disabilities (EPD) Waiver provider quality.

Partially Achieved. DHCF has developed a process for assessing "readiness" of existing and prospective providers. The readiness process includes a face-to-face conference with service providers' agency seeking approval for delivery of an EPD service. However, this process has not yet been fully operationalized because of a significant competing and unexpected crisis, including a federal raid of PCA service providers. As a result of the scope and intensity of the federal raid, the agency head enforced an "all hands on deck" approach to triaging the immediate and potentially negative impact of the raid. While DHCF originally anticipated developing and/or revising processes; the raid that unfolded on February 20, 2014 initiated a crisis that extended to September 2014. DHCF also enhanced its approach to monitoring service providers to include a requirement of a face-to face conference at least annually with each provider. DHCF anticipates that these initiatives will extend into FY15.

INITIATIVE 3.7: Implement a new 1915(i) State Plan Adult Day Healthcare Program.

Not Achieved. This initiative was not met in FY14; nonetheless, DHCF has been working diligently to ensure the state plan application is approved by CMS. The initial 1915(i) State Plan Option was submitted to CMS on April 25, 2014. Since then, DHCF has received and responded to several formal and informal questions from CMS. On November 5, 2014, CMS advised DHCF to withdraw its most recent response as there are additional new requirements to be met. DHCF plans to resubmit its responses to CMS no later than November 14, 2014. It is important to note that this is as a result of CMS imposing additional new requirements to its new rules on Home & Community-Based Services (HCBS). DHCF has scheduled a meeting with stakeholders for Monday, November 10, 2014, to provide a status update.

OBJECTIVE 4: Improve health outcomes for District residents.

INITIATIVE 4.1: Implement a risk-adjusted rate model for the Medicaid managed care program.

Fully Achieved. Effective May 1, 2014, DHCF implemented risk-adjusted rates with the MCOs. Currently, the model does not include risk-adjustments for the Alliance Program because the benefit package does not align with a standard Medicaid benefit package underlying the nationally available risk-adjustment model. The population has recently undergone change in size and the pharmacy data used to risk-adjust the Medicaid population is not readily available.

INITIATIVE 4.2: Improve the quality of services provided by District nursing facilities.

Not Achieved. For FY14, providing payments for quality improvement initiatives did not receive approval from the Centers for Medicare and Medicaid Services; therefore, it could not be implemented. Specific to the nursing facility report card, the agency determined it was best to refer to the nursing home performance data that is available to the public on the CMS website (Nursing Home Compare).

INITIATIVE 4.3: Assist Medicaid beneficiaries moving from institutions to the community.

Partially Achieved. During FY14, twenty (20) DC Medicaid beneficiaries were transitioned from long term care institutions to the community through MFP. Over the year, the LTC Administration worked closely with the office of the Deputy Mayor for Health and Human Services, its Special Assistant on Community Living, and the DC Office on Aging/Aging & Disability Resource Center (DCOA/ADRC) to streamline transition coordination for nursing facility residents who need long term care services and supports to return to the community. This collaboration intensified as the transfer of MFP transition coordination team members from DHCF to the DCOA/ADRC was finalized in the last quarter of the fiscal year. The first of two Memorandums of Understanding between DHCF and DCOA/ADRC, including the transfer, was executed September 29, 2014, with the transfer of staff slated for the first quarter of FY15. Consistent with this timeline, oversight and monitoring tools for DCOA/ADRC transition coordination activities will be finalized in the first quarter of FY15. By the end of FY14, the regulations for the MFP Demonstration including the new services Peer Counseling and Enhanced Primary Care Coordination progressed to the 2nd notice of proposed rulemaking.

INITIATIVE 4.4: Increase collaboration between Primary Care Providers (PCP) and Dentists on oral healthcare for young children.

Fully Achieved. Starting in October 2013, fluoride Varnish trainings were conducted in person and via on-line through dchealthcheck.gov. A formal provider Transmittal was sent to all providers serving children concerning fluoride varnish trainings. Additionally, a notice is included in each Provider Bulletin sent to all Medicaid providers on a bi-monthly basis. The Dental HelpLine continues to be managed and supported. In October 2013, a meeting of the DC Chapter of the American Academy of Pediatrics was held to discuss primary care and oral health integration, including a focus on fluoride varnish training.

OBJECTIVE 5: Improve the efficiency of program operations.

INITIATIVE 5.1: Improve provider payment efficiency.

Not Achieved. Enrollment to be paid via EFT is voluntary and providers must elect to use EFT. DHCF continued outreach efforts, including highlighting the EFT option in the July/August provider bulletin. Additionally, EFT applications are provided to providers who had returned checks to the agency. Despite the outreach efforts, there has not been a significant increase in the number of providers that have enrolled in the EFT program.

OBJECTIVE 6: Strengthen program integrity.

INITIATIVE 6.1: Strengthen strategies to prevent provider fraud and abuse.

Partially Achieved. DHCF implemented the system changes associated with new provider screening and enrollment requirements in FY14. However, DHCF was delayed with beginning the re-enrollment of providers including conducting the mandatory site visits because of administrative actions which needed to take place prior to implementation. DHCF Provider Services Management revised employee's position descriptions and enrollment policies and procedures as well as held staff trainings to inform them of the new changes. In addition, providers were notified of the changes via the provider bulletins, provider-type specific meetings, press release and transmittal. Xerox, DHCF's fiscal agent, issued the first round of re-enrollment letters to the providers on September 30, 2014. These providers are expected to re-enroll by December 31, 2014.

INITIATIVE 6.2: Work with the Division of Managed Care and the Managed Care Organizations (MCOs) to improve compliance with federal and state fraud waste and abuse rules and regulations.

Partially achieved. DHCF implemented regular meetings with the MCOs. The purpose of these meetings is to discuss issues related to fraud, waste and abuse; share information about Medicaid Fee for Service providers who were referred to law enforcement; and provide technical assistance around issues related to program integrity.

OBJECTIVE 7: Develop and implement a comprehensive health information technology (HIT) plan.

INITIATIVE 7.1: Expand partnerships with other District agencies and external stakeholders to utilize health information technology to deliver better coordinated patient care and cost savings.

Partially Achieved. By the close of FY14, HCRIA exceeded or came close to meeting the four metrics directly tied to this initiative. In FY14, HCRIA aggressively recruited individuals to sign-up to use Direct, which resulted in subscription from health care stakeholders internal and external to District government. In FY14, DHCF transferred $2.1 million to DOH to expand its capacity to gather information connected to syndromic surveillance, laboratory data, immunizations and the

cancer registry. DHCF also issued sub grants to hospitals, enabling them to connect to Maryland's established state HIE to receive real-time admission, transfer and discharge (ADT) data, through Direct, on Medicaid beneficiaries using hospitals in DC and Maryland. However, HCRIA was unable to harness the ADT and public health information newly available through Direct and the public health reporting to determine the utilization patterns and the health conditions leading to potentially avoidable hospital admissions and ER use. The level of staff effort needed to accomplish this objective was not available. To fully accomplish this initiative, DHCF submitted an application for a State Innovation Model Grant from CMS. If awarded, DHCF will leverage the new staff, consultants and expertise that the grant will fund to perform the 'hot-spotting activities' planned for this Initiative.

INITIATIVE 7.2: Implement and Monitor the District's Medicaid Electronic Health Record Incentive Payments Program.

Partially Achieved. As of September 2014, the District's Medicaid EHR Incentive Program (MEIP) is in full operation. In FY14, DHCF approved 70 MEIP provider payments. Compared to the number of MEIP payments made in FY13 to providers (10), DHCF achieved a 700% increase in the number of MEIP payment made to providers in FY14. Of those that received the MEIP payments in FY14, 37 were clinicians practicing in FQHCS, followed by 33 individuals practicing in non-FQHC clinics. No hospitals were awarded a provider payment in FY14. While the number of payments made in FY14 is substantially more than in FY13, it is also significantly lower than HCRIA's original FY14 MEIP provider payment projections. Through additional research completed after the FY14 MEIP provider payment projections were submitted, HCRIA learned that over 200 eligible providers were issued MEIP payments from Maryland's State Level Registry before the District's MEIP was fully functional. Further, many providers eligible for the MEIP are not motivated to attest to the first phase of the MEIP for payment before the federally-mandated deadline of 2016, since there are no penalties by the federal government for not attesting to the additional MEIP phases (i.e. Meaningful Use) for Medicaid-only providers. As a result, the initial FY14 MEIP provider payment projections were too high, and should have been around 100.

OBJECTIVE 8: Implement Health Care Reform and increase the number of District residents with health insurance (One City Action Plan Indicator 3G).

INITIATIVE 8.1: Research, develop or support payment reform models to deliver improved care to Medicaid beneficiaries and cost savings for the program.

Partially Achieved. While the program design for the initial Medicaid Health Home State Plan benefit targeting individuals with severe mental illness (SMI) was completed in FY14, the provider community submitted multiple comments to DHCF requesting that the proposed payment methodology of the benefit be revised to better reflect the acuity of the target SMI beneficiary population. As such, DHCF continued its partnership with DBH to develop a tiered payment methodology based on the cost, hospital utilization and health conditions of the individuals eligible to enroll in the Health Home program. The time required to determine the revised payment methodology required that the Health Home SPA submission be postponed to FY15.

Performance Initiatives – Assessment Details

Performance Assessment Key:

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

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
Agency Management								
	1.1	Number of consumers served by Ombudsman	3,528	3,700		7,220	195.14%	AGENCY MANAGEMENT PROGRAM
	1.2	Percentage of closed/resolved cases among OHCBR consumers	94%	95%		91.58%	96.40%	AGENCY MANAGEMENT PROGRAM
	1.3	Percentage of commercial cases overturned	68%	80%		26.67%	33.33%	AGENCY MANAGEMENT PROGRAM
	2.1	Number of adults in 1115 Childless Adults Waiver	4,716	5,453		7750	142.12%	HEALTHCARE POLICY AND PLANNING
	2.2	Number of Adults enrolled in Medicaid Emergency Psychiatric Demonstration	N/A[1]	235		235	100.00%	HEALTHCARE POLICY AND PLANNING
	4.1	Percent of beneficiary satisfaction with their health plan	73.5%	81%		Data not reported[2]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
	4.2	Percent of eligible children receiving preventative dental services	47%[3]	60%		Data not reported[4]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
	4.3	Number of reported complaints on transportation broker services per 1,000 trips (including missed/late trips)	1.8	2		2.16	92.7%	HEALTHCARE DELIVERY MANAGEMENT

[1] New measure as of FY 14.
[2] YE Actual not available until July 2015.
[3] Includes District average of all health plans and fee-for-service.
[4] Final due in April 2015; will submit by May 30, 2015.

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
●	**4.4**	Adverse perinatal outcomes per 1,000 pregnancies and infants.	0[5]	195		Data not reported[6]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
●	**4.5**	Adverse chronic disease outcomes per 1,000 people (asthma, diabetes, hypertension, congestive heart failure)	0[7]	340		Data not reported[8]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
●	**4.6**	Percent of children received age-appropriate immunizations (HEDIS measure)	79.3%[9]	88%		Data not reported[10]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
●	**4.8**	Percent of timeliness of prenatal care	79.8%	83		Data not reported [11]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
●	**4.9**	Percent of adults enrolled in health plans who accessed preventive/ambulatory care (age 20-44)	76%[12]	89		Data not reported[13]	Not Rated	HEALTHCARE DELIVERY MANAGEMENT
●	**5.1**	Total dollars recovered from Third Party Liability (TPL)	$3,500,000	0	$4,000,000	$5,176,519	>100%	HEALTH CARE OPERATIONS
●	**5.2**	Percentage of providers paid electronically	38.7%	60%		39.12%	65.20%	HEALTH CARE OPERATIONS

[5] Due to health plans transitioning in/out of the District of Columbia, Medicaid Program, on or about July 2013, actual data for Measurement Year (MY) 2013 (January 2013 - December 2013) is unavailable. The actual data will be available in 2015.
[6] Data not available until July 2015; will resubmit by August 31, 2015.
[7] Due to health plans transitioning in/out of the District of Columbia, Medicaid Program, on or about July 2013, actual data for Measurement Year (MY) 2013 (January 2013 - December 2013) is unavailable. The actual data will be available in 2015.
[8] Data not available until July 2015; will resubmit by August 31, 2015.
[9] District average of Health Plan rates only.
[10] YTD data due in April 2015, final due in July 2015; will resubmit by August 31, 2015.
[11] YTD data due in April 2015, final due in July 2015; will resubmit by August 31, 2015.
[12] District average of two Health Plan rates only (HSCSN and MSFC).
[13] YTD data due in April 2015, final due in July 2015; will resubmit by August 31, 2015.

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
	5.3	Average time (days) to process Medicaid provider applications	30.5	30		37.81	79.35%	HEALTH CARE OPERATIONS
	6.1	Number of referrals to the Medicaid Fraud Control Unit (MFCU)	15	20		9	Baseline Measure Not Rated	HEALTH CARE OPERATIONS
	7.1	Total number new users enrolled in DIRECT	150	225		137	60.89%	HEALTH CARE REFORM & INNOVATION
	7.2	Number of active DIRECT users	50	70		159	227.14%	HEALTH CARE REFORM & INNOVATION
	7.3	Number of Medicaid providers receiving incentive payments	400	450		71	15.78%	HEALTH CARE REFORM & INNOVATION
	7.4	Number of hospitals connected to HIE	0	8		6	75%	HEALTH CARE REFORM & INNOVATION
	7.5	Number of new provider organizations transmitting public health data in electronic format to DOH	0	50		44	88%	HEALTH CARE REFORM & INNOVATION
	8.1	Percentage of District residents insured	93.8%	95%		Data not reported[14]	Not Rated	HEALTH CARE REFORM & INNOVATION

[14] Census data not available until October 2015.