FY 2015 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 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 DHCF's Medicaid and Alliance programs. DHCF strives to provide these services in the most appropriate and cost-effective settings possible.

PERFORMANCE PLAN DIVISIONS
- Office of the Director
- Health Care Finance[1]
- Health Care Policy and Research Administration
- Health Care Delivery Management Administration
- Health Care Operations Administration
- Health Care Reform and Innovation Administration
- Long Term Care Administration

AGENCY WORKLOAD MEASURES

Measures	FY 2012 Actual	FY 2013 Actual[2]	FY 2014 YTD[3]
Number of District residents covered by Medicaid (Year End)	218,968	TBD	TBD
Number of District residents covered by Alliance (Year End)	17,289	TBD	TBD
Percentage of District residents insured	92.1%	93.8%	TBD

[1] Health Care Finance represents the agency's provider payments. Objectives and initiatives related to Health Care Finance are integrated throughout each Administration's objectives and initiatives.
[2] Census data unavailable
[3] Census data unavailable

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 health care for District residents.

INITIATIVE 1.1: Increase the number of commercial appeal/grievance cases that are eligible for external review or reconsideration.
The Office of Health Care Ombudsman and Bill of Rights will continue to conduct research using medical journals/periodicals, medical research websites and communication with providers to assist in obtaining information to support the medical services that are being denied. These resources allow the staff to strengthen the cases before requesting reconsideration of the cases in efforts to have the denials overturned.
Completion Date: September, 2015.

INITIATIVE 1.2: Work with various community-based organizations and DC Government agencies that serve residents with mental health and substance abuse (behavioral health) issues.
Staff will attend community meetings and participate in outreach events to guide and educate this population of the services available for their use through the Office of Health Care Ombudsman. We will include two (2) members from mental health and substance abuse (behavioral health) community-based organizations on the Advisory Council.
Completion Date: September, 2015.

OBJECTIVE 2: Improve access to health care by developing cost effective reimbursement methodologies and budget process.

INITIATIVE 2.1: Develop reimbursement rates that reasonably reflect the actual costs of providing quality care to Medicaid beneficiaries.
DHCF will analyze, develop, and implement at least two provider reimbursement methodologies in FY15 for Medicaid services. The methodologies will be representative of the costs of providing quality care to Medicaid beneficiaries.
Completion Date: September 30, 2015.

KEY PERFORMANCE INDICATORS – Office of the Director

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (Actual or YTD)[4]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Number of consumers served by Ombudsman	6,507	3,700	7220	5,000	5,200	5,500
Percentage of closed/resolved cases among Office of the Health Care Ombudsman Bill of Rights' consumers	98%	90%	91.58%	98%	98%	98%
Percentage of commercial cases overturned	11%	80%	26.67%	12%	13%	14%
Number of provider categories to be audited and related financial reviews	N/A	N/A	N/A	6	6	6
Number of new reimbursement methodologies and rates to be developed	N/A	N/A	N/A	2	2	2
Percentage of invoices processed accurately and in compliance with Prompt Payment Act	N/A	N/A	N/A	95%	96%	97%

[4] Actual as of September 30, 2014

Health Care Policy and Research Administration

SUMMARY OF SERVICES

The Health Care Policy and Research Administration (HCPRA) maintains the Medicaid and Children's Health Insurance Program (CHIP) state plans that govern eligibility, scope of benefits, reimbursement and program integrity policies; develops policies for the DC Healthcare Alliance and other publicly funded health care programs administered or monitored by DHCF. HCPRA uses sound analysis of local and national policies and strategies related to health care and reimbursement; and it ensures coordination and consistency among health care and reimbursement policies developed by the various administrations within DHCF. The Administration also conducts research and preliminary evaluations of health care programs.

OBJECTIVE 1: Develop policies, plans, and data to enable effective program administration and utilization of resources.

Initiative 1.1: Streamline and improve eligibility policy and operations.
Develop and design system functionality for the implementation of Non-MAGI eligibility determinations in D.C. Health Link. HCPRA continues to participate in daily meetings to discuss the design and build of the eligibility system to include Non-MAGI eligibility groups and provides Medicaid eligibility subject matter expertise to system developers to ensure system rules and logic comply with federal and state regulations.
Completion Date: September, 2015.

Initiative 1.2: Complete State Plan Amendments and MOUs needed to implement Medicaid eligibility changes as mandated by the ACA.
DHCF submitted and received approval from the Centers for Medicare and Medicaid Services (CMS) for 43 State Plan Amendments to establish authority to implement ACA-mandated Medicaid eligibility changes. To support the approval of these SPAs, rules have been drafted that correlate to each SPA. Currently these rules are under review by the Office of the General Counsel in preparation for publication in the District of Columbia Municipal Regulations (DCMR). Further the Division of Eligibility has drafted and executed Agreements with the DC Health Benefits Exchange, the Department of Human Services and the Office of Hearing and Appeals establishing the respective responsibilities of these agencies to implement and administer the new streamlined, automated and integrated Medicaid eligibility system.
Completion Date: February, 2015.

Initiative 1.3: Increase sister agency personnel and public awareness of Medicaid's regulatory obligations, services, utilization, costs and changes related to the Affordable Care Act.
HCPRA will continue to increase public knowledge of agency activities through public reporting activities; HCPRA staff will support the development and publication of two or more distinct quarterly public reports. These reports will cover topics such as Medicaid managed care, nursing facility care, or other subjects, and will increase agency oversight, transparency, and public knowledge of the selected subjects.
Completion Date: September, 2015.

Initiative 1.4: Develop, submit, and implement a state plan amendment for Medicaid coverage for childless adults.
DHCF successfully submitted an application for an extension for the Childless Adults Demonstration through calendar year 2014, and plans to develop, submit, and implement a state plan amendment in order to continue to enroll and cover childless adults at incomes between 133 and 200% of the federal poverty level. **Completion Date: September 2014**.

KEY PERFORMANCE INDICATORS – Health Care Policy and Research Administration

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (YTD)	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Number of adults in 1115 Childless Adults Waiver	4,202	5,453	7,750[5]	6,190	6,617	7,294
Number of adults enrolled in the Medicaid Emergency Psychiatric Demonstration	N/A	235	235[6]	235	N/A[7]	N/A[8]

[5] FY14 YTD data as of 9/30/14
[6] FY14 YTD data as of 6/30/14
[7] Medicaid Emergency Psychiatric Demonstration Project ends 2015
[8] Medicaid Emergency Psychiatric Demonstration Project ends 2015

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

INITIATIVE 1.1: Improve primary care provider well-child visit documentation and billing.

DHCF will improve the billing procedures for well-child visits to better document the various components of a well-child visit (or primary care visit) for Medicaid beneficiaries under the age of 21 receiving the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit. The overall goal of this project is to incorporate all aspects of health into a well-child visit in the primary care setting, including oral, behavioral, and developmental health. DHCF will revise the billing instructions for providers and will have a new billing manual in FY15. DHCF will also conduct provider training and work to promote widespread adoption among the pediatric provider community. Finally, DHCF will develop a report template and set a baseline to determine progress in future years. **Completion Date: September 30, 2015.**

INITIATIVE 1.2: Revise the Managed Care enrollment process for the Immigrant Children Program (ICP).

DHCF will revise the managed care enrollment process for the Immigrant Children Program (ICP). Currently, the ICP enrollment is based on DHCF's receipt of eligibility in the Medicaid Management Information System (MMIS). Consequently, it may not become effective the same month in which the application was received by the Department of Human Services, Economic Security Administration's (ESA) eligibility determination system. The revision will replicate the Managed Care enrollment process "rules" for the Alliance Program to ensure immigrant children are immediately enrolled in managed care with access to medical services. Additionally, this will prevent many of the requests for fair hearings due to balance-billing to the population for medical services rendered when managed care eligibility was not effective.
Completion Date: March, 2015.

INITIATIVE 1.3: Plan, develop and implement methodology for validating the adequacy of the MCO networks.
The Managed Care Organizations (MCOs) contract with many of the same providers to provide services to the enrolled membership. Each MCO presents with an adequate number of primary and specialty providers that meet the ratio requirements within the Managed Care contracts, but additional evaluations are necessary to ensure that members have timely access to care in accordance to the *Appointment Times for Services* in Section C.9.3.4. DHCF will collaborate with the Enrollment Broker to expand Secret Shopper activities to confirm provider participation with MCO networks, active and inactive status, review GeoAccess reports to assess locations within the various Wards and conduct onsite visits to monitor wait times within provider offices. The top 3 high-volume provider offices that are shared amongst the MCOs will be targeted each quarter. A review of current contract provisions on network adequacy will be conducted to ensure clear and concise language that defines the requirements and consequences for non-compliance. All initial findings will be shared with the health plans and interventions will be implemented to ensure proper adequacy within the Medicaid managed care program. **Completion Date: March 30, 2015.**

OBJECTIVE 2: Improve health outcomes for District residents.

INITIATIVE 2.1: Assess, plan, develop and implement a quality improvement strategy.
During FY15, DHCF will develop quality improvement strategies that are effective and designed to achieve improved health outcomes. DHCF will convene collaborative work groups and meetings with internal staff, external stakeholders, sister-agencies and MCOs to identify barriers to care and access by our beneficiaries. DHCF will prepare root-cause analyses, collect baseline data and develop strategies and interventions in an effort to eliminate these challenges. DHCF will measure and analyze outcomes of each intervention and implement new interventions as necessary**. Completion Date: September, 2015.**

INITIATIVE 2.2: Plan, develop and implement standards for Case Management (CM) for use by the MCOs/CASSIP.
The Division of Quality and Health Outcomes will implement a comprehensive Case Management Program for the MCOs/CASSIP that will enhance outreach to enrollees who may qualify for Case Management services and work to increase the quality of those services. The program will be developed with input from the MCOs/CASSIP and community stakeholders. In addition, the program will include education and training for all Case Managers, Providers and Enrollees, including establishment of minimum caseloads per Case Manager. Further development of the program will include consistent minimum standards of services offered, interventions and performance outcome measurement. Success will be determined by the amount of Medicaid beneficiaries who participate in the program and improved health outcomes for those beneficiaries. The goal is to implement a program that allows the Department of Health Care Finance (DHCF) to measure Case Management services provided by each MCO/CASSIP to ensure that quality Case Management services are received by eligible enrollees that are

aligned with national standards of care to produce positive health outcomes. A completed program description and timeline for baseline measurement will be submitted by February 27, 2015. **Completion Date: March 30, 2015**

INITIATIVE 2.3: Improve timeliness of acute and specialty hospital utilization reviews to ensure timely access of services for Medicaid FFS.

In FY2015, DHCF will work with its QIO contractor, Qualis, to improve the timeliness of acute and specialty hospital reviews. Specifically, DHCFs goal is to have 98 percent of emergency hospital admissions and continued stay acute and specialty hospital reviews complete within 24 hours. For other hospital review, including, acute pre-authorization and specialty hospital reviews, DHCFs goal is for 98 percent of reviews to be complete within 5 days. DHCF will track timeliness on a daily, monthly and quarterly basis through data reports from Qualis. The data from the October 2014 Quality Report will be used as baseline data for this project. The success of the project is dependent on collaboration with Qualis to change internal processes and improve the outcomes within the reported data. **Completion Date: September 30, 2015.**

KEY PERFORMANCE INDICATORS – Health Care Delivery Management Administration

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (Actual or YTD[9])	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Percent of Medicaid beneficiaries satisfied with their health plan	N/A[10]	81%	TBD	82%	83%	84%
Percent of children (age 3+) receiving preventive dental services	53%	60%	TBD	62%	64%	66%
Reported complaints on transportation broker services per 1,000 trips (incl. missed/late trips)	1.8/1,000 trips	2.0/1,000 trips	[11]8.45/1,000 trips	1.9/1,000 trips	1.8/1,000 trips	1.7/1,000 trips
(Quality Improvement Initiative) Adverse Perinatal Outcomes per 1,000 pregnancies and infants	N/A[12]	<195	TBD	<190	<185	<180
(Quality Improvement Initiative) Adverse Chronic Disease Outcomes per 1,000 people with asthma, diabetes, hypertension, congestive heart failure	N/A[13]	<340	TBD	<335	<330	<225
Healthcare Effectiveness Data and Information Set measures for childhood immunization	N/A[14]	88%	TBD	89%	90%	91%
Healthcare Effectiveness Data and Information Set measures for timeliness of prenatal care	N/A[15]	83%	TBD	84%	85%	86%
Adult access to preventive, ambulatory care services (adults 20-44, enrolled in health plans)	N/A[16]	89%	TBD	90%	91%	92%

[9] Year-to-date data is not available until October 2015
[10] Data unavailable due to new MCO contracts effective July 2013
[11] Actual as of September 30, 2014
[12] Data unavailable due to new MCO contracts effective July 2013
[13] Data unavailable due to new MCO contracts effective July 2013
[14] Data unavailable due to new MCO contracts effective July 2013
[15] Data unavailable due to new MCO contracts effective July 2013
[16] Data unavailable due to new MCO contracts effective July 2013.

SUMMARY OF SERVICES

The Health Care Operations Administration includes divisions that pertain to the payment of claims; management of the fiscal agent contract; management of several administrative contracts, notably the Pharmacy Benefits Manager and the Medicaid Management Information System Fiscal Intermediary contract; management of the systems; and provider enrollment and requirements.

OBJECTIVE 1: Improve the efficiency of program operations.

INITIATIVE 1.1: Implement a new Pharmacy Benefit Management System (PBM).
In FY15, DHCF will implement a new PBM. The new system will allow DHCF to implement new programs such as SMART PA and Pharmacy lock-in that will allow the District to respond more quickly to changes in the management of the pharmacy benefits. **Completion Date: September, 2015.**

INITIATIVE 1.2: Identify beneficiaries with other insurance coverage to reduce the financial exposure for DHCF.
In FY15, DHCF will work with a Third Party Liability (TPL) vendor to identify Medicaid beneficiaries with TPL coverage. This information will be used to avoid future payments where the TPL carrier is the primary payer and to recover payments that were made to providers as a primary payer when Medicaid should have been the secondary payer. In FY 15, DHCF's goal is to have $3M in TPL recoveries. **Completion date: September 2015.**

OBJECTIVE 2: Strengthen program integrity.

INITIATIVE 2.1: Implement Provider Re-enrollment Process.
As a result of the Patient Protection and Affordable Care Act (ACA), DHCF is responsible for enforcing new provider screening and enrollment requirements. These requirements include, but are not limited to, mandatory re-enrollment for all providers; payment of an application fee from institutional providers; assignment of categorical risks for providers - "limited," "moderate" and "high;" unannounced site visits at pre-enrollment and post-enrollment for "moderate" and high" risk providers; and mandatory submission of criminal background checks and fingerprints for "high" risk providers. DHCF estimates re-enrolling approximately 1,100 providers in FY15. **Completion Date: September, 2015**.

KEY PERFORMANCE INDICATORS – Health Care Operations Administration

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (Actual)[17]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Percent of providers paid electronically	37.61%	60%	39.12%	70%	80%	80%
Avg. time to process Medicaid provider applications	35 days	30 days	37.81 days	30 days	30 days	30 days
Avg. time to process Medicaid "low risk provider" application	N/A	N/A	N/A	30 days	30 days	30 days
Avg. time to process Medicaid "moderate" risk provider application	N/A	N/A	N/A	60 days	60 days	60 days
Avg. time to process Medicaid "high risk" provider application	N/A	N/A	N/A	90 days	90 days	90 days
Number of referrals to the Medicaid Fraud Control Unit	23	20	9	20	20	20
Total dollars recovered from Third Party Liability (in millions)	$4.8M	$4M	$5,176,519	$3M	$2M	$1.5M

[17] Actual as of September 30, 2014

Health Care Reform and Innovation Administration

SUMMARY OF SERVICES

The mission of the Health Care Reform and Innovation Administration (HCRIA) is to improve the health outcomes of those served by DHCF by developing and implementing innovative payment and service delivery models and the technology platforms to support these activities. HCRIA validates and disseminates innovative new models of integrated care delivery and seeks to connect the delivery of health care services with public and population health programs. In addition, the administration coordinates payments to providers for adoption of electronic medical records and lead's DHCF's health information exchange (HIE) efforts, which aim to support quality improvement and effective Medicaid spending through HIE. All of the aims of the Administration are pursued in collaboration with other DHCF departments and with agencies and stakeholders across the District.

OBJECTIVE 1: Develop and implement a comprehensive health information technology (HIT) plan.

INITIATIVE 1.1: Expand partnerships with other District agencies and external stakeholders to utilize health information exchange to deliver better coordinated patient care and cost savings.

DHCF will work with DBH and local FQHCs to improve data exchange to support health homes and ongoing care coordination efforts. In addition, DHCF is facilitating a broad-based stakeholder input process to develop a five-year road map for health information exchange in the District. HCRIA will host an HIE Summit and will facilitate a committee decision-making process to develop a five-year road map that will be completed February, 2015. **Completion Date: September, 2015.**

INITIATIVE 1.2: Implement and monitor the District's Medicaid Electronic Health Record Incentive Payments Program.

DHCF distributes federal incentive payments to Medicaid providers who adopt, implement and meaningfully use electronic health records. Providers receive a schedule of payments over several years based on increasing expectations for how the EHRs will be used and how health information will be exchanged, though the highest payments are in the first year. Hospitals with Medicaid volume of at least 10 percent and eligible providers with 30 percent Medicaid patient volume (with lower thresholds for those serving children) are eligible to receive funding. **Completion Date: September, 2015**.

OBJECTIVE 2: Implement innovative delivery system and payment reform models and provide input on updates.

INITIATIVE 2.1: Obtain federal approval and implement a health homes program.

DHCF, in collaboration with the Department of Behavior Health, will design a health homes program that will serve Medicaid-eligible individuals with severe mental illness. Through the program, Core Service Agencies and Assertive Community Treatment providers will provide a range of case management and care coordination services, seeking to better integrate behavioral health with primary care. DHCF will submit a state

plan amendment for approval to the Centers for Medicare and Medicaid Services. Once approved by CMS, DHCF will implement the program and will work with DBH to monitor the program and communicate with providers about performance. **Completion Date: September, 2015.**

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

INITIATIVE 3:1: Successful implementation of Hospital Based Presumptive Eligibility for individuals presumptively determined eligible for Medicaid through DC hospitals.
DHCF will implement Hospital Based Presumptive Eligibility in the District of Columbia which will allow hospitals to determine eligibility for patients and their family members who attest to meeting the financial and non-financial eligibility requirements for D.C. Medicaid. **Completion Date: September, 2015.**

KEY PERFORMANCE INDICATORS – Health Care Reform and Innovation Administration

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (Actual)[18]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Amount paid to DC providers through the Medicaid EHR Incentive Program	N/A	NA	N/A	$12M	$3.5M	$1.4M
Number of hospitals connected to HIE	N/A	8	6	8	8	8
Number of CRISP encounter alerts sent	N/A	N/A	N/A	100,000	150,000	200,000
Number of individuals enrolled in health homes	N/A	N/A	N/A	5,000	10,000	15,000
Number of monitoring reports sent to health home providers	N/A	N/A	N/A	6	12	12
Percentage of District residents insured	93.8%	95%	TBD[19]	95%	96%	96%

[18] Actual as of September 30, 2014
[19] Census data unavailable

Long Term Care Administration

SUMMARY OF SERVICES

The Long Term Care Administration (LTCA) provides oversight and monitoring of programs targeted to elders, persons with physical disabilities, and persons with intellectual and developmental disabilities (ID/DD). Through program development and day-to-day operations, the LTCA also ensures access to needed cost-effective, high quality extended and long-term care services for Medicaid beneficiaries residing in home and community-based or institutional settings.

OBJECTIVE 1: Improve access to high quality services and improve resource management.

INITIATIVE 1:1 Implement Conflict Free Assessment process for all Long Term Care Support Services (LTCSS) programs other than those for the ID/DD target group.

For FY15, DHCF will expand comprehensive conflict-free assessment to other long term care programs other than the ID/DD programs. Currently, conflict-free assessment is in place for personal care services. This effort will ensure comprehensive reliable sources of information, assistance and access; coordinated eligibility criteria; and a "standardized" person-centered assessment process that works for people of all ages, income-levels and abilities. Long Term Care Support Services (LTCSS) provides beneficiaries with crucial services including assistance with basic tasks of every-day life. These include those services provided in institutional/facility based settings, and supports and services provided in the community and/or in a person's home. The adoption of the conflict-free assessment for LTCSS services will (1) establish standards for the implementation of a standardized tool for assessing a person's needs for LTCSS; and (2) establish numerical scores pertaining to the level of need necessary to establish eligibility for a range of LTCSS. **Completion Date: September 30, 2015.**

INITIATIVE 1.2: Improve Elderly and Persons with Physical Disabilities (EPD) Waiver provider quality.

DHCF will develop and submit an amendment to the current EPD Waiver to reflect new CMS requirements and other improvements to the waiver. Specifically, DHCF will revamp its case management services under the EPD Waiver to meet the new federal requirements. All EPD waiver providers and new provider applicants will be required to comply with the new waiver requirements that will include a new an enhancement of the established Provider Readiness process in FY15.
Completion Date: September 30, 2015.

INITIATIVE 1.3: Implement a new 1915(i) State Plan Adult Day Healthcare Program.

In FY15, DHCF will implement a new 1915(i) State Plan Option, Adult Day Health Program (ADHP) to replace the existing Day Treatment, which was noncompliant with federal regulations. This new service under the Home and Community-Based Services Medicaid State Plan Option is designed to encourage older adults to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

Completion Date: September 30, 2015.

INITIATIVE 1.4: Eliminate enhanced monitoring by CMS on the ID/DD waiver.

In 2011, DHCF was placed on enhanced monitoring by the Centers for Medicare and Medicaid Services (CMS); whereby CMS strengthened its oversight activities to ensure the District's ability to monitor and continuously improve the quality and integrity of services offered though the DC Waiver for the Intellectually Disabled/Developmentally Disabled (ID/DD). In FY 2015, DHCF will collaborate with the DC Department on Disability Services to implement a quality improvement strategy to ensure that waiver services provided to Medicaid-enrolled ID/DD beneficiaries are in compliance with the ID/DD waiver. The strategy will focus on improving performance for all metrics below the 86% target. DHCF will work with the Department of Disability Services to implement Continuous Quality Improvement processes and monitor timely implementation of interventions to achieve at least the baseline goal for all performance measures. **Completion Date: February, 2015.**

KEY PERFORMANCE INDICATORS – Long Term Care Administration

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 (YTD)[20]	FY 2015[21] Projection	FY 2016[22] Projection	FY 2017[23] Projection
Number of individuals moved from institutions into the community (Money Follows the Person Program)	24	35[24]	20	0	0	0
Percentage of beneficiaries receiving LTCSS	N/A	N/A	N/A	80%	90%	100%
Percentage of prospective EPD Waiver providers who complete the EPD Waiver Provider Readiness process (note that this number will reflect applicants, not those approved)	N/A	N/A	N/A	90%	100%	100%

[20] FY14 YTD as of June 30, 2014
[21] Program transferred to the DC Office on Aging
[22] Program transferred to the DC Office on Aging
[23] Program transferred to the DC Office on Aging
[24] Benchmark changed with CMS