Department of Health Care Finance FY2016

Agency 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 DHCFâ€™s Medicaid and Alliance programs. DHCF strives to provide these services in the most appropriate and cost-effective settings possible.

2016 Objectives

FY16 Objectives

Objective Number	Objective Description
Health Care Delivery Management Administration (2 Objectives)	
1	Improve access to high quality services and improve resource management.
2	Improve health outcomes for District residents.
Health Care Operations Administration (1 Objective)	
1	Improve the efficiency of program operations and provider relations.
Health Care Policy and Research Administration (1 Objective)	
1	Develop policies, plans, and data to enable effective program administration and utilization of resources.
Health Care Reform and Innovation Administration (3 Objectives)	
1	Promote the adoption and meaningful use of electronic health records by Medicaid providers in the District and expand the use of health information exchange.
2	Implement innovative delivery system and payment reform models.
3	Implement Health Care Reform and increase the number of District residents with health insurance.
Long Term Care Administration (1 Objective)	
1	Improve access to high quality services and improve resource management.
Office of the Director (2 Objectives)	
1	Increase access to health care for District residents
2	Improve access to health care by developing cost effective reimbursement methodologies and budget processes.

2016 Key Performance Indicators

Measure	Division	Frequency of Reporting	FY 2013	FY 2014	FY 2015	FY 2015 Target	FY 2016 Target
1 - Develop policies, plans, and data to enable effective program administration and utilization of resources. (1 Measure)							

Number of adults in 1115 Childless Adults Waiver		Quarterly	4,716	0	0	6,190	8464
1 - Improve access to high quality services and improve resource management. (6 Measures)							
Percent of Medicaid beneficiaries satisfied with their health plan		Annually	73.5	73.5		74.5	75.5
Percent of children three and over with 90 days of continuous enrollment receiving preventive dental services		Annually	47	56	51	60	57
Reported complaints on transportation broker services per 1,000 trips (incl. missed/late trips) within the Medicaid Fee For Service Population		Quarterly	1.8	2.1	2.1	2.1	1.8
Percent of children 0-20 years with 90 days of continuous enrollment receiving a routine well-child examination		Annually		63	63	65	65
Percentage of case management providers who completed EPD Waiver Provider Readiness Process.		Quarterly				50	100
Number of monitoring reports sent to EPD Waiver providers including but not limited to home health agencies		Quarterly			0	5	9
1 - Improve the efficiency of program operations and provider relations. (5 Measures)							
Average time to process Medicaid provider applications		Quarterly	30.5	37		30	30
Average time to process Medicaid "low risk provider" application		Quarterly				30	30
Average time to process Medicaid "moderate" risk provider application		Quarterly				60	60
Average time to process Medicaid "high risk" provider application		Quarterly				90	90
Number of referrals to the Medicaid Fraud Control Unit or other agencies for criminal or civil resolution.		Quarterly	15	0	0	6	10
1 - Increase access to health care for District residents (3 Measures)							
Number of Non-Commercial Consumers served by Ombudsman (to include Medicare, Medicaid, Alliance, and DC Health Link)		Quarterly	3,528	0	0	8,000	8200
Percent of closed/resolved cases among Non-Commercial Consumers served by the Ombudsman (to include Medicare, Medicaid, Alliance, and DC Health Link)		Quarterly	94	95		95	95

Percent of adjusted/overturned/partial payment/resolved/reversed/written-off cases among Commercial Consumers served by the Ombudsman (appeals and grievances)		Annually	68	47.3		50	50
1 - Promote the adoption and meaningful use of electronic health records by Medicaid providers in the District and expand the use of health information exchange. (3 Measures)							
Amount paid to DC providers through the Medicaid EHR Incentive Program		Quarterly			0	5,600,000	3500000
Number of Chesapeake Regional Information System for our Patients (CRISP) encounter alerts sent		Quarterly			0	100,000	150000
Number of individuals enrolled in health homes		Quarterly					3825
2 - Improve access to health care by developing cost effective reimbursement methodologies and budget processes. (1 Measure)							
Percent of invoices processed accurately and in compliance with the Prompt Payment Act		Quarterly				95	96
2 - Improve health outcomes for District residents. (6 Measures)							
Quality Improvement Initiative Percent of Unduplicated Pregnancies with > 1 Adverse Event		Annually				198	196
Quality Improvement Initiative Management of Pediatric Asthma 0-20 years of age: Asthma Medication Management – Remain on Asthma Controller 50% of Treatment Period		Annually		59.29		61.29	63.29
Healthcare Effectiveness Data and Information Set measures for childhood immunization enrolled in Managed Care		Annually	79.3	75.5		77.75	79.75
Healthcare Effectiveness Data and Information Set measures for timeliness of prenatal care enrolled in Managed Care		Annually	79.8	73.31		75.31	77.31
Healthcare Effectiveness Data and Information Set adult access to preventive, ambulatory care services for adults 20-44, enrolled in Managed Care		Annually	76	68.64		70.64	72.64
Quality Improvement Initiative Management of Pediatric Asthma 0-20 years of age: Asthma Medication Management – Remain on Asthma Controller 75% of Treatment Period		Annually		41.74		43.74	45.74

2016 Workload Measures

Measure	Frequency of Reporting	FY 2013	FY 2014	FY 2015
Workload Measure (3 Measures)				
Number of District residents covered by Medicaid (Year End)	Annually	226,051	244,039	248,775
Number of District residents covered by Alliance (Year End)	Annually	14,813	15,275	15,059
Percentage of District residents insured	Annually	93.3	94.7	96.2

2016 Initiatives

Objective Number	Objective Title	Initiative Number	Initiative Title	Initiative Description
Health Care Delivery Management Administration - 1 (2 Initiatives)				
1		1.1	Develop and implement Managed Care Organization Pay-for-Performance Program.	In FY16, the DHCF will implement Phase 1 of a Pay-for-Performance (P4P) Program for the three (3) Managed Care Organizations (MCOs). A two percent (2%) profit margin is included in the development of the actuarially sound capitation rates paid to the MCOs. This amount will be withheld from the MCOs' capitation payments and each will have an opportunity to regain those funds by demonstrating improved outcomes within the following three (3) performance measures: 1) Reducing Potentially Preventable Hospital Admissions (PPA); 2) Reducing Low Acuity Non-Emergent (LANE) Visits; and 3) Reducing 30-Day Readmissions for the same diagnosis. Performance outcomes achieved during CY14 serve as the baseline for improvement during the performance period of FY16. DHCF is collaborating with its Actuary to develop the methodology for analyzing performance, along with timelines for initial data collection and determination of baseline information for presentation to the MCOs. The MCO contracts will be modified to provide a complete explanation of P4P Program.
1		1.2	Monitor Beneficiary Access to Care through the Managed Care Organizations.	In FY15, DHCF developed and implemented a methodology to validate the adequacy of the MCO provider networks. A database was constructed to record the results based on telephonic outreach to random provider offices within the MCO networks. During FY16, DHCF will routinely conduct Secret Shopper survey activities to confirm beneficiaries' access to participating MCO providers. The initial provider-types selected for the surveys include PCPs, pediatricians, behavioral health and dentists. The survey will assess beneficiary access and appointment wait times. Survey analysis and findings will be broken down by each specific MCO and reported quarterly to the DHCF.
TOT				
Health Care Delivery Management Administration - 2 (3 Initiatives)				

2		2.1	Assess, plan, develop and implement a quality improvement strategy within the Fee-For-Service (FFS) and Managed Care Programs.	The FY2015 - 2018 Quality Strategy will focus on the performance of important functions that significantly affect the health outcomes and perceptions of all Medicaid beneficiaries related to the quality, safety and value of services provided. The Quality Strategy is aligned with the Department of Health and Human Services National Strategy for Quality Improvement in Health Care, which pursues three broad aims: 1) Better Care and Lower Costs: Improve the overall quality by making health care more patient-centered, reliable, accessible and safe; 2) Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental detriments of health in addition to delivering higher-quality care; and 3) Affordable Care: Reduce the cost of quality health care for individuals, families, employers and government. DHCF will convene collaborative discussions with executive leadership, internal staff, external stakeholders, District agencies and MCOs to ensure mutual agreements and understanding of the strategy(s). The Quality Strategy will serve as a framework for evaluating and monitoring quality improvement activities for all Medicaid beneficiaries. In FY16, the strategy will be implemented throughout the fee for service and managed care programs by establishing a baseline of data. An annual evaluation will occur by the close of the first quarter of FY17. The Quality Strategy will serve as the framework for monitoring and evaluating quality improvement activities for all Medicaid beneficiaries.
2		2.2	Improve timeliness of acute and specialty hospital utilization reviews to ensure timely access of services for Medicaid Fee-For-Service (FFS).	During FY16, DHCF will focus on continued stay reviews. DHCF will work with its Quality Improvement Organization (QIO) to improve the timeliness of acute and specialty hospital reviews. Specifically, DHCF continues the goal to achieve 98% of emergency hospital admissions and continued stay acute reviews completed within 24 hours of receipt. For other hospital reviews, including acute pre-authorization and specialty hospital reviews, DHCF's goal is completion of 98% of reviews within 5 days of receipt. DHCF will track timeliness on a monthly and quarterly basis through data reports from the Contractor. The data from the September 2015 Quality Report will be used as baseline data for this project. This effort will improve beneficiary access to necessary medical care. Furthermore, it will ensure that hospitalized Medicaid beneficiaries can transfer in a safe and timely manner from one level of care to another.

2		2.3	Increase the compliance rate of well-child visits for children and adolescents.	DHCF will develop and implement strategies and interventions to increase the compliance rate of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including preventive dental services and lead screens for children and adolescents enrolled in the FFS Program. Recognizing the varying needs of the different sub-populations that comprise the FFS enrollment group, DHCF will impose a multi-faceted approach to target each population. The sub-populations that make up FFS children are: (1) children with disabilities not residing in an institution; (2) children residing in a nursing home or other long-term care facility; (3) CFSA children in foster care; (4) adopted/ permanent placement children; and (5) children committed to DYRS residing in the community. DHCF will construct an outreach plan for each sub-population in coordination with other District agencies as required. Additional outreach activities and interventions will occur in concert with the Managed Care Organizations, as appropriate, in an effort to present similar messages to the targeted age groups of 0 through 20 years of age.
TOT				
Health Care Operations Administration - 1 (3 Initiatives)				
1		1.1	Implement a new Pharmacy Benefit Management System.	In FY16, DHCF will implement a new Pharmacy Benefit Management System (PBM). The new system will allow DHCF to implement programs such as SMART PA and Pharmacy lock-in. The SMART PA program is a more efficient process for authorizing medications. As a result, access to medications will improve for beneficiaries. The pharmacy lock-in program safeguards the appropriate use of medications and helps prevent fraud, waste, and abuse in the pharmacy program.
1		1.2	Implement provider enrollment safeguards.	As a result of the Patient Protection and Affordable Care Act, 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 2,000 providers in FY16.
1		1.3	Improve provider screening.	In FY16, DHCF will improve provider safeguards and screening by implementing a new Provider Data Management System (PDMS) as a part of the new Medicaid Enterprise System. In addition to maintaining the provider's demographic information, the system will also validate the provider's eligibility to participate in the Medicaid program by validating the provider's status in a number of federal databases both at initial enrollment and on a regular monthly basis.
TOT				
Health Care Policy and Research Administration - 1 (2 Initiatives)				

1		1.1	Streamline and improve eligibility policy and operations.	DHCF will develop five (5) Medicaid and Alliance policies and procedures in FY16. The policies and procedures are used to develop and design system functionality for the implementation of Non-MAGI eligibility determinations in D.C. Health Link and to provide guidance to other District agencies. DHCF will work in conjunction with the Division of Regulations and Policy Management to develop Non-MAGI Eligibility regulations.
1		1.2	Develop State Plan Amendments to Support Federal and District Policy Initiatives.	In FY16 DHCF will develop the necessary State Plan Amendments (SPAs) to support federal and District policy initiatives. The Medicaid State Plan governs the District's Medicaid program and any major programmatic changes must be incorporated into the State Plan. Changes to the State Plan are accomplished by drafting and submitting a SPA to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval. SPAs will address a variety of areas, including benefit design, reimbursement methodologies, and quality standards.
TOT				
Health Care Reform and Innovation Administration - 1 (2 Initiatives)				
1		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 collaborate with the Department of Behavioral Health and local Federally Qualified Health Centers (FQHC) to build new connectivity that will enable real-time data exchange between FQHCs and Core Service Agencies to support health homes and ongoing care coordination efforts. In addition, DHCF is working with the DC Health Information Exchange (HIE) Policy Board to develop an Implementation Advanced Planning Document (IAPD) to request funds from CMS to expand HIE services in the District.
1		1.2	Promote adoption and meaningful use of electronic health records through outreach, education and technical assistance.	DHCF will outreach to providers who are eligible to receive meaningful use payments. The outreach will educate providers about the program and support their ability to apply for incentive payments. In addition, the DHCF will support technical assistance to providers to enable them to adopt electronic health records (EHRs) and increase their ability to meaningfully use them to support quality improvement activities. DHCF will request federal support for this initiative and intends to procure a vendor to implement the outreach and technical assistance strategies.
TOT				
Health Care Reform and Innovation Administration - 2 (2 Initiatives)				

2		2.1	Improve integration of behavioral and primary health care through a health homes model.	In collaboration with the Department of Behavioral Health (DBH), DHCF will implement a Health Homes program for individuals with severe mental Illness enrolled in the Medicaid program. Through the health homes program, Core Service Agencies will provide a range of case management and care coordination services, seeking to better integrate behavioral health with primary care. DHCF is specifically focused on working with DBH to monitor provider performance and support quality improvement efforts.
2		2.2	Develop a State Health Innovation Plan (SHIP).	DHCF was granted nearly $1 million from the CMS State Innovation Models (SIM) program to support a planning process in FY16 that will bring stakeholders together to consider value-based purchasing strategies designed to reduce health disparities and achieve the Triple Aim of improved health outcomes, better patient experience of care, and reduced health care costs. An Advisory Committee of District agency directors and key stakeholders has been assembled and working groups will meet throughout FY16 with the goal of finalizing a State Health Innovation Plan by July, 2016. The SHIP will seek to set a vision for the city in the areas of value-based payment, delivery system design, improving population health, and health IT.
TOT				
Health Care Reform and Innovation Administration - 3 (1 Initiative)				
3		3.1	Develop Medicaid State Plan Amendment (SPA) for Childless Adults to ensure residents continue to have access to health care coverage.	DHCF will develop and submit a Medicaid State Plan Amendment to expand Medicaid coverage to low-income childless adults. Childless adults may currently be eligible for Medicaid through a waiver program, which ends in December 2015. The SPA will ensure that the childless adults are able to maintain Medicaid coverage and have access to health care services.
TOT				
Long Term Care Administration - 1 (3 Initiatives)				

1		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.	DHCF will expand comprehensive conflict-free assessment to other long term care programs other than the Intellectual Disability (ID)/Development Disability (DD) programs in FY16. Currently, conflict-free assessment is in place for personal care services and Adult Day Health Program (ADHP). Effective January 2016, DHCF will determine eligibility for LTCSS by establishing numerical scores based on the conflict-free level of need assessment. LTCSS are designed to assist persons with a range of services and supports including assistance with basic tasks of everyday life over an extended period of time. These include, but are not limited to, the Elderly and Persons with Physical Disabilities home and community-based waiver (EPD Waiver), Personal Care Assistance (PCA) services under the District's Long Term Care Program (Medicaid State Plan and EPD Waiver), nursing home services, Adult Day Health Program (ADHP) services under the 1915 (i) Home and Community-based State Plan Option, and other services not intended to serve individuals with IDD.
1		1.2	Implement Conflict Free Case Management Services for the Elderly and Persons with Physical Disabilities (EPD) Waiver program.	DHCF will revamp case management services under the EPD Waiver to meet the new federal requirements that any new entity cannot enroll as a Medicaid reimbursable provider of case management if that entity is a Medicaid provider of Personal Care Aide Services (PCA) or any other direct services under the EPD Waiver. All EPD waiver providers and new provider applicants will be required to comply with the new waiver requirements that will include a new enhancement of the established Provider Readiness process in FY15.
1		1.3	Implement Participant Directed Community Support (PDCS) and Individual Directed Goods and Services.	The DHCF will implement participant directed services (PDS) for selected services within the Elderly and Persons with Disabilities (EPD) waiver in FY16. PDS allows individuals greater control and choice over the services they receive by determining how services are provided and by whom. All EPD waiver participants will be afforded the opportunity to self-direct the following services: participant-directed community support (PDCS) and individual-directed goods and services. To assist participants choosing to self-direct these services, DHCF will engage a District-wide, IRS-approved Vendor Fiscal/Employer Agent, FMS-Support Broker entity will provide financial management services (FMS) and information and assistance (I&A) support.
TOT				

Office of the Director - 1 (1 Initiative)

1		1.1	Increase awareness of services offered by the Office of Health Care Ombudsman and Bill of Rights.	In FY16 DHCF will conduct marketing and outreach efforts to increase awareness of the services offered by the OHCBR. Efforts will include Tele-Town Hall meetings, placement media buys, newspaper publications and the use of social media platforms such twitter and Facebook. DHCF will continue to initiate conversation with local community groups and organizations to host Health Care on Tap events, fun and casual forums for persons to ask health insurance and coverage questions and expand the distribution of the OHCBR PSA "Connection."
TOT				
Office of the Director - 2 (2 Initiatives)				
2		2.1	Develop reimbursement rates for Personal Care Aide Services (PCA) that reasonably reflects the actual costs of providing quality care to Medicaid beneficiaries.	In FY16 DHCF will implement a new rate methodology for Personal Care Aide Services (PCA) to ensure access while curtailing overpayment. DHCF will develop a new cost report format to ensure all allowable costs are captured accurately, and will provide detailed written guidance to the Home Health Agencies (HHA) on Cost Report submission requirements. DHCF will ensure that submitted cost reports meet state and federal reporting guidelines. DHCF will also formulate a comprehensive policy that will cover both reimbursements of all services provided by HHAs and DHCF's enhanced oversight and monitoring responsibilities of all HHA services.
2		2.2	Develop reimbursement rates for Federally Qualified Health Centers that reasonably reflect the actual costs of providing quality care to Medicaid beneficiaries.	DHCF will implement a new rate methodology for Federally Qualified Health Centers (FQHC) in FY16 that will include three separate prospective payment system (PPS) rates for primary care/medical services, dental services and behavioral health services (including both substance abuse and mental health services). DHCF will publish the list of services covered under each area and FQHCs will be paid the PPS rate for covered services only.
TOT				
TOT				