Department of Health Care Finance (DHCF)
FY2016 Performance Accountability Report (PAR)

Introduction

The Performance Accountability Report (PAR) measures each agency's performance for the fiscal year against the agency's performance plan and includes major accomplishments, updates on initiatives' progress and key performance indicators (KPIs).

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.

Overview – Agency Performance

The following section provides a summary of DHCF performance in FY 2016 by listing DHCF's top accomplishments, and a summary of its progress achieving its initiatives and progress on key performance indicators.

Top Agency Accomplishments

Accomplishment	Impact on Agency	Impact on Residents
Developed reimbursement rate methodology for Federally Qualified Health Centers (FQHCs) that reasonably reflect the actual costs of providing quality care to Medicaid beneficiaries.	In the last 10 years, FQHC rate methodology had not changed and the SPA did not have any language that allowed for oversight and management of the Medicaid services provided by this provider group. The SPA will now provide in detail all aspects of allowable services provided by this provider type and will allow for enhanced oversight, monitoring and management of these services. In addition, the FQHCs are now encouraged through payment incentives for achieving certain quality benchmarks.	Improved access to quality health care and other services provided by the FQHCs. The FQHCs are a critical component in the safety net infrastructure that provides health care services to vulnerable and underserved District residents. This accomplishment contributes to better health outcomes for District residents.
Implemented Conflict Free Case Management for the Elderly and Persons with Disabilities (EPD) Waiver. The DHCF revamped 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.	The District reconstructed case management by mitigating undue interest for self-referral and having person-centered planning processes with integrity in integrated care.	This initiative created an objective representative and neutral advocate and prohibits providers from being able to self-refer across service areas.
Seamless implementation of a new pharmacy benefit manager that increased access to pharmaceuticals for Medicaid beneficiaries	The SMART PA program reduced the number of requests for prior authorization of prescription drugs. The system is able to make a determination based on the beneficiary's medical and prescription history.	This accomplishment allows DC Medicaid beneficiaries quicker access to their medication because the SMART PA program reviews beneficiary utilization and their medical claim history to determine the medical necessity of the prescribed drug. If the history is there, the system will authorize payment for the drug without a need for additional information from the beneficiary's prescribing physician.

In FY 2016, DHCF had 25 Key Performance Indicators. Of those, 5 were neutral, and another 8 were not able to be reported by the end of the fiscal year. Of the remaining measures, 40% (10 KPIs) were met, 8% (2 KPIs) were nearly met, and 0% (0 KPIs) were unmet. In FY 2016, DHCF had 21 Initiatives. Of those, 62% (13)

were completed and 19% (4) were nearly completed, and 19% (4) were not completed. The next sections provide greater detail on the specific metrics and initiatives for DHCF in FY 2016.

FY16 Objectives

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

FY16 KPIs

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

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of adults in 1,115 Childless Adults Waiver	8,464	A	11,039				11,039	Met	

Objective: Improve access to health care by developing cost effective reimbursement methodologies and budget processes.

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers

Percent of invoices processed accurately and in compliance with the Prompt Payment Act	96	Q	98	92.47	94.42	90.5	92.4	Nearly Met	ORRFA processed 1,146 invoices in FY16 and of those, 1,067 were processed in a timely manner. In the FY, we faced various challenges that resulted in late submittal of invoices. Two main examples are vendors sending invoices to the wrong email address resulting in the inability to track the invoice; secondly, Contract Administrators holding onto invoices and not submitting them for processing. In late August, ORRFA conducted a training session with all staff involved in the invoice payment process and set standard office procedures and forms to improve the invoice process. The enhancements included correspondence was sent to vendors, revised certification of goods forms and training was provided to employees. We anticipate these steps will improve the process in the coming fiscal year and increase the percentage of timely payments to vendors.

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

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Percent of children three and over with 90 days of continuous enrollment receiving preventive dental services	57	A							This data is received from CMS 416 and we typically do not receive the data until April of the following year. So in this instance we will not receive the data for FY16 until April 2017.
Percent of children 0-20 years with 90 days of continuous enrollment receiving a routine well-child examination	65	A							This data is received from CMS 416 and we typically do not receive the data until April of the following year. So in this instance we will not receive the data for FY16 until April 2017.
Percent of Medicaid beneficiaries satisfied with their health plan	75.5	A					76.8	Met	
Reported complaints on transportation broker services per 1,000 trips (incl. missed/late trips) within the Medicaid Fee For Service Population	1.8	Q	1.78	1.81	1.98	1.8	1.8	Met	
Percentage of case management providers who completed EPD Waiver Provider Readiness Process	100	Q	100	100	100	25	97.2	Nearly Met	DHCF has 30 business days to review a complete application - if an application contains insufficient information, a notice is sent to the applicant giving them 30 days to provide the required information. Delays to the implementation of the provider data management system also impacted the readiness process.
Number of monitoring reports sent to EPD Waiver providers including but not limited to home health agencies	9	Q	2	1	1	3	7	Neutral Measure	

Objective: Improve health outcomes for District residents.

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers

Quality Improvement Initiative Management of Pediatric Asthma 0-20 years of age: Asthma Medication Management - Remain on Asthma Controller 50% of Treatment Period	63.29	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.
Healthcare Effectiveness Data and Information Set measures for childhood immunization enrolled in Managed Care	79.75	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.
Healthcare Effectiveness Data and Information Set measures for timeliness of prenatal care enrolled in Managed Care	77.31	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.
Healthcare Effectiveness Data and Information Set adult access to preventive, ambulatory care services for adults 20-44, enrolled in Managed Care	72.64	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.
Quality Improvement Initiative Management of Pediatric Asthma 0-20 years of age: Asthma Medication Management - Remain on Asthma Controller 75% of Treatment Period	45.74	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.
Quality Improvement Initiative Percent of Unduplicated Pregnancies with > 1 Adverse Event	31.92	A		The data is reported in FY2016 but the measurement period is 2015. DHCF will not have the data for FY2016 until FY2017.

Objective: Improve the efficiency of program operations and provider relations.

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
NA	30	Q	3	5.1	4.2	5.3	4.8	Met	
NA	90	Q	54	47.4	34.8	30.1	41.3	Met	
NA	60	Q	16	22.3	29.3	18.2	24.1	Met	
Average time to process Medicaid provider applications	30	Q	4	5.5	4.3	4.7	4.9	Met	
Number of referrals to the Medicaid Fraud Control Unit or other agencies for criminal or civil resolution	10	Q	0	1	0	9	10	Met	N/A

Objective: Increase access to health care for District residents

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Percent of adjusted/overturned/partial payment/resolved/reversed/written-off cases among Commercial Consumers served by the Ombudsman (appeals and grievances)	50	A					64.8	Met	
Percent of closed/resolved cases among Non-Commercial Consumers served by the Ombudsman (to include Medicare, Medicaid, Alliance, and DC Health Link)	95	Q	96	95.96	94.06	96.9	95.7	Met	
Number of Non-Commercial Consumers served by Ombudsman (to include Medicare, Medicaid, Alliance, and DC Health Link)	8,200	Q	2,025	2,127	1,885	2,127	8,164	Neutral Measure	

Objective: Promote the adoption and meaningful use of electronic health records by Medicaid providers in the District and expand the use of health information exchange.

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of individuals enrolled in health homes	3,825	A					1,516	Neutral Measure	
Amount paid to DC providers through the Medicaid EHR Incentive Program	3,500,000	Q	497,250	59,500	85,000	320,503	962,253	Neutral Measure	
Number of Chesapeake Regional Information System for our Patients (CRISP) encounter alerts sent	150,000	Q	181,498	217,218	240,755	319,967	959,438	Neutral Measure	

FY16 Workload Measures

Measure	Freq	Q1	Q2	Q3	Q4	Total
Number of District residents covered by Medicaid (Year End)	A					Not Available
Percentage of District residents insured	A					Not Available
Number of District residents covered by Alliance (Year End)	A					Not Available

FY16 Initiatives

Title: Develop and implement Managed Care Organization Pay-for-Performance Program.

Description: 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.

Complete to Date: 75-99%

Status Update: The initiative was implemented 10/1/16

If Incomplete, Explanation: In April 2016, CMS enforced a regulation, requiring approval of capitation rates paid to the MCOs prior to entry into MMIS. DHCF was required to rollback rates that had not received prior approval. In an effort to implement a clean program and eliminate the need for multiple contract modifications and reinstatement of the withhold, DHCF suspended the P4P program and will implement on 10/1/16.

Title: Monitor Beneficiary Access to Care through the Managed Care Organizations.

Description: 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.

Complete to Date: Complete

Status Update: The DHCF conducted a Secret Shopper Survey on the contracted MCO network providers serving the Medicaid Managed Care population. The Survey was conducted for the purposes of assessing the Medicaid beneficiary experience of provider access and availability of requested covered services. A confidence interval of 5 and a confidence level of 95% were utilized to determine the representative sample of 309

Title: Assess, plan, develop and implement a quality improvement strategy within the Fee-For-Service (FFS) and Managed Care Programs.

Description: 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.

Complete to Date: 25-49%

Status Update: Unexpected turn-over in staffing has resulted in the need to hire new staff. The recruitment process is lengthy and causes a delay in securing staff to assume the responsibilities. The selection of a candidate occurred in June; however, it will not relieve the responsibility of existing staff. In addition, during the 2nd quarter, competing priorities of an accelerated MCO RFP process has impacted this project. The initiative will continue in FY17

If Incomplete, Explanation: Unexpected turn-over in staffing has resulted in the need to hire new staff. The recruitment process is lengthy and causes a delay in securing staff to assume the responsibilities. The selection of a candidate occurred in June; however, it will not relieve the responsibility of existing staff. In addition, during the 2nd quarter, competing priorities of an accelerated MCO RFP process has impacted this project. The initiative will continue in FY17.

Title: Improve timeliness of acute and specialty hospital utilization reviews to ensure timely access of services for Medicaid Fee-For-Service (FFS).

Description: 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.

Complete to Date: Complete

Status Update: The Contractor will implement the following changes: (1)Recruitment for an additional management position is in process to support staff and daily operations; (2) Staff stabilization efforts continue; (3) Ongoing emphasis on Qualis Health Provider Portal training for improved quality and timeliness of review; (4) Continued education to the Providers/Facilities to substantiate the appropriate submission of clinical information elimination of duplicate requests; and (5) Consistently meet or exceed timeliness on contract.

If Incomplete, Explanation: The Contractor was able to achieve a 98% compliance rate for completion of timely reviews; the prior rate was 94%. Some of the barriers include: 1) the need for continued encouragement to use the Qualis Health Provider Portal with complete information submitted the first time; 2) provider submission errors in the Qualis Health Provider portal require ongoing provider education.

Title: Increase the compliance rate of well-child visits for children and adolescents.

Description: 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.

Complete to Date: Complete

Status Update: DHCF identified FFS beneficiaries under 21 that were in need of specific EPSDT services, which included well-child visits, lead screening and preventive dental services. This was the first time DHCF initiated the effort. DHCF completed outreach by sending notices and postcards to non-compliant FFS beneficiaries. The targeted group of FFS beneficiaries were the disabled children that do not reside in an institution. DHCF has developed draft MOAs with CFSA and DYRS to target additional FFS sub-populations

Title: Implement a new Pharmacy Benefit Management System.

Description: 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.

Complete to Date: Complete

Status Update: The Pharmacy lock-in function and policies and procedures for assigning a beneficiary to a specific pharmacy has been fully implemented

Title: Implement provider enrollment safeguards.

Description: 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.

Complete to Date: 75-99%

Status Update: Testing of the new Provider Data Management System identified issues that require us to delay the planned implementation.

If Incomplete, Explanation: Testing of the new Provider Data Management System identified issues that require us to delay the planned implementation on October 3, 2016. We anticipate that the implementation will happen in the second quarter of FY17.

Title: Improve provider screening.

Description: 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.

Complete to Date: 50-74%

Status Update: Testing of the new provider data management system identified issues that caused DHCF to delay the system's implementation. We anticipate that the implementation will happen in the second quarter of FY17

If Incomplete, Explanation: Testing of the new provider data management system identified issues that caused DHCF to delay the systems implementation. We anticipate that the implementation will happen in the second quarter of FY17.

Title: Develop State Plan Amendments to Support Federal and District Policy Initiatives.

Description: 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.

Complete to Date: Complete

Status Update: DHCF was successful in ensuring that all SPAs needed to support District policymaking/compliance with federal requirements were timely submitted. In FY16, DHCF submitted and received CMS approval on 5 SPAs and submitted 7 additional SPAs and 1 waiver renewal for approval.

Title: Streamline and improve eligibility policy and operations.

Description: 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.

Complete to Date: Complete

Status Update: DHCF exceeded the goal of developing five Medicaid and Alliance P and P. In FY16, DHCF published 2 Non-MAGI eligibility rules, developed Medicaid P and P for the timely enrollment of Deemed Newborns into Medicaid, policy guidance, an MOA between DHCF and hospitals regarding eligibility for Hospital-based presumptive eligibility, and provided eligibility P and P guidance to the DHS' ESA and DC CFSA regarding adopted foster care children outside of DC. DHCF issued new LTC application submission P and P guidance to ESA and Department on Aging.

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

Description: 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.

Complete to Date: 25-49%

Status Update: As a result of the limited functionality of DBH's iCAMS, and its inability to accept data from the FQHCs at the level approved by CMS, DHCF is unable to continue work toward this part of the goal. With respect the development of an IAPD-Update to request additional funds from CMS to expand HIE services, CMS approved DHCF's IAPD on 7/19/16

If Incomplete, Explanation: DBHs electronic health record system (iCAMS) is not configured in a way that would enable the automatic and electronic exchange of person-level data between DBH (and thus the CSAs that use iCAMS) and the FQHCs at the level of connectivity approved by CMS. As stated in the Q3 update, the DBH-FQHC connection as approved by CMS will not be implemented by September 30, 2016. At this juncture we are unable to state when the DBH technical issues will be resolved.

Title: Promote adoption and meaningful use of electronic health records through outreach, education and technical assistance.

Description: 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.

Complete to Date: 75-99%

Status Update: DHCF sought proposals for the EHR/MU Technical Assistance and Outreach during Q4. DHCF convened the evaluation panel and as of the end of Q4 was in the last stages of awarding a contract. The work is expected to begin in FY17.

If Incomplete, Explanation: DHCF sought proposals for the EHR/MU Technical Assistance and Outreach during Q4. DHCF convened the evaluation panel and as of the end of Q4 was in the last stages of awarding a contract. The work is expected to begin in FY17.

Title: Develop a State Health Innovation Plan (SHIP).

Description: 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.

Complete to Date: Complete

Status Update: DHCF completed and submitted the District's State Health Innovation Plan (SHIP) to CMS on July 29, 2016. CMS approved our SHIP on September 12, 2016.

Title: Improve integration of behavioral and primary health care through a health homes model.

Description: 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.

Complete to Date: Complete

Status Update: The My DC Health Home (HH) program for Medicaid beneficiaries with severe mental illness was implemented on 1/1/16, and 11 HH providers currently participate. At the end of Q4 1,516 beneficiaries are enrolled. This trend towards lower-than-anticipated enrollment mirrors other state HH programs and has led the team to revisit series of assumptions. Two of the four mitigation strategies to boost enrollment have been completed. DHCF is working with DBH to develop strategies to enhance enrollment and ensure sustainability and quality

Title: Develop Medicaid State Plan Amendment (SPA) for Childless Adults to ensure residents continue to have access to health care coverage.

Description: 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.

Complete to Date: Complete

Status Update: Initiative 3.1 was approved on November 24, 2015 with an effective date of January 1, 2016.

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

Description: 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.

Complete to Date: 50-74%

Status Update: Rules are currently in circulation with PDS rules, EPD rules, which include case management sections, are all on track to be published in January 2017.

If Incomplete, Explanation: This initiative is pending the implementation of the new EPD waiver in January 2017.

Title: Implement Conflict Free Case Management Services for the Elderly and Persons with Physical Disabilities (EPD) Waiver program.

Description: 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.

Complete to Date: Complete

Status Update: The Conflict Free Case Management was successfully completed on 6/30/16

Title: Implement Participant Directed Community Support (PDCS) and Individual Directed Goods and Services.

Description: 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 and A) support.

Complete to Date: Complete

Status Update: PDS was implemented effective March 28, 2016 with current active enrollment

Title: Increase awareness of services offered by the Office of Health Care Ombudsman and Bill of Rights.

Description: 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.

Complete to Date: Complete

Status Update: The OHCOBR provided marketing and outreach efforts to increase awareness of their services. Efforts included Tele-Town Hall meetings, media buys, newspaper publications and the use of social media platforms. OHCOBR continued to initiate conversation with local community groups and hosted Health Care on Tap events, fun and casual forums for persons to ask health insurance and coverage questions and expand the distribution of the PSA Connection.

Title: Develop reimbursement rates for Federally Qualified Health Centers that reasonably reflect the actual costs of providing quality care to Medicaid beneficiaries.

Description: 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.

Complete to Date: 75-99%

Status Update: DHCF during the 4th quarter completed several critical milestones. Specifically, DHCF obtained documented acceptance of the proposed FQHC Alternative Payment Methodology (APM) from all of the FQHCs participating in the DC Medicaid program, publication of FQHC rules on 8/5/16,

and DHCF held a public forum to solicit comments and provide clarifications regarding the published FQHC rules. Lastly, the proposed FQHC reimbursement methodology SPA was submitted to CMS for approval.

If Incomplete, Explanation: While DHCF has completed and published the FQHC rules, the implementation is pending approval of the State Plan Amendment (SPA) submitted to CMS for approval. Once approved, the rates will be made retroactive to September 1, 2016 at which point DHCF will be able to report the impact on District residents and the agency.

Title: Develop reimbursement rates for Personal Care Aide Services (PCA) that reasonably reflects the actual costs of providing quality care to Medicaid beneficiaries.

Description: 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.

Complete to Date: Complete

Status Update: The new reimbursement methodology with a rate of $20.00 went into effect on October 1, 2015. Since this implementation the rate has subsequently been adjusted to incorporate changes to the DC living wage rate as published by the District's Department of Employment Services (DOES).