Department of Health Care Finance FY2017

FY2017 Performance Accountability Report

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, 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.

FY17 Top Accomplishments

Accomplishment	Impact on Agency	Impact on Residents
Implementation of new Long Term Care Administration (LTCA) assessment process across all Long-Term Services and Supports (LTSS) programs.	The implementation of one assessment function for all long-term care services and supports provided greater oversight and control for DHCF. By transitioning this function to one contractor, it eliminated process bifurcation, created a unified mechanism for reporting, and allows for increased quality oversight of the assessment process overall.	It provided a standardized process using one assessment function for accessing all long-term care services and supports, decreasing administrative burden on beneficiaries/applicants.
Implementation of My Health GPS.	The program's overarching aim is to improve health outcomes for residents of the District while reducing inappropriate hospital utilization and hospital readmissions, a major priority of the agency. The 12 participating organizations have already demonstrated innovative approaches to care coordination, including developing new outreach programs to engage more residents, leveraging technology to facilitate person-centered care, and hiring and training care teams to help beneficiaries get health and stay healthy.	My Health GPS is a new care coordination program designed to help Medicaid beneficiaries who have three or more chronic conditions get the care and services they need. The My Health GPS services are administered by 12 approved primary care organizations at 33 care centers across the District. The program launched on July 1, 2017 and is available to ~35,000 Medicaid beneficiaries, with nearly 3,000 beneficiaries taking advantage of the program in the first 3 months since it launched.
In FY17, DHCF obtained approval from the Centers for Medicare and Medicaid Services (CMS) t0 implement a new rate methodology for Federally Qualified Health Centers (FQHC). The old rate methodology has been in effect since January 1, 2001. Since that time the number of FQHCs operating in the District, the services offered and the number of	The DHCF is now able to implement an innovative rate methodology that: (1) better reimburses the FQHCs through an Alternative Payment Methodology (APM) for primary care services, behavioral health services, preventive, diagnostic, and comprehensive dental	This accomplishment helps to promote access to quality primary and preventative health care services for District residents by tying reimbursement to quality and allowing same day billing for behavioral health services. The new reimbursement

residents served has increased. The new rate methodology establishes separate rates for physical, behavioral health and dental encounters. It also includes new quality reporting requirements and a performance-based incentive payment for FQHCs that meet or exceed performance benchmarks.	services; (2) is cost-effective by capping administrative costs; (3) provides additional payment based upon performance of each FQHC beginning in January 2018; and (4) promotes accuracy in billing and accountability by requiring FQHCs to submit more detailed information when submitting claims. DHCF now has better oversight and monitoring of the FQHC payments through the reporting of procedure code details on their submitted claims and the automation of the wrap-around payment process.	methodology supports FQHCs as they expand their services to treat District residents with substance use disorders.

2017 Strategic Objectives

Objective Number	Strategic Objective
1	Provide access to comprehensive healthcare services for District residents.
2	Ensure the delivery of high quality healthcare services to District residents.
3	Deter fraud, waste, and abuse by promoting integrity throughout the Medicaid program.
4	Create and maintain a highly efficient, transparent and responsive District government.**

2017 Key Performance Indicators

Measure	Freq	Target	Q1	Q2	Q3	Q4	FY 2017	KPI Status	Explanation
1 - Provide access to comprehensive healthcare services for District residents. (5 Measures)									
Percent of children, ages 1 – 20 years, enrolled in the Medicaid program (Fee-for-Service and Managed Care) with 90 days of continuous enrollment that received preventive dental services during the fiscal year.	Annually	58%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Data Forthcoming		Do not have this data until we receive CMS 416. We will have final FY17 numbers by April 2018.
Percent of children, ages 1-20 years, enrolled in the Medicaid program (Fee-for-Service and Managed Care) with 90 days of continuous enrollment that received a routine well-child examination during the fiscal year.	Annually	68%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Data Forthcoming		Do not have this data until we receive CMS 416.

									We will have final FY17 numbers by April 2018.
Participation rate among Medicaid and CHIP eligible children ages 0 through 18 in the District of Columbia	Annually	95%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	96.9%	Met	
Percentage of Medicaid renewals as a result of the passive renewal process	Quarterly	75%	64.6%	89.8%	91.7%	89.1%	85.4%	Met	
Percentage of District Residents covered by Medicaid	Annually	35%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	35.5%	Met	
2 - Ensure the delivery of high quality healthcare services to District residents. (3 Measures)									
Reduce hospital admissions of Medicaid Managed Care enrollees due to health conditions that may have been prevented through appropriate outpatient care.	Annually	5%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Data Forthcoming	Met	Data will not be available until the end of Q2 FY18
Reduce hospital discharges of Medicaid Managed Care enrollees that were followed by a readmission for any diagnosis within 30 days.	Annually	5%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Data Forthcoming	Met	Data will not be available until the end of Q2 FY18
Reduce potentially preventable Emergency Department visits by Medicaid Managed Care enrollees that may have been avoided or appropriately treated at a lower level of care.	Annually	5%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Data Forthcoming	Met	Data will not be available until the end of Q2 FY18
3 - Deter fraud, waste, and abuse by promoting integrity throughout the Medicaid program. (1 Measure)									
Number of referrals to the Medicaid Fraud Control Unit or other agencies for criminal or civil resolution.	Quarterly	14	0	9	0	5	14	Met	
4 - Create and maintain a highly efficient, transparent and responsive District government. ** **(1 Measure)**									
Percent of invoices processed accurately and in compliance with the Prompt Payment Act.	Quarterly	97%	99.1%	99.1%	99.7%	98.7%	99.1%	Met	

We've revisited a project to standardize District wide measures for the Objective "Create and maintain a highly efficient, transparent and responsive District government." New measures will be tracked in FY18 and FY19 and published starting in the FY19 Performance Plan.

2017 Workload Measures

Measure	Freq	Q1	Q2	Q3	Q4	FY 2017
1 - Benefits (6 Measures)						
Produce and disseminate three (3) data snapshots to share utilization and spending patterns with external stakeholders and the general public.	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	3
Number of beneficiaries receiving a conflict free assessment for long-term care services and supports.	Quarterly	1997	228	1234	1309	4768
Number of District residents covered by Medicaid (Year End)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	241871
Number of District residents covered by Alliance (Year End)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	15318
Percentage of District residents insured	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	96.1%
Number of Elderly & Persons with Disabilities Waiver (EPDW) beneficiaries enrolled in services My Way	Quarterly	14	59	102	83	258
1 - Eligibility (1 Measure)						
A minimum of three (3) policy training sessions conducted per quarter for DHCF, sister agencies and other external stakeholders on eligibility related policies and procedures to ensure staff and community partners receive the training needed to accurately determine eligibility for Medicaid, and the District's locally funded health care programs.	Quarterly	7	7	4	7	25
2 - Claims Processing (1 Measure)						
Percentage of procurement process completed for the acquisition of a new Medicaid Management Information System (MMIS) that will be a multi-payor claims adjudication system for Medicaid and other DC Government programs that process medical claims.	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	20%
2 - Provider Enrollment and Screening (2 Measures)						
Number of newly enrolled providers	Quarterly	555	404	712	676	2347
Number of re-enrolled providers	Quarterly	163	138	438	342	1081
3 - Program Integrity (5 Measures)						
Conduct investigations based on complaints data analysis, input from internal and external partners, and other indications of abnormal or suspect claims.	Quarterly	33	32	31	48	144
Conduct Surveillance and Utilization Review Section (SURS) audits based on data analysis, input from internal and external partners, and other indications of abnormal or suspect claims.	Quarterly	108	115	97	66	386
Conduct liaison, education, and training with other DHCF divisions, outside agencies, providers, and other groups in support of program integrity mission.	Quarterly	No data available	45	No data available	44	89
Number of adjusted/overturned/upheld/partial payment/resolved/reversed/written-off cases among commercial consumers served by the Ombudsman (appeals and grievances)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	241

Number of non-commercial consumers served by Ombudsman (to include Medicare, Medicaid, Alliance, and DC Health Link)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	9010

2017 Strategic Initiatives

Title	Description	Complete to Date	Status Update	Explanation
HEALTH CARE OPERATIONS SUPPORT (2 Strategic initiatives)				
Improve provider screening.	In FY17, DHCF will continue its efforts to 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	System implementation complete.	
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.	Complete	System implementation complete.	
HEALTH CARE POLICY & PLANNING SUPPORT (3 Strategic initiatives)				
School-Based Services (Free Care) Group	With support and from the Deputy Mayor for Education and the Deputy Mayor for Health and Human Services, the Office of the State Superintendent, of Education (OSSE) , the DC Department of Health Care Finance (DHCF) and other stakeholders are exploring Medicaid policies for expanding reimbursement of health services delivered in schools, including those delivered in DC Public Schools and DC Public Charter Schools. Ongoing meetings are taking place to insure uniform understanding and agreement on a State Plan Amendment (SPA) regarding the Free Care Rule. In FY17, in addition to an ongoing, cross-sector, cross-agency working group, and our review of costs/savings for DCPS and Charters, DHCF will be developing a framework, cost savings estimate, and cost projection for this work. Timeline for SPA rollout will likely be FY18.	75-99%	The working group has completed the financial impact analysis on DCPS and on KIPP DC as well as the accompanying sensitivity analysis on the Medicaid enrollment ratios and RMTS ratio. Based on the financial impact analysis, the working group has drafted policy recommendations for District Leadership. Upon OCFO review of the methodology and fiscal impact analysis, a report	The interagency collaboration and significant data analysis took much longer than anticipated. The results of the work of the Working Group was completed by 9/30, but the follow-up meetings with DHCF leadership just began. More work needs to be done based on a review with OCFO, and then final review with DHCF

			highlighting the work will be drafted, and meetings held with senior management at DHCF, DCPS, OSSE, DCPCS, and the Mayors Office.	executive management can happen, as well as meetings with other agencies.
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 FY17 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	DHCF has obtained final approval of the FQHC reimbursement methodology SPA from CMS. Implementation is already underway with the DHCF Health Care Operations Administrations working on the recycling of all claims for dates of service on or after September 1, 2016. Further DHCF is also working with the external auditors, on the FY 2016 cost report, which will be used to rebase the rates in January 2018.	
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. In FY17, DHCF anticipates the implementation of the new EPD waiver.	Complete	EPD Waiver renewal effective and rules published in April 2017.	

MANAGED CARE MGT (13 Strategic initiatives)				
Monitor Beneficiary Access to Care through the Managed Care Program.	In FY17, DHCF will continue to validate the adequacy of the MCO provider networks. A database is used to record the results based on telephonic outreach to random provider offices within the MCO networks. During FY16, DHCF routinely conducted Secret Shopper survey activities to confirm beneficiaries' access to participating MCO providers. In FY17, surveys will continue for 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 Director of DHCF Health Care Delivery Management Administration (HCDMA).	Complete	Initiative was completed and outcomes analysis compiled for the final Q4 report.	
Initiate a Survey for Medicaid Fee-For-Service (FFS) Beneficiaries regarding Access and Quality.	In FY17, DHCF will develop a new system for monitoring and identifying FFS beneficiary experience accessing care. This initiative will promote access to benefits for District beneficiaries and transparency and responsiveness to the needs of the District's Medicaid beneficiaries.	Complete	Initiative was terminated; see Q3 update.	The initiative was terminated due to the need to implement a similar activity mandated by CMS. See Q3 comments.
Develop a New Reimbursement Methodology for Nursing Homes that Aligns Payment to Promote Access to High Quality and Value Based Healthcare.	In FY17, DHCF will develop a new reimbursement methodology for Nursing Homes. The new reimbursement methodology will reflect both the qualitative and quantitative reforms that have been brought about by the Affordable Care Act of 2010, and changes in the health care payment innovation landscape. The methodology will also take into account several policies and program changes, such as the integration of mental health services into the payment structure. While the effective date of the new methodology is anticipated to be in FY18, all of the necessary analysis, stakeholder engagement, drafting of the state plan amendment (SPA) and rule for publication, and implementation planning will occur throughout FY17.	75-99%	The policy designs, reimbursement simulations, and numerous stakeholder engagements were performed and completed during this quarter. Moreover, the proposed rules and SPA has been drafted and pending final review by the OGC and EOM. Once these reviews are finalized, the proposed rules will be published, and the SPA submitted to CMS for approval, with the effective dates of January 1, 2018.	In order to stay within the FY 2018 budget for Nursing Facilities, DHCF decided to change the implementation date of the new reimbursement methodology to February 1, 2018. Overall the new reimbursement methodology adds incentives for care of special needs patients and quality improvement; and the new rates are aligned to each beneficiary's acuity level making the overall nursing facility rates more equitable.

Increase Awareness of Services offered by the Office of Health Care Ombudsman and Bill of Rights.	In FY17, DHCF will continue our outreach efforts to educate the residents and employees of the District of Columbia regarding the services offered by the OHCOBR. DHCF will continue to initiate conversations 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	The Office of Ombudsman exhibited and gave a brief overview of the Ombudsman at (7) Community, Health & Informational Fairs. A total of 2,710 residents participated in these events and the Office of the Ombudsman's educational brochures were distributed at each of the events.	
Improve Appropriate Utilization of Hospital Services in the Managed Care Organization (MCO) Program.	In FY17, the DHCF will implement a 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 FY17. DHCF collaborated with its Actuary to identify baseline data and develop the methodology for analyzing MCO performance. DHCF will provide MCO encounter data to its Actuary for analysis and establishment of performance baselines within each of the three measures. A percentage weight will be assigned to each measure, totaling a sum of 100%. Based on initial baseline performance, MCOs must achieve targeted reductions within each measure to regain percentages of the withheld capitation payments. Encounter data will be used to generate quarterly reports that demonstrate performance during the previous 3-month period. Upon conclusion of FY17, an additional 3 months will be allotted to collect data on all services paid by the MCO during FY17. In collaboration with the Actuary, a final evaluation of performance throughout the FY will be completed and any payouts will be presented during or before Q3 of the following fiscal year.	Complete	The P4P program is well underway and performance is evaluated quarterly, after a 3 month run-out period of encounter data. Quarterly updates are shared with each MCO. Through the run-out period of March 2017, each MCO had specific metrics that have shown improvement from the baseline and P4P target.	
Increase Access of Preventive Dental Services for All Medicaid Children and Adolescents	In FY17, DHCF will collaborate with the MCOs, CFSA, DYRS and DOH to develop and implement strategies to increase the compliance rate for completion of preventive dental services of children and adolescents enrolled in the Managed Care and FFS Programs. DHCF will collect baseline information to determine utilization rates during FY16, within designated age groups. The results will be compared to national averages to establish goals for achievement during FY17. Outreach activities and interventions will occur in concert with all entities, as appropriate, in an effort to present similar messages to the targeted population, 0 through 20 years of age. Quarterly reports will be generated to assess	Complete	The CFSA and DYRS MOAs have been signed. In FY18, we will be able to share data with the respective agencies in order provide better outreach for	

	performance and address barriers and/or challenges to care delivery.		children in need of well-child visits and dental services. Targeted outreach will continue for FFS beneficiaries under the age of 21 who are in need of well-child visits, dental and lead screening.	
Develop a Quarterly Performance Report for the Medicaid Fee-For-Service (FFS) Program.	DHCF currently prepares a quarterly and annual report of MCO performance in finance, service delivery and network adequacy to understand MCO performance to inform decision making. In FY17, DHCF will develop a quarterly report that will detail performance within the FFS program. Various categories will be presented, including but not limited to expenditures, utilization management and quality performance associated with implementation of a primary care Health Home. The report will be distributed internally and to community stakeholders in an effort to further demonstrate performance of both the Managed Care and FFS Programs.	Complete	A DRAFT report was developed; additional changes and updates are necessary. Will continue to develop until agreement of a final report.	
Implement a new Case Management System to support the District's 'No Wrong Door' Initiative.	To ensure that DC residents have access to available services that impact their medical care, DHCF in partnership with the Department of Disability Services and Department of Aging is leading the implementation of a new case management system. The system will streamline eligibility and enrollment and give providers increased access to information to coordinate care. This initiative will continue in FY18.	75-99%	The contract was awarded to FEI Systems and the project officially started on 8/24/2017. We anticipate an implementation date in August 2018.	The procurement process and CMS approval took longer than anticipated.
Promote Adoption and Meaningful use of Electronic Health Records by Providing Incentive Payments to Providers and offering Outreach, Education and Technical Assistance.	In FY17, DHCF will continue to conduct outreach activities related to the adoption and meaningful use of Certified Electronic Health Record Technology (CEHRT). By the end of FY16, DHCF will hire a vendor to strengthen these activities and provide targeted technical assistance. However, most of the vendor's work will be conducted in FY17. This work will include collaborating with DHCF to pinpoint the providers that need assistance particularly smaller practices and organizations with fewer resources to do their own electronic health record and meaningful use work in-house.	Complete	The EHR Incentive Program Year ended in August and resulted in 238 individual provider attestations. Of those, our third party contractor assisted with 68 in attestations.	
Strengthen the Overall Connectivity and Interoperability of the District's	DHCF will leverage its grant-making authority to design and implement health information exchange (HIE) initiatives targeted to bolster the exchange of health-related data between key District stakeholders. Through its Grants Management Office (GMO), DHCF will issue a competitive Request for Applications (RFA) and select one or more grantees based on the qualifications stipulated by the RFA to implement	Complete	DHCF has received working prototypes of the HIE tools which were presented in a live	

current Health Information Exchange.	the selected HIE initiatives. This initiative will support improved health outcomes, control healthcare costs, and enhance patient experiences.		demonstration for DHCF leadership on 9/28/17. Formal public launch of the tools is set for early November to allow sufficient time to load data and test with users.	
Improve Integration of Medical and Behavioral Health Care through a Health Homes Model for Individuals with Severe Mental Illness.	In FY17 DHCF will expand the Health Homes program to individuals with physical chronic conditions enrolled in the Medicaid program. DHCF will continue to partner with the Department of Behavioral Health (DBH) in the execution of the Medicaid Health Homes program for individuals with severe mental illness. Unlike the focus in FY16, this fiscal year DHCF's primary efforts will focus on the assessment of each Health Home provider's performance against CMS' performance metrics. Through the health homes program, care coordination teams embedded in community mental health setting (core service agencies) where health home providers provide a range of case management and care coordination services. The primary goals of the program are to improve the integration of physical and behavioral health care; reduce healthcare costs and inappropriate utilization; improve the quality of services delivered; and improve health outcomes.	50-74%	A new SPA with updated rates has been developed to ensure that beneficiaries currently served by the My DC Health Home program can continue to receive services. We continue to work on new ways to better integrate medical and behavioral health. Now that My Health GPS (HH2) has launched, we are working on new ways for the programs to complement each other and take advantage of the HIE tools to better integrate care.	DHCF has been very supportive of DBH's efforts to enhance the sustainability of the My DC Health Home program, however, this program is now run by DBH. DHCF does not have an anticipated completion date as this initiative is now solely under DBH.
Increase Access to Home and Community-Based Services (HCBS) for the Elderly and People with Physical Disabilities.	In FY17 DHCF will increase streamlining eligibility and access to state plan and home and community based waiver services. This will include enhancing the recertification eligibility processes and EPD waiver improvements. DHCF will also implement a new assessment process as part of the Long Term Care Assessment Rule, which will be implemented January 1, 2017, DHCF will be responsible for the operationalization of this process by working with its Contractor to broaden the use of the Long Term Care Assessment Tool as the mechanism for entry for all Long Term Care Supports and Services (LTCSS) programs.	Complete	New streamlined assessment processes and pathways implemented as of 7/1/2017.	
Improve Integration of	In FY17 DHCF will design and launch a second Health Homes program to for individuals with physical chronic conditions enrolled in the Medicaid	Complete	DHCF has continued to	

Medical and Behavioral Health Care through a Health Homes Model for Individuals with Chronic Physical Health Conditions	program. Through this Health Homes program, care coordination teams embedded in the primary care setting will provide a range of case management and care coordination services. The key goals of the program are to improve the integration of physical and behavioral health care; reduce healthcare costs and inappropriate utilization; improve the quality of services delivered; and improve health outcomes.		support the My Health GPS entities through the early rollout of the program, including a 2-day training workshop. The team has also developed marketing materials and outreach messages, and has recently engaged a local consulting firm, HMA, to provide individual technical assistance to sites, which is being supported with funding from CMS.	
PERFORMANCE MANAGEMENT (2 Strategic initiatives)				
Strengthen Provider Standards.	In FY17, DHCF will improve provider enrollment screening by establishing standards for certain Medicaid provider categories. This initiative will provide a definitive standard for determining whether a provider has adequate resources to provide quality care services to District residents. DHCF will promulgate rulemaking setting forth the standards.	Complete	Given the success and efficacy of the five-step analysis established during FY 2017, DHCF is now working on a comprehensive set of rules, establishing specific timelines and thresholds that will applied across a wider provider base and categories.	
Increase information sharing and coordination with other agencies to ensure appropriate administrative actions are	In FY17, DHCF will foster increased information sharing with program integrity partners to ensure that providers who have conducted health care fraud or abuse in the District's Medicaid program are prosecuted or subject to appropriate administrative sanctions. In particular, DHCF will ensure the information is provided to the Department of Health (DOH), DOH's various licensure boards, and the Office of the Attorney General (OAG). The DHCF will also provide additional assistance to the DOH and OAG, as needed, during presentations to the related licensure board to ensure the required information is available to support administrative actions deemed appropriate.	Complete	DHCF conducted meetings with MCOs and law enforcement partners regarding suspect providers, trends, and suspicious Medicaid billing activity.	

taken against providers found to have conducted Medicaid program fraud or abuse.			Conducted Payment Suspension Review Committee meetings. DHCF collaborating with DOJ and law enforcement partners to prosecute Health Care Fraud cases in the District as part of the Strike Force program. Based on coordination and collaboration with DHS over 800 Medicaid beneficiaries found to be residing out of DC were terminated from the program.	