Department of Health Care Finance FY2018

FY2018 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.

FY18 Top Accomplishments

What is the accomplishment that your agency wants to highlight?	How did this accomplishment impact residents of DC?	How did this accomplishment impact your agency?
The Department of Health Care Finance implemented a new Nursing Home Rate methodology that became effective in FY18. The new methodology is based on NH resident's acuity level and provides add on payments when the NH resident has increased needs such as bariatric, behavioral health and/or ventilation requirements.	Providing this payment methodology encourages District Nursing Homes to assist in the care of more District residents with supported cost for the increased care needed; as well as assists in Nursing Homes having the financial ability to support more quality care to our District residents.	
The Department of Health Care Finance's goal is to ensure Medicaid health care insurance is provided to eligible District residents. Each year we increase outreach, as well as partner with other agencies to ensure residents receive assistance, when necessary, in completing the application. In FY18, we exceeded our target for the percent of District residents covered by Medicaid	More District residents will have access to health care thereby improving health outcomes.	
The Department of Health Care Finance, in collaboration with the Department on Disability Services, offers a Waiver for the IDD population in the District to receive care outside of an institutional setting (or an Intermediate Care Facility (ICF)) and within the home or community. Until FY18, the IDD Waiver was under enhanced monitoring with the Center for Medicare and Medicaid Services (CMS). Due to increased reporting, review and analysis; as well as corrections to program delivery; the District was notified that they have met the expectations of CMS Home and Community Based Services program and have been released from enhanced monitoring.		This is a great accomplishment and demonstrates the great work that occurs with cross agency collaboration. In addition, this is a major accomplishment and testament to the dedication and hard work that DHCF staff demonstrate on a daily basis.
In FY18, the Department of Health Care Finance assumed responsibility of building the DC Access system (DCAS) to replace the current system, ACEDS. Through the various challenges of building all-inclusive eligibility	The DC Access system will ensure that the eligibility and enrollment system keeps pace with modern service delivery options	

What is the accomplishment that your agency wants to highlight?	How did this accomplishment impact residents of DC?	How did this accomplishment impact your agency?
system; in partnership with other sister agencies, we have accomplished many milestones that were delayed. Most important, we have entered the final stage of design and development,Release 3. The contract was awarded in the 3rd quarter of FY18 and will bridge all categories of eligibility into one user friendly resident facing system.	to District residents. DCAS R3 will facilitate improved customer service and seamless access to health care and human services and benefits for all District residents.	

2018 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.**

2018 Key Performance Indicators

Measure	Freq	Target	Q1	Q2	Q3	Q4	FY2018	KPI Status	Explanation
1 - Provide access to comprehensive healthcare services for District residents. (5 Measures)									
Percent of Medicaid renewals as a result of the passive renewal process	Quarterly	80%	80.5%	71.6%	72%	67.7%	72.2%	Nearly Met	The degradation in passive rates can be attributed to the reinstatement of electronic residency verification (a policy decision made by DHCF). Prior to the reinstatement, DCAS accepted self-attestation to residency and did not check electronic resources to verify.
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	Waiting on Data		Although we conduct outreach to boost enrollment we have no control over the participation rate.
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	60%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data		

Measure	Freq	Target	Q1	Q2	Q3	Q4	FY2018	KPI Status	Explanation
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	70%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data		
Percent of District residents covered by Medicaid	Annually	35%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	37.2%	Met	
2 - Ensure the delivery of high quality healthcare services to District residents. (3 Measures)									
Reduce hospital discharges of Medicaid Managed Care enrollees that were followed by a readmission for any diagnosis within 30 days	Annually	10%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data		
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	10%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data		
Reduce hospital admissions of Medicaid Managed Care enrollees due to health conditions that may have been prevented through appropriate outpatient care	Annually	10%	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data		
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	1	9	8	18	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	98%	98.8%	99%	98.1%	97.4%	98.4%	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.

2018 Workload Measures

Measure	Freq	Q1	Q2	Q3	Q4	FY 2018
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	2
Number of beneficiaries receiving a conflict free assessment for long-term care services and supports	Quarterly	985	2630	2349	1062	7026
Number of District residents covered by Medicaid (Year End)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	258,482
Percent of District residents insured	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data
Number of Elderly and Persons with Disabilities Waiver (EPDW) beneficiaries enrolled in services My Way	Quarterly	95	76	588	651	1410
Number of District residents covered by Alliance (Year End)	Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	Waiting on Data
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	5	5	4	9	23
2 - Claims Processing (1 Measure)						
Percent 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	-70%
2 - Provider Enrollment and Screening (2 Measures)						
Number of newly enrolled providers	Quarterly	826	4773	2763	1672	10,034
Number of re-enrolled providers	Quarterly	275	167	232	137	811
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	45	43	60	40	188

Measure	Freq	Q1	Q2	Q3	Q4	FY 2018
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	69	53	55	56	233
Conduct liaison, education, and training with other DHCF divisions, outside agencies, providers, and other groups in support of program integrity mission	Semi-Annually	Annual Measure	Annual Measure	Annual Measure	Annual Measure	189
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	11,004
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	126

2018 Strategic Initiatives

Title	Description	Complete to Date	Status Update	Explanation
HEALTH CARE OPERATIONS SUPPORT (4 Strategic initiatives)				
Reduce Low-Acuity Non-Emergent (LANE) Visits Among My Health GPS (MHGPS) Beneficiaries	Throughout FY18, DHCF will collaborate with MHGPS providers to reduce the percentage of LANE visits amongst actively enrolled My Health GPS beneficiaries. By use of FY16 utilization data as a baseline, DHCF seeks to improve performance by two percentage points during FY18. DHCF will monitor outreach activities performed by the MHGPS providers to ensure educational messaging and strategies are implemented to encourage use of preventive and primary care services by the beneficiaries.	75-99%	Currently in the 3-month claims run-out period. Data is expected to be available January 2019.	There are no barriers to completing the initiative, only require the necessary time frame for data collection .
Promote Adoption and Meaningful Use of Electronic Health Records by Providing Incentive Payments to Providers and Offering Outreach, Education and Technical Assistance	In FY18 DHCF will continue to promote the adoption and use of certified EHR technology through outreach and technical assistance efforts. Specially, technical assistance will be provided to at least 100 eligible providers to help them attest for meaningful use stages 2 and 3. Participation in the meaningful use program is an important building block towards continuous quality improvement and value-based purchasing (which seeks to pay for the value - improved health outcomes - rather than volume of services). Because outcomes in these payment models are generally assessed using validated quality measures that increasingly rely on electronic health data, a critical step in this direction is ensuring providers have technical assistance to use electronic medical records effectively. Increasing the technical capabilities	50-74%	The technical assistance (TA) team continued recruitment efforts and are now working with 40 practices. The team has completed 37 detailed practice assessments and is implementing individualized TA plans with 28 practices. The team is collaborating with a specialized T/A effort from Health Management Associations, also supported by DHCF, to assist My Health GPS providers in utilizing health information technology to exceed program goals. DHCF received approval from CMS to exercise Option Year 2 of this contract, beginning on 10/1/2018. CMS also approved a separate contract with HealthTech Solutions to provide the technology solution for providers to	In FY2018, DHCF faced contracting challenges with the incumbent contractor for the State Level Registry, Conduent. As a result, a substantial amount of time was spent developing a new procurement. In addition, as staff work with practices to determine eligibility for the program, many Medicaid providers are right at or do not meet the threshold of Medicaid volume required to be eligible for the program, however, it can take time to come to this assessment, which slows the process of meeting outreach and TA goals.

Title	Description	Complete to Date	Status Update	Explanation
	of District providers, and the cache of digital health data in the District, benefits Medicaid beneficiaries across all eight wards in the District.		attest to the program and be paid. This will require training of providers on a new system and the T/A team is assisting with that.	
Strengthen the Overall Connectivity and Interoperability of the District's Current Health Information Exchange	DHCF will extend the existing grant to CRISP/DCPCA to develop four HIE tools through December 31, 2017 to complete work that began later than expected. In FY18 DHCF will build on the recently developed HIE infrastructure and expand access to HIE tools to a broader set of physician practices, in addition to Fire Department nurses, FQHCs, behavioral health providers (with DBH) and hospital emergency departments. DCHF will focus on continuously improving the timeliness and accuracy of data transmitted through the HIE. The DC HIE advances health and wellness for all persons in the District by providing actionable health-related information whenever and wherever it is needed.	Complete	DHCF completed a grant period with CRISP/DCPCA at the end of the fiscal year that resulted in new health information exchange services being implemented by hundreds of Medicaid providers. CRISP rolled out new HIE services to emergency department staff in Q4 at all hospitals in DC and staff at two of three MCOs. CRISP has 104 DC provider practices (at 143 sites) live with HIE services, up from 41 in Q2. Those practices are receiving ~42,000 encounter notifications per week for their patients who were admitted, discharged or transferred from area hospitals. DHCF received approval for CMS 90% matched funding in Q4 for a new, five-year grant to improve, maintain and widen the use of HIE services beginning in FY19. That grant RFA is open as of 10/15.	
Enhance and Expand the My Health GPS for Individuals with Chronic Physical Health Conditions to Improve Integration of Medical and Behavioral Health Care through a Health Homes Model	In FY18, the My Health GPS program aims to grow substantially, both with respect to increasing enrollment in the program, and enhancing providers' capacity to successfully implement value-based models of care. Providers participating in the program estimate that they will enroll approximately 10,000 beneficiaries in the program by the end of FY18. In addition, we anticipate that the size of the provider network and number of new health home teams will nearly double. DHCF will also implement a technical assistance contract to help support providers efforts to re-design care delivery workflow in order to improve quality. The My Health GPS program is offered to District Medicaid beneficiaries with the highest burden of chronic illness (three or more chronic conditions). Improved care coordination to reduce utilization of preventable, high-cost services stands to improve overall health and wellness for District Medicaid beneficiaries, and is an important building block to promote new models of care within the District.	50-74%	Based on claims data, My Health GPS program has enrolled 4,642 beneficiaries as of September 30, 2018. Though one entrant to the program has since left the My Health GPS program, two new practices have applied to serve the beneficiaries and we anticipate they will be approved to become My Health GPS providers in the Fall. DHCF completed year one of a technical assistance contract and all providers are receiving support to help them re-design care delivery workflow in order to improve quality.	Increasing enrollment to the level projected by the practices has proved challenging given the level of effort required to reach beneficiaries who are disconnected from care, or may receive services from other sites of care. Policy efforts such as a pending SPA change to compensate providers for the additional time and effort to initiate or annually update care plans are currently underway to minimize barriers to enrollment

Title	Description	Complete to Date	Status Update	Explanation
MANAGED CARE MGT (5 Strategic initiatives)				
Increase Awareness of Services offered by the Office of Health Care Ombudsman and Bill of Rights	In FY18, DHCF will increase outreach efforts specifically to educate non-English speaking residents and employees of the District of Columbia regarding the services offered by the Office of Health Care Ombudsman and Bill of Rights (OHCOBR). In addition, DHCF will seek to expand outreach efforts by collaboratively working with other District government agencies such as the District of Columbia Department of Human Resources (DCHR) and Mayor's Office on Latino Affairs (OLA). In addition, OHCOBR will seek to join forces with non-government agencies such as the DC Chamber of Commerce to increase awareness.	Complete	The Office of Ombudsman exhibited and gave a brief overview of the Office at four (4) Community, Health & Informational Fairs. A total of 2,900 residents participated in these events and the Office of the Ombudsman's educational brochures were distributed at each of the events.	
Implement a Survey for Medicaid Fee-For-Service (FFS) Beneficiaries regarding Access and Quality	In FY18, DHCF will implement a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to evaluate the health care experience of a statistical sample size of beneficiaries enrolled in the FFS program. This initiative will promote access to benefits for District beneficiaries and transparency and responsiveness to the needs of the District's Medicaid beneficiaries.	Complete	Survey completed successfully; full results of the survey available for adult, child and child w/chronic conditions.	
Implement Pay-for-Performance (P4P) Program in New Managed Care Program	In FY18, DHCF will begin a new 5-year Managed Care program, with one new Managed Care Organization (MCO) and two returning MCOs. A two percent (2%) withhold from the MCOs' actuarial capitation rates will fund the program. Each MCO 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. DHCF will provide MCO encounter data to its Actuary to establish baselines within each of the three measures. MCOs must achieve targeted reductions within each measure to earn back all or a portion of the withheld capitation payments.	Complete	The initiative was completed on 9/30/18, however the outcomes will not become available until on or before 1/31/19. This is due to claims lag time; an additional 3 months of claims submissions is necessary to capture all claims submitted w/DOS through 9/30/18.	

Title	Description	Complete to Date	Status Update	Explanation
Increase Access of Preventive Dental Services for FFS Medicaid Children and Adolescents	Throughout FY18, DHCF will collaborate with the MCOs, CFSA, DYRS and DOH to develop and implement strategies to increase the compliance rate by 2 percentage points for completion of preventive dental services of children and adolescents enrolled in the FFS Program. Outreach activities and interventions will occur in concert with all entities, as appropriate, in an effort to present similar messaging to the targeted population, 0 through 20 years of age. Quarterly reports will be generated to assess performance and address barriers and/or challenges to care delivery.	Complete	DHCF Division of Children's Health Services (DCHS) worked with CFSA and DYRS to finalize the MOAs to share data to provide outreach to FFS children in need of well-child visits and dental utilization. A plan is in place with CFSA to begin data sharing, and we are planning to meet with DYRS to implement the MOA	
Increase Well-Child Visit Utilization for FFS Medicaid-Enrolled Children	Throughout FY18, DHCF will collaborate with CFSA, DYRS and entities managing long-term care placements for children enrolled in FFS Medicaid to implement outreach strategies to increase well-child visit utilization. By use of FY16 utilization data as a baseline, DHCF seeks to improve performance by two percentage points during FY18. Outreach activities and interventions will occur in concert with all entities, as appropriate, in an effort to present similar messaging to the targeted population, 0 through 20 years of age.	Complete	We have completed MOAs with CFSA and DYRS and have begun implementation for data sharing. We also worked with many long-term care facilities to assist with access to dental services.	
MEDICAID INFORMATION SYSTEMS (2 Strategic initiatives)				
Implement the New Reimbursement Methodology for Nursing Homes that Aligns Payment to Promote Access to High Quality and Value Based Healthcare	In FY18, DHCF will fully implement the 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. During FY17, DHCF kicked off all of	Complete	Completed and fully implemented. Also conducted additional post implementation analysis.	

Title	Description	Complete to Date	Status Update	Explanation
	the necessary analysis, stakeholder engagement, developed the reimbursement methodology and drafted the state plan amendment (SPA) and rule for publication. The full implementation of the new reimbursement methodology and add-on payments for behaviorally complex and bariatric support will be completed by March 31, 2018. Specifically, DHCF will obtain approval of the rate methodology from CMS and issue out rate letters to the nursing homes. From an operations standpoint, the DHCF MMIS system will be updated to enable billing, processing and payment of claims under the new reimbursement methodology. DHCF will also conduct several provider training sessions, implementation testing and monitoring, to ensure compliance with the new methodology. This new reimbursement methodology, will further the DHCF's goal of providing residents with better access to quality nursing home services. For example, it will incentivize nursing homes to accept more behaviorally complex cases, align reimbursement to patients' acuity/severity of illness, and provide an opportunity to increase the number of residents residing in District nursing homes.			
Implement the District's Integrated Health and Human Services Eligibility System	In FY18 DHCF will begin work to automate eligibility and verification systems support needed to determine Non-MAGI Medicaid for District residents. The system will support the requirements needed to determine eligibility for all Insurance Affordability Programs as defined by the Affordable Care Act (ACA) including eligibility and verifications needed to determine Modified Adjusted Gross Income (MAGI) and Advanced Premium Tax Credits (APTC), and provide all the systems support needed for	75-99%	Work on Non-MAGI Medicaid has begun. R3 which is the work-stream that will implement non-MAGI Medicaid work. Work continues on obtaining "full functionality" systematically to support the eligibility determinations for Cash/Food programs with expected completion this calendar year.	The final phase of integration of health and human services eligibility did not officially launch until July 2018 with the award of the Release 3 contract.

Title	Description	Complete to Date	Status Update	Explanation
	other federal assistance programs like SNAP/TANF.			
PERFORMANCE MANAGEMENT (1 Strategic Initiative)				
Develop Sanctions for Beneficiary and Provider Fraud	In FY18 DHCF will develop sanctions and other administrative actions for incidents of fraud conducted by Medicaid program beneficiaries. Changes will be submitted for inclusion in the DCMR and/or State Plan to establish sanctions and other administrative actions applicable in response to incidents of fraud. Medicaid fraud currently has a significant impact on program expenditures. The District does not have a range of sanctions in place to address fraud committed by program beneficiaries. This initiative will reduce costs and increase the resolution of incidents of Medicaid program fraud and abuse.	50-74%	Proposed regulations discussed with DHCF administrations and Office of General Counsel (OGC) to discuss potential DCMR changes. Additional meetings scheduled to complete process to prepare proposed changes for senior management review. Adverse beneficiary actions will also include termination for eligibility fraud. OGC completed a summary of other states' sanctions and regulations. OGC sanctions research shared with DHCF administrations, including application of sanctions primarily in HHA/PCA and dental fraud. Recommended sanctions include warning letters, required education, reassessment of service authorizations, beneficiary lock-in program, and termination. Interdisciplinary Committee would meet to review allegations and determine any applicable sanction.	New regulations require briefing and approval of DHCF administrations involved in sanctions and may require changes to State Plan. Will also seek approval of new Medicaid Director who arrives in late October 2018 prior to DCMR change process.