FY 2015 Performance Accountability Report
Department of Health Care Finance

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 2015 by listing DHCF's top three accomplishments, and a summary of its progress achieving its initiatives and progress on key performance indicators.

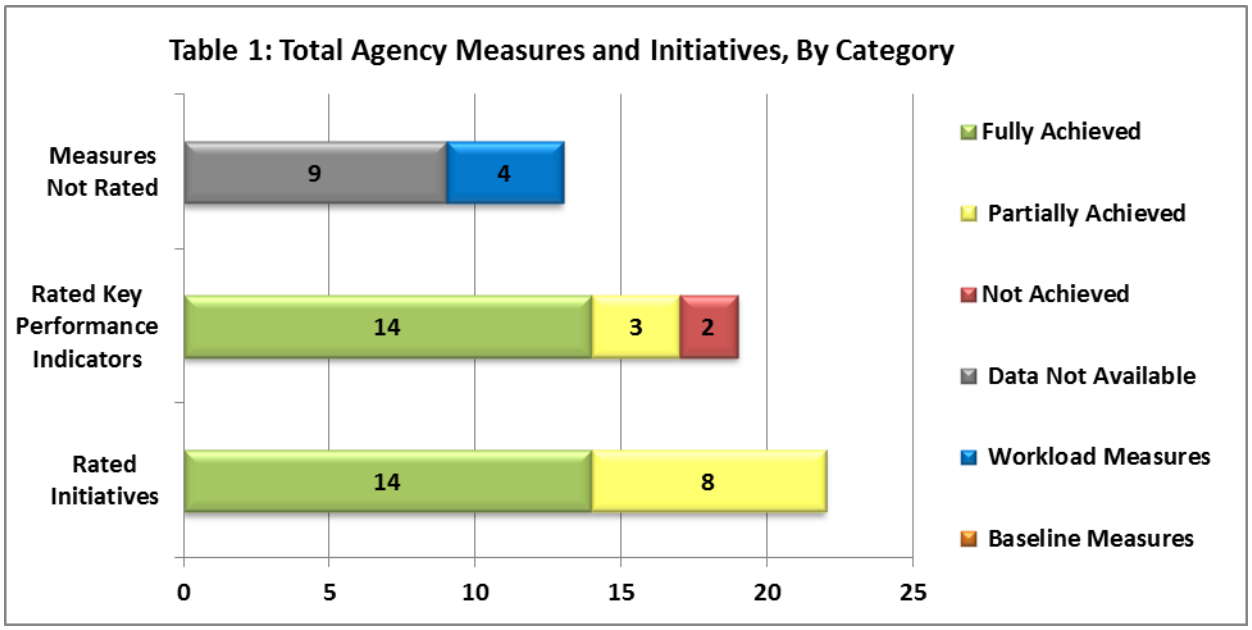
TOP THREE ACCOMPLISHMENTS

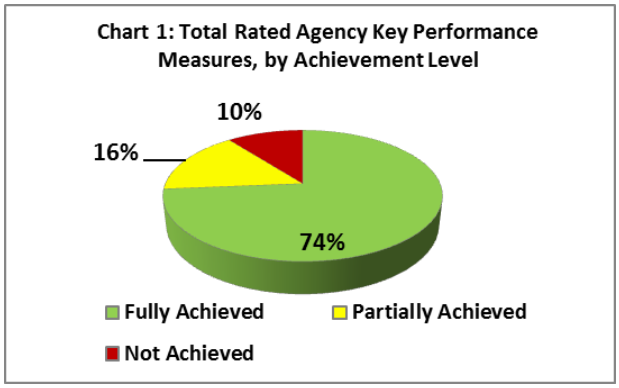
The top three accomplishments of DHCF in FY 2015 are as follows:

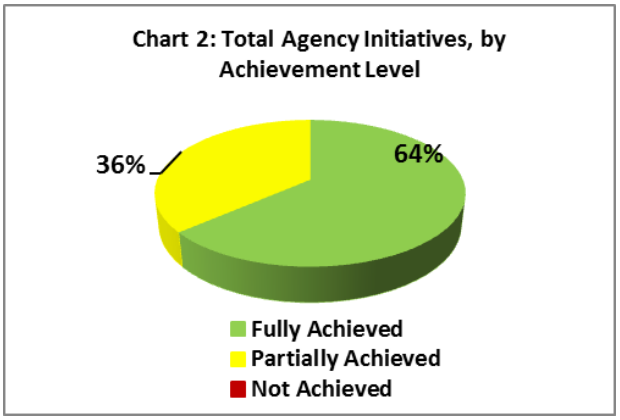
- ✓ Implemented new billing procedures to better monitor the quality of well-child visits.
- ✓ Developed a health homes program to better integrate primary and behavioral health care.
- ✓ Implemented a new outpatient hospital reimbursement model that is sustainable, pays the same for similar care, and provides greater transparency.

SUMMARY OF PROGRESS TOWARD COMPLETING FY 2015 INITIATIVES AND PROGRESS ON KEY PERFORMANCE INDICATORS

Table 1 (see below) shows the overall progress the DHCF made on completing its initiatives, and how overall progress is being made on achieving the agency's objectives, as measured by their key performance indicators.







Default KPI Rating:	
>= 100%	Fully Achieved
75 - 99.99%	Partially Achieved
< 75%	Not Achieved

In FY 2015, DHCF fully achieved more than two-thirds of its initiatives and more than 70 percent of its rated key performance measures. **Table 1** provides a breakdown of the total number of performance metrics DHCF uses, including key performance indicators and workload measures, initiatives, and whether or not some of those items were achieved, partially achieved or not achieved. **Chart 1** displays the overall progress being made on achieving DHCF's objectives, as measured by their rated key performance indicators. Please note that **Chart 2** contains only rated performance measures. Rated performance measures do not include measures where data is not available, workload measures or baseline measures. **Chart 2** displays the overall progress DHCF made on completing its initiatives, by level of achievement.

The next sections provide greater detail on the specific metrics and initiatives for DHCF in FY 2015.

PERFORMANCE INITIATIVES – ASSESSMENT DETAILS

Office of the Director

OBJECTIVE 1: Increase access to health care for District residents.

INITIATIVE 1.1: Increase the number of commercial appeal/grievance cases that are eligible for external review or reconsideration.

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) will continue to conduct research using medical journals/periodicals, medical research websites and communication with providers to assist in obtaining information to support the medical services that are being denied. These resources allow the staff to strengthen the cases before requesting reconsideration of the cases in efforts to have the denials overturned.

Completion Date: September, 2015.

Performance Assessment Key: **Fully Achieved.** The Office of Health Care Ombudsman and Bill of Rights opened a total of 201 Commercial Cases of which 118 cases were overturned, reversed or resolved—representing a 58.71% closure rate which is an increase over the 50% projected for FY 2015.

INITIATIVE 1.2: Work with various community-based organizations and DC Government agencies that serve residents with mental health and substance abuse (behavioral health) issues.

Staff will attend community meetings and participate in outreach events to guide and educate this population of the services available for their use through the Office of Health Care Ombudsman and Bill of Rights. We will include two (2) members from mental health and substance abuse (behavioral health) community-based organizations on the Advisory Council.

Completion Date: September, 2015.

Performance Assessment Key: **Fully Achieved.** The Office of Health Care Ombudsman and Bill of Rights fully achieved this goal by attending various community outreach/education events

as an exhibitor or speaker. In FY 2015, OHCOBR participated in a total of thirty-one (31) outreach/education events which included approximately 17,065 attendees. Furthermore, the Advisory Council now has two additional members.

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

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

Performance Assessment Key: **Fully Achieved.** DHCF successfully developed new reimbursement methodologies for the Home Health program under both the State Plan services and Waiver benefits. The new reimbursement methodologies include several policy designs to ensure the reimbursement rates are reflective of costs by factoring in adjustments for the following: District's Living Wage increases, estimates for the provision of mandatory health insurance benefits and sick leave time for employees of Home Health Agencies. Additionally, DHCF conducted an in-depth review and update to the Medicaid Fee-for-Service fee schedule.

KEY PERFORMANCE INDICATORS- Office of the Director

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
	1.1	Number of consumers served by Ombudsman (Medicare, Medicaid, Alliance, DC Health Link)	7712	5,000	8,000	8,241	103.01%	Agency Management
	1.2	Percentage of closed/resolved cases among Non-Commercial consumers (Medicare, Medicaid, Alliance, DC Health Link)	95%	98%	95%	95.89%	100.93%	Agency Management
	1.3	Percentage of overturned/reversed/resolved cases among Commercial	74.3%	12%	50%	58.71%	117.41%	Agency Management

		consumers served by Health Care Ombudsman (Appeals/Grievances)						
		Number of provider categories to be audited and related financial reviews	Not Applicable	6	Not Applicable	Not Applicable [1]	Not Applicable	Agency Management
	2.1	Number of new reimbursement methodologies and rates to be developed	Not Applicable	2	1	1	100%	Agency Management
	2.2	Percentage of invoices processed accurately and in compliance with Prompt Payment Act	Not Applicable	95%	Not Applicable	96.42%	101.50%	Agency Management

Health Care Policy and Research Administration

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

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

Performance Assessment Key: **Partially Achieved.** The DHCF provided policy subject matter expertise needed to develop and design system functionality for the implementation of Non-MAGI eligibility in D.C. Health Link, however, due to major system defects and other issues, the implementation of Non-MAGI eligibility determinations in D.C. Health Link has been delayed until Winter 2017.

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

Appeals establishing the respective responsibilities of these agencies to implement and administer the new streamlined, automated and integrated Medicaid eligibility system. **Completion Date: February, 2015.**

Performance Assessment Key: **Fully Achieved.** The final rule to support the authority granted under the approved Affordable Care Act mandated Statement Plan Amendments was published August 14, 2015 in the D.C. Register.

Initiative 1.3: Increase sister agency personnel and public awareness of Medicaid's regulatory obligations, services, utilization, costs and changes related to the Affordable Care Act.

HCPRA will continue to increase public knowledge of agency activities through public reporting activities; HCPRA staff will support the development and publication of two or more distinct quarterly public reports. These reports will cover topics such as Medicaid managed care, nursing facility care, or other subjects, and will increase agency oversight, transparency, and public knowledge of the selected subjects. **Completion Date: September, 2015.**

Performance Assessment Key: **Fully Achieved.** HCPRA conducted outreach and numerous trainings for sister agencies, providers and other stakeholders on a number of policy and programmatic areas, including long-term care. DHCF held regular monthly meetings with providers. In addition, DHCF issued quarterly MCO reports and an annual MCO report card. DHCF continues to publish the monthly enrollment report.

Initiative 1.4: Develop, submit, and implement a state plan amendment for Medicaid coverage for childless adults.

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

Performance Assessment Key: **Fully Achieved.** The Medicaid State Plan Amendment to authorize the continuation of Medicaid service delivery to childless adults who are between 133% and 200% Federal Poverty Level has been submitted to CMS. The District is awaiting approval.

KEY PERFORMANCE INDICATORS- Health Care Policy and Research Administration

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
	1.1	Number of adults in 1115 Childless Adults Waiver	7,750	6,190	Not Applicable	8,308	134%	Health Care Policy and Research
	1.2	Number of adults enrolled in the Medicaid Emergency Psychiatric Demonstration (MEPD)	235	235	Not Applicable	235	100%	Health Care Policy and Research

Health Care Delivery Management Administration

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

INITIATIVE 1.1: Improve primary care provider well-child visit documentation and billing. DHCF will improve the billing procedures for well-child visits to better document the various components of a well-child visit (or primary care visit) for Medicaid beneficiaries under the age of 21 receiving the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit. The overall goal of this project is to incorporate all aspects of health into a well-child visit in the primary care setting, including oral, behavioral, and developmental health. DHCF will revise the billing instructions for providers and will have a new billing manual in FY 2015. DHCF will also conduct provider training and work to promote widespread adoption among the pediatric provider community. Finally, DHCF will develop a report template and set a baseline to determine progress in future years. **Completion Date: September 30, 2015.**

Performance Assessment Key: **Fully Achieved.** EPSDT billing instructions were revised to include specific codes and a modifier to identify when a child is referred for additional or specialty services exclusive of a well-child visit. Providers were educated on the new billing instructions and a reporting template was established for monitoring and tracking outcomes associated with the changes. The billing changes became effective October 1, 2014 for the FFS population and January 1, 2015 for Managed Care. The extended date for Managed Care was to accommodate system changes necessary by the MCOs to ensure proper codes and edits were aligned with the new billing instructions.

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

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

Performance Assessment Key: **Fully Achieved.** The Managed Care enrollment process for the Immigrant Children Program (ICP) was revised and implemented, effective April 1, 2015. Due to this change, beneficiaries that are eligible for the program are immediately enrolled into one of the Managed Care Organizations (MCOs). This new process eliminates delays in access to care and other billing issues that are imposed on the family due to intervals in health coverage.

INITIATIVE 1.3: Plan, develop and implement methodology for validating the adequacy of the MCO networks.

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

Performance Assessment Key: **Partially Achieved.** In FY 2015, 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. Although DHCF made significant progress on this project full and consistent implementation of the initiative did not occur. Implementation will ensue in FY 2016.

OBJECTIVE 2: Improve health outcomes for District residents.

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

Performance Assessment Key: **Partially Achieved.** During FY 2015, DHCF assessed the Quality Strategy previously implemented and determined that the focus was narrowly defined to only include Managed Care beneficiaries. The Quality Strategy developed for FY2015 – FY2018 focuses 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 Strategy is aligned with the Department of Health and Human Services National Strategy for Quality Improvement in Health Care and will serve as a framework for evaluating and monitoring quality improvement activities for all Medicaid beneficiaries. The initiative will continue in FY 2016.

INITIATIVE 2.2: Plan, develop and implement standards for Case Management (CM) for use by the MCOs/CASSIP.
The Division of Quality and Health Outcomes will implement a comprehensive Case Management Program for the MCOs/CASSIP that will enhance outreach to enrollees who may qualify for Case Management services and work to increase the quality of those services. The program will be developed with input from the MCOs/CASSIP and community stakeholders. In addition, the program will include education and training for all Case Managers, Providers and Enrollees, including establishment of minimum caseloads per Case Manager. Further development of the program will include consistent minimum standards of services offered, interventions and performance outcome measurement. Success will be determined by the amount of Medicaid beneficiaries who participate in the program and improved health outcomes for those beneficiaries. The goal is to implement a program that allows the DHCF to measure Case Management services provided by each MCO/CASSIP to ensure that quality Case Management services are received by eligible enrollees that are aligned with national standards of care to produce positive health outcomes. A completed program description and timeline for baseline measurement will be submitted by February 27, 2015. **Completion Date: March 30, 2015**

Performance Assessment Key: **Partially Achieved:** During FY 2015, DHCF held a series of meetings with the MCOs to ascertain the current status and framework of their respective

Case Management Programs. Each presented comprehensive details about their processes, internal and external collaborations, resulting in differences and similarities within each program. Discussions were stalled when MCOs expressed concerns about recommended changes and the potential impact on the National Committee for Quality Assurance (NCQA) requirements; an accreditation that each MCO must maintain for participation in the District's Medicaid Managed Care Program.

The initiative will continue in FY 2016 and is expanded to include the FFS program and newly planned and developed Health Homes in an effort to sustain standardization across the Medicaid programs.

INITIATIVE 2.3: Improve timeliness of acute and specialty hospital utilization reviews to ensure timely access of services for Medicaid FFS.
In FY 2015, DHCF will work with its QIO contractor, Qualis, to improve the timeliness of acute and specialty hospital reviews. Specifically, DHCF's goal is to have 98 percent of emergency hospital admissions and continued stay acute and specialty hospital reviews complete within 24 hours. For other hospital reviews, including, acute pre-authorization and specialty hospital reviews, DHCF's goal is for 98 percent of reviews to be complete within 5 days. DHCF will track timeliness on a daily, monthly and quarterly basis through data reports from Qualis. The data from the October 2014 Quality Report will be used as baseline data for this project. The success of the project is dependent on collaboration with Qualis to change internal processes and improve the outcomes within the reported data. **Completion Date: September 30, 2015.**

Performance Assessment Key: **Partially Achieved:** During FY 2015, the QIO Contractor partially met the established goals, accomplishing significant improvements in all categories. However, the Contractor did not complete 98% of emergency hospital admission reviews within 24 hours. Instead, there was an average of 90%, a vast improvement from a start of 13%. Performance of the Contractor will continued to be monitored and tracked for targeted improvement.

KEY PERFORMANCE INDICATORS– Health Care Delivery Management Administration

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
	1.1	[2]Percent of children age 3 and over with 90 days of continuous enrollment receiving preventive	56%	62%	60%	Not Available	TBD	Health Care Delivery Management

		dental services						
	1.2	Reported complaints on transportation broker services per 1,000 trips (incl. missed/late trips) within the Medicaid Fee-for-Service population	2.1/1,000 trips	1.9/1,000 trips	2.1/1,000 trips	2.1/1,000 trips	100%	Health Care Delivery Management
	1.4	[3]Percent of Medicaid beneficiaries satisfied with their health plan	73.5%	74.5%	Not Applicable	Not Available	TBD	Health Care Delivery Management
	2.1	[4]Healthcare Effectiveness Data and Information Set measures for childhood immunization enrolled in Managed Care	76%	77%	Not Applicable	Not Available	TBD	Health Care Delivery Management
	2.2	[5]Healthcare Effectiveness Data and Information Set measures for timeliness of prenatal care enrolled in Managed Care	73%	75%	Not Applicable	Not Available	TBD	Health Care Delivery Management
	2.3	[6]Adult access to preventive, ambulatory care services (adults 20-44, enrolled in Managed Care)	69%	70%	Not Applicable	Not Available	TBD	Health Care Delivery Management
	2.4	[7](Quality Improvement Initiative) Adverse	198	<190	<198	Not Available	TBD	Health Care Delivery Management

		Perinatal Outcomes per 1,000 pregnancies and infants enrolled in Managed Care						
⬤	**2.5**	[8](Quality Improvement Initiative) Adverse Chronic Disease Outcomes per 1,000 people with asthma, diabetes, hypertension, congestive heart failure	TBD	TBD	Not Applicable	Not Available	TBD	Health Care Delivery Management

Health Care Operations Administration

OBJECTIVE 1: Improve the efficiency of program operations.

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

⬤ ***Performance Assessment Key:*** **Partially Achieved.** This initiative was not fully achieved in FY 2015 as a result of delays in the procurement process. However, DHCF is on target to fully accomplish this initiative in the first quarter of FY 2016.

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

Performance Assessment Key: **Fully Achieved.** In FY 2015 the Third Party Liability unit collected over $10.2M.

OBJECTIVE 2: Strengthen program integrity.

INITIATIVE 2.1: Implement Provider Re-enrollment Process.

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

Performance Assessment Key: **Fully Achieved.** In FY 2015 the DHCF implemented provider re-enrollment and successfully met the re-enrollment goal of 1,100 providers. The re-enrollment of providers will continue until March 2016.

KEY PERFORMANCE INDICATORS- Health Care Operations Administration

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
	1.1	Percent of providers paid electronically	39.12%	70%	45%	39.32%	87.37%	Health Care Operations
	1.2	Avg. time to process Medicaid provider applications	37.81 days	30 days	Not Applicable	38 days	78.59%	Health Care Operations
	1.3	Avg. time to process Medicaid "low risk provider" application	Not Available	30 days	Not Applicable	42 days	70.57%	Health Care Operations
	1.4	Avg. time to process Medicaid "moderate" risk provider application	Not Available	60 days	Not Applicable	11 days	517.03%	Health Care Operations
	1.5	Avg. time to process Medicaid "high risk" provider application	Not Available	90 days	Not Applicable	22 days	392.13%	Health Care Operations

	1.6	Total dollars recovered from Third Party Liability (in millions)	$5,176,519	$3M	Not Applicable	$10,215,921	Neutral	Health Care Operations
	2.1	Number of referrals to the Medicaid Fraud Control Unit	9	20	6	5	83.33%	Health Care Operations

Health Care Reform and Innovation Administration

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

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

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

Performance Assessment Key: **Fully Achieved.** During FY 2015 DHCF facilitated a stakeholder input process that included an HIE Summit (attended by between 100-150 individuals), led a committee process under the auspices of the HIE Policy Board, and completed a five-year HIE Road Map that was approved by the HIE Policy Board. In addition, DHCF submitted a request for federal funding for a project to improve data exchange to support health homes. That request is pending CMS approval.

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

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

***Performance Assessment Key*: Fully Achieved.** In FY 2015 the DHCF continued to operate the District's Medicaid Electronic Health Record Incentive Payments program. District hospitals and eligible providers received $5.6 million in federal incentive payments in FY 2015. The program is scheduled to continue through 2021.

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

INITIATIVE 2.1: Obtain federal approval and implement a health homes program.
DHCF, in collaboration with the Department of Behavior Health, will design a health homes program that will serve Medicaid-eligible individuals with severe mental illness. Through the program, Core Service Agencies and Assertive Community Treatment providers will provide a range of case management and care coordination services, seeking to better integrate behavioral health with primary care. DHCF will submit a state plan amendment for approval to the Centers for Medicare and Medicaid Services. Once approved by CMS, DHCF will implement the program and will work with DBH to monitor the program and communicate with providers about performance. **Completion Date: September, 2015.**

Performance Assessment Key: **Fully Achieved.** The DHCF submitted a health homes state plan amendment (SPA) for a health homes program for individuals with severe mental illness. The SPA was approved by CMS and the program is scheduled to launch on January 1, 2016.

OBJECTIVE 3: Implement Health Care Reform and increase the number of District residents with health insurance.

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

Performance Assessment Key: **Fully Achieved.** DHCF has implemented Hospital Based Presumptive Eligibility (HPBE) in the District of Columbia. D.C. Health Link has the system functionality to complete HPBE eligibility determination.

KEY PERFORMANCE INDICATORS– Health Care Reform and Innovation Administration

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
	1.1	Total amount paid to DC providers through the Medicaid EHR Incentive Program	Not Applicable	$12M	$5.6M	$6.6M	117.20%	Health Care Reform and Innovation
	1.2	Number of hospitals connected to HIE	6	8	6	6	100%	Health Care Reform and Innovation
	1.3	Number of CRISP encounter alerts sent	Not Applicable	100,000	Not Applicable	410,402	410.40%	Health Care Reform and Innovation
	1.4	[9]Number of individuals enrolled in health homes	Not Applicable	5,000	Not Available	Not Available	Not Available	Health Care Reform and Innovation
	3.1	[10]Percentage of District residents insured	94.7%	95%	Not Available	Not Available	Not Available	Health Care Reform and Innovation

Long Term Care Administration

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

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

For FY 2015, DHCF will expand comprehensive conflict-free assessment to other long term care programs other than the ID/DD programs. Currently, conflict-free assessment is in place for personal care services. This effort will ensure comprehensive reliable sources of information, assistance and access; coordinated eligibility criteria; and a "standardized" person-centered assessment process that works for people of all ages, income-levels and abilities. Long Term Care Support Services (LTCSS) provides beneficiaries with crucial services including assistance with basic tasks of every-day life. These include those services provided in institutional/facility based settings, and supports and services provided in the community

and/or in a person's home. The adoption of the conflict-free assessment for LTCSS services will (1) establish standards for the implementation of a standardized tool for assessing a person's needs for LTCSS; and (2) establish numerical scores pertaining to the level of need necessary to establish eligibility for a range of LTCSS. **Completion Date: September 30, 2015.**

***Performance Assessment Key*: Partially Achieved.** The implementation of this initiative includes the publication of the Long Term Care Support and Service (LTCSS) rule and the implementation of the conflict-free assessment for all LTCSS. The LTCSS rule has been drafted and is in the final stages of the rulemaking process. The implementation of conflict-free assessment for LTC Programs is pending the publication of the rule, system design and provider training.

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

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

***Performance Assessment Key*: Fully Achieved.** The EPD Waiver amendment was submitted in June 2015 and approved in October 2015. The EPD Waiver rules are being drafted for the implementation of the approved Waiver. The conflict-free case management rule was published in July 2015 and case management providers submitted the decision and transition plan for conflict-free case management. The deadline for transitioning approximately 2000 EPD waiver beneficiaries to conflict-free case management agencies is by June 30, 2016. Provider readiness review is conducted for the new EPD providers that are currently being enrolled. LTCA continues its aggressive outreach for new providers.

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

In FY 2015, DHCF will implement a new 1915(i) State Plan Option, Adult Day Health Program (ADHP) to replace the existing Day Treatment, which was noncompliant with federal regulations. This new service under the Home and Community-Based Services Medicaid State Plan Option is designed to encourage older adults to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care. **Completion Date: September 30, 2015.**

***Performance Assessment Key*: Fully Achieved.** The Adult Day Health Program was implemented in August 2015. Currently, there are six (6) ADHP enrolled providers.

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

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

- ***Performance Assessment Key:*** **Partially Achieved.** CMS acknowledged the District's progress on the ID/DD Waiver and has advised they would request information for evidentiary review in November 2015. CMS intends to review the evidentiary review information in order to make a decision on removing the District from enhanced monitoring.

KEY PERFORMANCE INDICATORS- Long Term Care Administration

	KPI	Measure	FY 2014 YE Actual	FY 2015 YE Target	FY 2015 YE Revised Target	FY 2015 YE Actual	FY 2015 YE Rating	Budget Program
		Number of individuals moved from institutions into the community (Money Follows the Person Program)	20	0[11]	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	1.1	Percentage of beneficiaries receiving LTCSS PCA Services	Not Applicable	80%	Not Applicable	63.67%	79.59%	Long Term Care Administration
	1.2	Percentage of case management providers who complete EPD Waiver Provider Readiness process (note	Not Applicable	90%	50%	20.51%	41.03%	Long Term Care Administration

		that this number will reflect applicants, not those approved)						
	1.3	Number of monitoring reports sent to EPD Waiver Providers, including but not limited to home health agencies	Not Applicable	5	Not Applicable	8	160%	Long Term Care Administration

WORKLOAD MEASURES – APPENDIX

WORKLOAD MEASURES

Measure Name	FY 2013 YE Actual	FY 2014 YE Actual	FY 2015 YE Actual[12]	Budget Program
Number of District residents covered by Medicaid (Year End)	226,051	244,039	248,775	OFFICE OF THE DIRECTOR
Number of District residents covered by Alliance (Year End)	14,813	15,275	15,059	OFFICE OF THE DIRECTOR
Percentage of District residents insured	93.3%	94.7%	TBD	OFFICE OF THE DIRECTOR

[1] This KPI was eliminated in Spring 2015 due to the large fluctuations that may occur with audits.

[2] The data will not become available until April 2016.
[3] The data will not become available until July 2016.
[4] The data will become available until June 2016.
[5] The data will not become available until June 2016.
[6] The data will not become available until June 2016.
[7] The data will not become available until June 2016.
[8] The date will not become available until June 2016.
[9] Program was not launched in FY 2015 therefore no data is available.
[10] Census data unavailable.
[11] This program is no longer with DHCF and has been transferred to the DC Office on Aging in October 2014 therefore this KPI was removed.

[12] Enrollment for FY 2015 YTD is through 6/30/15.