HCA Managed Care Program Oversight

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Program Integrity

CMS Review
## How we are accountable to CMS

**HCA created corrective action plan in response to CMS review**

<table>
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<th>Finding</th>
<th>Response</th>
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<td>Organize program integrity into one unit or common protocol</td>
<td>Fraud investigation moved into program integrity division; ongoing provider enrollment collaboration (September 2018)</td>
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<td>Ensure sufficient resources for prevention, detection, investigation, referral of suspected provider fraud</td>
<td>New dedicated managed care plan program integrity oversight unit (December 2018)</td>
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<td>Improve program integrity contract language with managed care plans</td>
<td>Contract language strengthened to be specific to Code of Federal Regulation (effective July 2019, January 2020)</td>
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<td>Conduct audits of encounter data to ensure rate setting integrity</td>
<td>Oversight plan roll-out March 2019 for HCA agency approval; audits/increased oversight in collaboration with Milliman</td>
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Quality Oversight
How we ensure plan accountability for quality

- All HCA Medicaid managed care plans must be:
  - Accredited by National Committee for Quality Assurance (NCQA)
    - Accreditation contingent on HEDIS* measure (46) performance that evaluates quality, access, and timeliness of care
  - Independently reviewed annually by contracted External Quality Review Organization – Qualis Health (per Code of Federal Regulations)
  - Evaluated annually by TEAMonitor, which includes HCA clinical and program staff
    - Includes review of managed care plan compliance with federal laws and contract requirements
    - CMS acknowledges is one of best approaches in nation for monitoring managed care plan performance

*The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely-used performance management tool.
Knowing the level of Medicaid managed care plan performance

- External Quality Review Organization provides 3 annual analysis reports
  - Comparative analysis report
  - Regional analysis report
  - Technical analysis report
- Released after end of each calendar year
- Analysis of each managed care plan’s performance in previous calendar year
Comparative analysis report

- Analysis of managed care plan performance on HEDIS* measures
- Provides performance data for each plan – across Medicaid managed care plans, across time
- Offers benchmark against other states’ Medicaid managed care performance, compared to national Medicaid 50th percentile level
- Provides insight into performance based on care recipients' demographics

*The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely-used performance management tool.
Regional analysis report

- In-depth analysis at regional level
- Provides insight into performance variation and trends in specific geographic areas and for demographic groups within a region
- Identifies opportunities to implement strategies that may have an impact on quality of care and life for people in that region and in sub-regions
Technical analysis report

- Summary report of managed care plan and behavioral health organization performance
  - Role-up of information from comparative analysis report, regional analysis report, and TEAMonitor reports produced by HCA staff

- Required by Code of Federal Regulations

- Explains if managed care plans are meeting federal and state regulations, contract requirements, and statewide goals

- Provides specific recommendations aimed at improving the Medicaid managed care delivery system of care
Tools for accountability and performance

- **Performance Improvements Projects (PIP)**
  - Code of Federal Regulations-required to improve clinical and non-clinical managed care plan performance
  - May be plan-specific or collaborative with all plans

- **Incentive programs**
  - HCA withholding 1.5% of the per member, per month (PMPM) costs; plan has to earn the withhold by achieving quality improvement
    - Improvement shown by reaching performance targets on specific HEDIS measures
  - Plans motivating providers to engage in shared responsibility for meeting targets with financial rewards for delivering quality care
  - Plans motivating care recipients through gift cards, reminder calls, and postcards
Tools for accountability and performance

Targeted strategies

- Data-driven, focused efforts to identify subpopulations not receiving recommended health care (so performance measure not achieved)
  - Example: Adolescents not getting well-child checks; visits improved when families responded to incentives, such as adolescents’ families getting gift cards
- Antidepressant Medication Management- Effective Acute Phase and Continuation Phase Treatment
  - Spanish-speaking individuals who are prescribed antidepressants affected by poor Rx adherence
  - Improvement strategies focus on education about treatment and cultural awareness
Quality Impact
Quality measure variation

- Preventive care
  - Ex: Women’s health screening in 20-39th percentile

- Chronic care management
  - Ex: Diabetes monitoring in 40-79th percentile (majority around 79th)

- Appropriateness of care
  - Ex: Respiratory conditions and low back pain in 60th or above percentile
Results show quality measure improvement

- All plans (5 of 5) earned back 100% of their withhold in fall 2018
  - Demonstrates that plans are working to improve contract quality measure performance (as part of value-based strategy)

- All 5 plans also showed improvement in several quality measures, among them are:
  - Controlling high blood pressure (<140/90)
  - Antidepressant medication management (effective acute phase treatment)
Questions?

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