HCA Managed Care Program Oversight

Senate Ways and Means Committee

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Gail Kreiger, BSN
Section Manager
Medicaid Compliance Review and Analytics

Washington State Health Care Authority

Program Integrity

CMS Review

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How we are accountable to CMS

- HCA created corrective action plan in response to CMS review

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

Quality Oversight

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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

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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

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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?

Gail Kreiger
Section Manager
Medicaid Compliance Review and Analytics
(360) 725-1681
gail.kreiger@hca.wa.gov

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