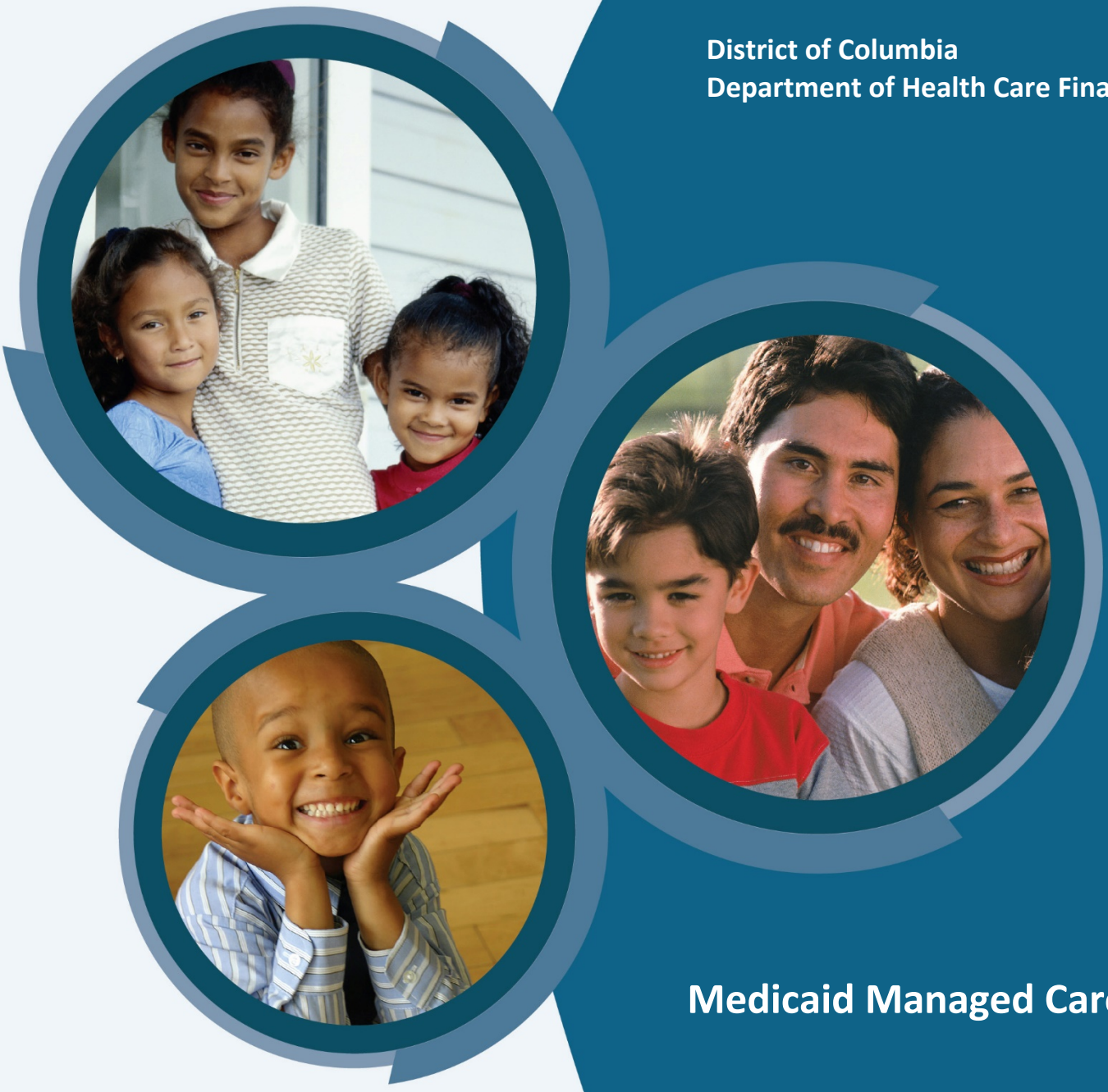
District of Columbia
Department of Health Care Finance



Medicaid Managed Care

2017 Annual Technical Report Executive Summary

Qlarant

DHCF The Department of Health Care Finance
INVESTING IN YOUR HEALTH

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Submitted by:
Qlarant
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District of Columbia Department of Health Care Finance

2017 Annual Technical Report

Executive Summary

Background

The District of Columbia's Department of Health Care Finance (DHCF) contracts with Qlarant, an External Quality Review Organization (EQRO), to evaluate its Medicaid managed care program—DC Healthy Families. There are three Medicaid managed care organizations (MCOs) and one health plan that provides health care services to Medicaid beneficiaries in the District's Child and Adolescent Supplemental Security Income Program (CASSIP). Collectively, the entities are referred to as MCOs to maintain uniform terminology. The following MCOs provided Medicaid managed care services to approximately 193,072 of the District's qualifying residents in 2017:

- AmeriHealth Caritas District of Columbia (ACDC)
- Amerigroup District of Columbia (AGP)[1]
- Health Services for Children with Special Needs (HSCSN)
- MedStar Family Choice (MFC)
- Trusted Health Plan (THP)

Using the Centers for Medicare and Medicaid Services (CMS) EQR protocols, Qlarant evaluated the quality, access, and timeliness of services provided to the Medicaid managed care beneficiaries by assessing MCO performance through the following External Quality Review (EQR) activities:

- Compliance Review, known as the Operational Systems Review (OSR)
- Performance Improvement Project (PIP) Review
- Performance Measure Validation (PMV)
- Network Adequacy Validation (NAV)

This 2017 Annual Technical Report (ATR), produced by Qlarant, provides DHCF with an assessment of quality, access, and timeliness of healthcare services provided to the District's Medicaid MCO beneficiaries during the period of January 1, 2017 through December 31, 2017.[2]

Key Findings

Operational Systems Review

The MCOs were reviewed against the revised Medicaid and CHIP managed care standards under the CMS Final Rule. The 2017 OSR results serve as baseline with the new and revised requirements. The standards include applicable elements of:

[1] AGP replaced MFC with the new MCO contract effective: October 1, 2017.
[2] For EQR activities completed January 1, 2017 through September 30, 2017, MFC was included in the review activities. From October 1, 2017 through December 31, 2017, AGP was reviewed.

- Subpart A: §438.10 - Information Requirements
- Subpart C: §438.100 - Enrollee Rights and Protections
- Subpart D: §438.206 - §438.242 - MCO Standards
- Subpart E: §438.330 - Quality Assessment and Performance Improvement Program
- Subpart F: §438.402 - §438.424 - Grievance and Appeal System
- Subpart B: §440.262 - Access and Cultural Considerations

Executive Summary (ES) Table 1 identifies results for each MCO by standard. Additionally, an overall weighted score is provided for each MCO.

ES. Table 1. 2017 MCO OSR Scores by Standard

OSR Standard	ACDC	AGP	HSCSN	THP
Subpart A: §438.10 - Information Requirements	95%	93%	89%	87%
Subpart C: §438.100 - Enrollee Rights and Protections	100%	69%	63%	67%
Subpart D: §438.206 - §438.242 - MCO Standards	99%	99%	94%	95%
Subpart E: §438.330 - Quality Assessment and Performance Improvement Program	100%	100%	93%	100%
Subpart F: §438.402 - §438.424 - Grievance and Appeal System	97%	76%	69%	70%
Subpart B: §440.262 - Access and Cultural Consideration*	100%	50%	50%	50%
Overall Weighted Score	**97%**	**87%**	**82%**	**82%**

*The Access and Cultural Consideration standard consists of a single element. Therefore, a partially met finding equates to a 50% compliance rating.

Baseline results were mixed for the MCOs. The overall weighted scores ranged from 97% to 82%. ACDC compared favorably to all MCOs.

Performance Improvement Project Review

The MCOs are conducting two PIPs:

- Improving Perinatal and Birth Outcomes
- Chronic Condition (Pediatric Asthma)

The MCOs have developed methodologically sound PIPs. They conduct annual barrier analyses and continue to refine and develop new multifaceted interventions. All MCOs reported sustained improvement in at least one performance measure per PIP. They were, however, challenged in reporting accurate PIP reports. Most MCOs were required to resubmit their PIP reports to correct errors in results and/or analyses. Tables 11 and 13 of the ATR include the PIP validation results.

The performance measure results are displayed in ES Tables 2-3.

ES. Table 2. Improving Perinatal and Birth Outcomes PIP Performance Measure Results

PIP Performance Measure	MY	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average
Neonates with weight <2,500 grams	2014	10.15	12.69	7.08	1.03	7.36
	2015	13.76	15.05	2.89	2.54	8.41
	2016	11.15	20.56	4.14	6.35	8.67
Neonates <37 weeks gestational age	2014	9.91	14.93	8.40	1.86	7.91
	2015	12.08	7.53	3.23	3.93	7.79
	2016	8.85	14.02	5.13	4.40	7.26
No maternal HIV testing	2014	65.87	5.97	59.85	77.56	64.63
	2015	52.96	4.30	28.94	35.03	41.29
	2016	16.56	0.00	16.96	15.15	16.05
Miscarriage or fetal loss	2014	13.02	15.67	12.57	5.07	11.31
	2015	9.73	17.20	12.94	7.74	10.45
	2016	15.29	4.67	17.20	11.56	15.02
Birth outcome unknown	2014	0	0	0	0	0.00
	2015	0	0	0	0	0.00
	2016	0	0	0	0	0.00
Unduplicated pregnancies with one or more adverse event*	2014	-	-	-	-	-
	2015	67.94	38.71	36.68	45.05	53.63
	2016	40.97	31.78	26.47	34.20	35.57
Infant death rate	2014	0.12	0.98	0.09	0.13	0.14
	2015	0.05	0.33	0.03	0.21	0.08
	2016	0.10	0.67	0.00	0.00	0.06

*New measure introduced in MY 2015.
- No results available for new measure in MY 2014.

Positive trends were noted in the MCO weighted averages for the following performance measures:

- Neonates <37 Weeks Gestational Age
- No Maternal HIV Testing
- Infant Death Rate

The Neonates with Weight <2,500 Grams performance measure remains an opportunity for improvement based on the MCO weighted average decline in performance.

ES Table 3. Chronic Conditions (Pediatric Asthma) PIP Performance Measure Results

PIP Performance Measure	MY	ACDC	HSCSN	MFC	THP	MCO Weighted Average
Emergency Department asthma visits (lower rate is better)	2014	46.09	28.98	35.04	89.35	44.11
	2015	44.19	24.72	31.67	65.14	44.76
	2016	40.12	25.33	30.22	53.31	39.56
Inpatient admissions for asthma (lower rate is better)	2014	10.11	3.00	5.02	10.97	7.70
	2015	8.63	4.01	3.18	2.50	5.24
	2016	7.53	4.44	4.70	2.61	5.30
Medication management for people with asthma—50% compliance	2014	49.92	76.86	45.98	6.45	49.33
	2015	53.21	96.66	41.83	12.76	44.10
	2016	52.15	49.35	40.82	15.10	39.64
Medication management for people with asthma—75% compliance	2014	29.98	75.44	33.13	6.45	35.86
	2015	32.41	95.10	29.31	9.34	31.77
	2016	27.49	21.67	29.03	10.12	23.14

An analysis of the MCO weighted averages revealed a concerning trend for the Medication Management for People with Asthma performance measures—both 50% and 75% compliance. A consecutive annual decline in performance was noted. However, the weighted averages for Emergency Department Asthma Visits and Inpatient Admissions for Asthma improved when comparing MY 2016 performance to MY 2014 performance.

Performance Measure Validation

Qlarant conducted two types of PMV audits in 2017. The first audit focused on the PIP performance measures and the second audit focused on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) performance measures.

Results of the PIP PMV indicated that the MCOs have sufficient information systems capabilities to capture and process data required for reporting. After Qlarant provided technical assistance, the MCOs were able to construct and calculate the performance measures according to specifications. At the conclusion of the PMV process, all MCOs received a Reporting Designation of Reportable (R). More detailed findings are included in Table 15 of the ATR.

Due to the timing of the reporting, the EPSDT PMV results are not reported in the ATR, and are instead reported in Appendix A3.

Network Adequacy Validation

Each MCO's provider network was evaluated through multiple means using data and results from Geographic Access Reports and Access and Availability surveys reported by the MCOs, as well as surveys conducted by Qlarant. The analysis included a review of the following facets:

- Provider Capacity
- Geographic Network Distribution
- Appointment Availability

- Provider Directory Information
- After-Hours Availability

Overall, the MCOs maintain provider networks that are sufficient in numbers and geographic access. All MCOs provide after-hours availability to ensure they meet the needs of their members outside of regular business hours. Timely access to provider appointments and accurate provider directory information present as opportunities for improvement. Tables 43 and 49, of the ATR, provide additional results.

Summary of Quality, Access, and Timeliness

Quality

The most recent DHCF Quality Strategy includes goals that aim to ensure appropriate access, proper management, and coordination of care for beneficiaries. The District has also implemented a pay-for-performance (P4P) program with goals to reduce potentially preventable admissions, low acuity non-emergent visits, and 30-day hospital readmissions for all causes. To achieve desired results and improve the quality of care and member outcomes, the MCOs participate in numerous quality-related initiatives and programs. For example, the MCOs participate in Quality Improvement Collaboratives for each of the PIPs. During collaborative meetings, the MCOs share lessons learned and best practices. The MCOs are also meeting Quality Assessment and Performance Improvement Program requirements as evidenced by the OSR results. The MCOs have quality structures in place to facilitate reporting, monitoring, and quality improvement activities.

The MCOs are striving to meet the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid 75th Percentile benchmarks in all performance measures. This has been a challenge for the MCOs as results for both the Healthcare Effectiveness Data and Information Set (HEDIS®)[3] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] measures are generally mixed. Results vary by MCO and performance measure.

Access

The MCOs not only have adequate provider networks in terms of numbers and geographic access, but the MCOs communicate member information including providing notice of how to access care, select providers, and obtain emergency services after hours. New standards require provider directories identify additional information such as physical access for patients with disabilities, provider office website URLs, and cultural competence training. As a result of the new requirements, the MCOs are making adjustments to their procedures and member materials to ensure full compliance in the next annual review. MCOs also have an opportunity for improvement in regard to maintaining accurate provider information in their directories. Correct information facilitates member access to needed care and services.

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Timeliness

All MCOs provide access to care 24 hours a day, 7 days a week. Nurse and after-hours call lines provide access to MCO resources to best direct members to necessary care and services after business hours. All MCOs have opportunity to improve timely access to next available appointments with providers for routine and urgent care. These findings are also validated by CAHPS® survey results for Getting Care Quickly for both adults and children. The composites for these measures perform below the NCQA Quality Compass Medicaid Averages.

Members also have rights to timely resolution for grievances and appeals and timely utilization management decisions. All MCOs have opportunities for improvement related to the following OSR elements: (1) Timely and Adequate Notice of Adverse Benefit Determination and (2) Resolution and Notification: Grievances and Appeals.

Conclusion

Overall, the MCOs are meeting most requirements. Performance varies by MCO. In regard to compliance, ACDC performs at a higher level than HSCSN and THP. While AGP is brand new to the District, the MCO appears to have the necessary framework and programs in place to grow and develop all requirements to meet the needs of its membership. Performance in HEDIS® and CAHPS® measures vary by MCO. Numerous positive trends in performance are evident; however, performance remains below District goals in many measures.

Within the ATR, recommendations are made for each MCO and DHCF. Should recommendations be acted upon, the Medicaid managed care program will continue to demonstrate improvement and provide quality, accessible, and timely services to the District's Medicaid beneficiaries.