DC 1115 for Childless Adults Demonstration (11-W-00251/3)
Section 1115 Quarterly Report
Demonstration Year 4 (10/1/2013 – 9/30/2014)
Federal Fiscal Quarter 2/2014 (01/01/2014 – 03/31/2014)

Introduction

The District of Columbia Childless Adults Demonstration (Demonstration) provides full Medicaid benefits to childless adults aged 21 through 64 with incomes above 133 percent of the Federal poverty level (FPL) to at or below 206 percent FPL. The Demonstration is funded by diverting a specified amount of funds from the Disproportionate Share Hospital (DSH) allotment. Benefits under the Demonstration are provided through the District's managed care delivery system and do not differ from the traditional Medicaid benefit package.

The goal of the Demonstration is to improve the health status of low-income adult District residents by:

- Improving access to health care;
- Increasing the health insurance rate; and
- Providing continuity of health insurance.

The Demonstration was approved by the Centers for Medicare and Medicaid Services (CMS) on October 28, 2010, and became effective on November 1, 2010. The Demonstration complements the District's new coverage option state plan amendment (SPA). The combination of the SPA and Demonstration provides coverage to all eligible low-income childless adults in the District.

Enrollment Information

For this reporting period, three Managed Care Managed Care Organizations (MCOs) are under contract: AmeriHealth District of Columbia (AmeriHealth), MedStar Family Choice (MedStar) and Thrive Health Plan dba Trusted Health Plan (Trusted).

Table 1: Enrollment Count

Demonstration Populations (as hard coded in the CMS-64)	Jan	Feb	March
Total Enrollment	**5,145**	**5,478**	**5,254**
Expired Eligibility	110	149	77
New Enrollment	661	383	972
Static Enrollment	4,375	4,946	5,254
Percentage of Enrollees by Plan			
Amerihealth DC	63%	63%	63%
MedStar	21%	21%	21%
Trusted	16%	16%	16%

Among waiver participants, there were 337 beneficiaries whose eligibility expired in the fourth quarter. Of this number 106 (39%) recertified in the waiver, 76 (23%) transitioned to our childless adult state plan expansion (for adults with incomes up to 133% FPL) and 87 (32%) transitioned to other Medicaid or Alliance eligibility categories. There were 10 (3%) waiver beneficiaries who disenrolled from (2 expired and 8 failed to recertify). See table below.

Table 2: Reasons for Disenrollment

Reason for Disenrollment	Beneficiaries
Total Disenrollment (Jan - March)	**273**
Recertified for Demonstration Waiver	106
Transition to State Plan Expansion (0-133 FPL)	76
Transition to Other Medicaid or Alliance Eligibility	87
Disenrolled from Alliance or Medicaid	10
Failed to Recertify	*8*
Deceased	*2*

Outreach / Innovative Activities

MCOs are required to provide marketing and outreach services to their members. Eligible beneficiaries within the Demonstration were afforded the following specific outreach activities conducted by each MCO:

AmeriHealth

1. Outbound calls to welcome all new members, which include health risk assessment interviews;
2. Home visits by community outreach staff, as appropriate, to reach members that cannot be reached successfully by phone. Successful visits include discussions about gaps in care; pending recertification expiration; upcoming health promotion and/or wellness programs; and attempts by the nurse case manager to reach the member;
3. Focused outreach activities to ensure the population receives age-appropriate preventive health services;
4. Disease management/case management programs based on medical condition and subsequent outreach activities related to assessment and follow-up;
5. Assignment of nurse case managers to all pregnant mothers and/or those members with chronic illnesses and other medical conditions, as appropriate;

6. Wellness Days with targeted screenings for those members with identified chronic conditions and or those members who are due or overdue for certain preventive care screenings;
7. Continued partnerships with trained/certified community health workers to provide health education and assistance to members diagnosed with HIV/AIDS (Positive Pathways Program); and
8. Collaborations with targeted community organizations to provide access to social behavioral services for those members who have related challenges that impact their ability to seek and receive care and/or live healthy.

MedStar Family Choice Plan

1. Community health screenings for glaucoma, blood pressure, diabetes, cholesterol and kidney function;
2. Meetings with faith-based organizations to garner community networking;
3. New member orientations at community libraries, which included distribution of health education flyers;
4. Collaboration with bilingual community organizations to provide health education materials on prostate and breast cancer;
5. The development of disease management and preventive health education materials for members; and
6. Distribution of health education flyers with community partners on diabetes management.

Trusted Health Plan

1. Outbound new member welcome phone calls to all new members, including interviews to complete the Health Risk Assessment;
2. Home visits by community outreach staff, as appropriate, to reach members that could not be reached successfully by phone. The visit includes discussions on gaps in care, pending recertification expiration, upcoming health promotion and/or wellness programs and attempts by their nurse Case Manager to reach them; and
3. Focused outreach activities to ensure the population receives age-appropriate preventive health services.

Operational / Policy Developments / Issues

There are no operational or policy development issues identified for the reporting period.

Financial / Budget Neutrality Developments / Issues

There are no financial or budget neutrality developments to report on in the first quarter. Please refer to the attached Budget Neutrality worksheet for detailed information on budget neutrality.

Consumer Issues

Tables 3, 4 and 5 below list the most frequent grievances or complaints reported by the three MCOs (AmeriHealth, MedStar and Trusted). Each MCO is contractually required to provide DHCF with a monthly report on all member grievances. The waiver population is not tracked separately by the MCOs; therefore, the information includes the waiver population as well as the traditional Medicaid population. The template for reporting these occurrences is currently under review and modification. The change is necessary to ensure proper collection and submission of all complaints and grievances. The goal is to implement a process that will provide an explanation about the complaint or grievance, as well as the proper disposition of the issue.

MedStar and Trusted have only reported complaints and no grievances. The totals in Tables 4 and 5, respectively, reflect complaints as defined in the Managed Care contracts and as follows:

> *Complaint: An expression of dissatisfaction about any matter related to the provision of health care delivery other than an Action, as "Action" is defined in Section C.1.3.2.*
>
> *C.1.3.2 Action: In the case of a MCO or any of its Providers, the Action is defined as follows:*
> *C.1.3.2.1 The denial or limited authorization of a requested service, including the type or level of service;*
>
> *C.1.3.2.2 The reduction, suspension, or termination of a previously authorized service,*
>
> *C.1.3.2.3 The denial, in whole or in part, of payment for a service;*
>
> *C.1.3.2.4 The failure to provide services in a timely manner as defined by the District; or*
>
> *C.1.3.2.5 The failure of Contractor to act within the timeframes for resolution and notification of Appeals and Grievances in Section C.14.*

Conversely, AmeriHealth has reported both grievances and complaints; only the reported grievances are listed in Table 3.

Per the Managed Care contract, the MCOs are required to address grievances and notify the enrollee or enrollee's designee in writing of such dispositions no later than 30 days from the date the grievance was received. The 30-day timeframe may be extended by up to 14 days if the enrollee or enrollee's representative requests the extension. MCOs are also required to have a Grievance Committee available to review and respond to all grievances received.

Table 3: Grievances Reported – AmeriHealth | Total average enrollment: 95,505

Grievance Topic	Number of Reported Incidents in Jan 2014	Number of Reported Incidents in Feb 2014	Number of Reported Incidents in Mar 2014	Total Reported Incidents in Q2 2014
Provider - Other Telephone Issue	8			8
Provider – Member Received Bill	33	53	48	134
Hospital – Member Received Bill			9	9
Provider – Dissatisfaction with Treatment or Service	7	14	11	32
MCO – Other Telephone Issue	4			4
MCO Denial of Care – Procedure Not Authorized	11	14		25
MCO – Denial or Limited Authorization of A Requested Service			50	50
Transportation – Excessive Waiting		3	5	8
Transportation – No Pick Up		3	**7**	10
Transportation – Other			8	8
Total Frequently Reported Grievances	**63**	**87**	**138**	**288**
Total Plan Enrollment	**93,966**	**95,620**	**96,931**	**95,505**

Table 4: Grievances Reported – MedStar | Total average enrollment = 33,414

Grievance Topic	Number of Reported Incidents in Jan 2014	Number of Reported Incidents in Feb 2014	Number of Reported Incidents in Mar 2014	Total Reported Incidents in Q2 2014
Provider – Problem Getting Referral	1	1		2
Provider – Other	1			1
MCO – Other	1			1
Provider – Rude Staff		1	1	2
Provider – Dissatisfied with Treatment or Service		1		1
Transportation – Excessive Waiting	1	1		2
Transportation – No Pick Up		1		1
Transportation - Staff Rude	1			1
Pharmacy – Attempt to Charge for Prescription			1	1
Total Grievances	**5**	**5**	**2**	**12**
Total Plan Enrollment	**31,238**	**32,202**	**33,411**	**33,414**

Table 5: Grievances Reported – Trusted | Total average enrollment = 24,459

Grievance Topic	Number of Reported Incidents in Jan 2014	Number of Reported Incidents in Feb 2014	Number of Reported Incidents in Mar 2014	Total Reported Incidents in Q2 2014
Provider – Dissatisfaction with Treatment or Service		1		1
MCO – Other	1			1
Provider – Office Staff Rude	1			1
Unable to Reach Provider by Phone	1			1
Transportation – Excessive Waiting		1		1
Transportation – No Pick Up	1		3	4
Hospital – Member Received Bill	9	24	5	38
Provider – Member Received Bill		2	11	13
MCO – Dissatisfied with Services		1		1
MCO – Other		1		1
Laboratory – Member Received Bill			3	3
Total Grievances	**13**	**30**	**22**	**65**
Total Plan Enrollment	**23,859**	**24,426**	**25,092**	**24,459**

Quality Assurance / Monitoring Activity

One of the requirements in the MCO contracts is that all MCOs are accredited by the National Committee for Quality Assurance (NCQA). This not only ensures that the MCOs meet national standards but also requires that the MCOs are capable of submitting audited HEDIS measures as part of their accreditation. This provides DHCF with an objective assessment of how the District's MCOs perform in comparison to other Medicaid MCOs across the country.

Each MCO is seeking accreditation as a New Health Plan. During the reported period, Consultants conducted Readiness "Gap" Assessments using NCQA standards and worked with staff to revise documents/programs, accordingly. Additionally, the MCO's policies and procedures were reviewed to ensure proper alignment with NCQA standards.
In addition to their requirements for NCQA accreditation, the MCOs are also required to submit a series of reports that improve DHCF's ability to monitor plans' performance. These reporting requirements were streamlined to ensure that DHCF receives the information it needs while allowing it to use validated performance measures whenever possible. The MCOs submit monthly, quarterly and annual reports per contract requirements.

The Division of Managed Care provides monthly and periodic outcomes analysis to the health plans on their self-reported data. Evidence of declining or improving performance trends are presented, allowing the health plans to provide feedback as necessary. Where poor outcomes are identified, MCOs work with DHCF to develop an action plan to address those issues. Conversely, positive outcomes allow MCOs and DHCF to collaborate in the identification of promising approaches to process and practice improvement.

Demonstration Evaluation

The agency submitted the draft evaluation to CMS on April 30, 2013. The draft report was completed by the Cloudburst Group, on DHCF's behalf, pursuant to the Demonstration's Terms and Conditions. The original Demonstration project term was November 1, 2010 through December 31, 2013. Currently, DHCF has an extension to continue until December 31, 2014. In the request for extension, DHCF agreed to submit all deliverables as required by the original contract.

Enclosures / Attachments

The following document is attached to this report:

- Budget Neutrality Spreadsheet

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Date Submitted to CMS: