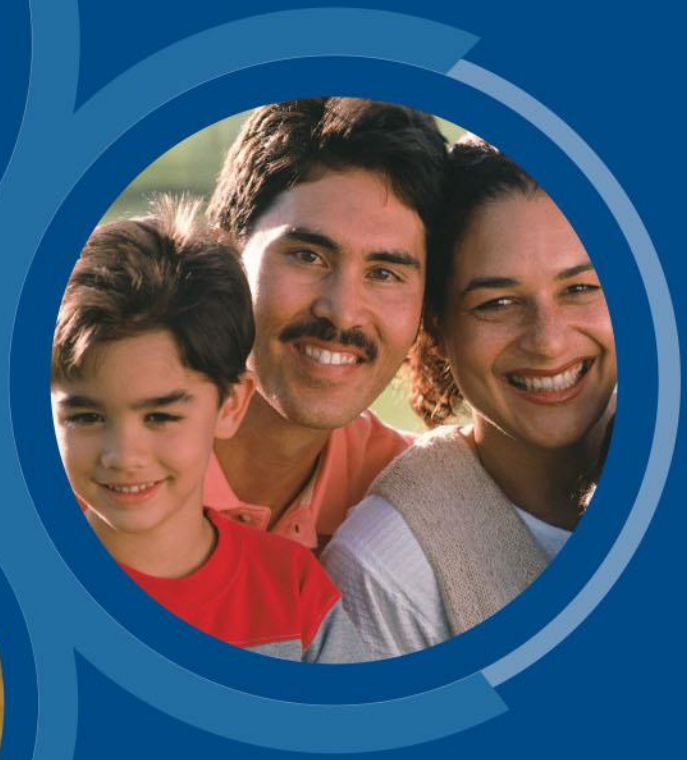
District of Columbia
Department of Health Care Finance



Medicaid Managed Care

2014 Annual Technical Report

Delmarva Foundation

A subsidieary of Quality Health Strategies

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Delmarva Foundation
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CY 2014 District of Columbia Annual Technical Report

Executive Summary

Introduction

The District of Columbia (the District) Department of Health Care Finance (DHCF) is the single state agency responsible for managing the District's Medicaid program which provides healthcare coverage to low-income children, adults, elderly, and persons with disabilities. As of December 2014, over 176,000 Medicaid enrollees were receiving healthcare services through one of three contracted managed care organizations (MCOs) or one health plan that provides health care services to Medicaid members in the District's Child and Adolescent Supplemental Security Income Program (CASSIP)[1].

The MCOs were selected to provide managed care services to the District's Medicaid residents beginning July 1, 2013. The CASSIP has been providing services to the Supplemental Security Income (SSI) population in the District since 1994. For purposes of this report, the MCOs and CASSIP are collectively referred to as the MCOs and include:

- AmeriHealth District of Columbia (AHDC);
- Health Services for Children with Special Needs (HSCSN);
- MedStar Family Choice (MSFC); and
- Trusted Health Plan (THP).

DHCF is charged with ensuring that Medicaid beneficiaries receive care that is of high quality, accessible, and timely. To accomplish this, DHCF mandates that MCOs:

- Achieve 100% compliance with federal and contractual operational requirements;
- Conduct ongoing quality improvement initiatives and submit performance results;
- Calculate and submit valid and reliable Healthcare Effectiveness Data and Information Systems (HEDIS®)[2] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] data; and
- Attain National Committee for Quality Assurance (NCQA) accreditation[4].

[1] Health Services for Children with Special Needs is the District's contractor for the CASSIP. It serves Supplemental Security Income eligible Medicaid members age 0-26 years.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[4] HSCSN is excluded from this requirement; however, it does maintain NCQA certification in Utilization Management and Credentialing.

Purpose

To ensure that managed care plans provide care and service that meets acceptable standards for quality, access, and timeliness, federal regulations require states contracting with managed care plans to perform an independent annual external review of each health plan to assess the quality of, access to, and timeliness of services provided to Medicaid beneficiaries. In fulfillment of this requirement, DHCF contracts with Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This document is Delmarva's report to DHCF on the quality and timeliness of, and access to healthcare services provided to DC Medicaid enrollees by MCOs during the period from January 1, 2014 through December 31, 2014.

Methodology

Federal regulations require that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the Centers for Medicare and Medicaid Services (CMS) for conducting the activities.[5] These protocols specify that the EQRO must conduct the following activities to assess managed care performance:

- A review conducted within the previous three year period to determine the MCOs' compliance with standards established by DHCF to comply with the requirements of 42 C.F.R. § 438.204(g), as well as applicable elements of the MCOs' contracts with DHCF;
- Validation of DHCF required performance measures (PMV); and
- Validation of DHCF required performance improvement projects (PIPs) that were underway during the prior 12 months.

Information from the mandatory activities is used by the EQRO to develop an Annual Technical Report (ATR) that addresses the quality of, access to, and timeliness of services provided to Medicaid managed care enrollees. This evaluation of MCOs' performance for the period January through December 2014 encompasses MCO contractual and federal regulatory compliance, PIP submissions, CAHPS results, and information systems capabilities assessments (ISCAs). During the period under review, the District's MCOs did not have data available to accurately and reliably calculate performance measures due to the limitations presented by continuous enrollment requirements for HEDIS measure indicators. MCOs will report HEDIS performance measures for the 2014 measurement year in June 2015 in alignment with the NCQA reporting cycle. In aggregating and analyzing the data from these activities, Delmarva allocates findings from key operational systems to domains indicative of quality, access, or timeliness to care and services.

[5] The protocols can be downloaded at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Findings

Quality

Quality, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." In assessing MCO performance for the quality domain, Delmarva considered key areas of MCO operations likely to have the largest impact on the quality of services and health outcomes for individuals. Therefore, the quality domain focuses on MCO Quality Assessment and Performance Improvement (QAPI) programs and participation in performance improvement initiatives.

In addition to requirements for MCOs to have quality programs in place, 42 C.F.R. § 438.202(a), states that "each state contracting with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs." States are required to submit regular reports on the implementation and effectiveness of the quality strategy.

DHCF monitors health outcomes and enrollee satisfaction through analysis of validated MCO HEDIS, CAHPS, and PIP results. MCO compliance with federal and contractual structure and operation requirements is assessed by the EQRO during the Operational Systems Reviews (OSRs), which take place annually. Quarterly analysis and reporting of key performance indicators began in 2014, allowing trending of performance results.

The DHCF, Division of Quality and Health Outcomes, began making revisions to its Quality Strategy in 2014 to serve as a framework for evaluating and monitoring quality improvement activities for Medicaid managed care programs. Although the Quality Strategy has not been finalized, it is intended to assess the effectiveness of programs and services as they relate to health outcomes for District MCO enrollees. The Quality Strategy objectives are in alignment with DHCF's overall strategic plan with an emphasis on two key goals:

1) Improving Health Outcomes, and
2) Enhancing Reporting Capabilities to Improve Outcomes and Performance Management.

In 2014, DHCF completed its first District of Columbia's Managed Care Quarterly Performance Report. Through this report, DHCF evaluates MCO performance across a number of domains including the health plans' financial condition, administrative performance, care management outcomes, trends in beneficiary utilization, and the MCOs' related medical care spending.

The MCOs have quality systems and procedures in place to promote high quality care with well-organized approaches to quality improvement. The MCOs' QAPI programs include annual planning, participation from providers and MCO leadership, and provide for ongoing assessment of quality improvement activities. The MCOs have developed QAPI work plans that describe a range of quality improvement (QI) and monitoring activities, timeframes for completion of activities, and identify roles and responsibilities. Additionally, the MCOs operate case management and disease management programs to improve access to services for members and have systems in place to identify members with special healthcare needs. All MCOs incorporate the use of evidence-based guidelines in provider contracts and utilization management decisions, and collect, monitor, and report data related to quality of care.

MCOs ensure that only qualified and screened medical professionals are selected to provide care to enrollees. The credentialing process requires verification of professional credentials and evidence of professional good standing. The recredentialing process also considers pertinent provider information obtained through member grievances, satisfaction surveys, utilization and member appeals, and quality initiatives.

Access

Access, as defined by the NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral healthcare, and member services." In assessing MCO performance for the access domain, Delmarva considered key areas of MCO operations likely to have the largest impact on access to services for individuals. Therefore, the access domain focuses on member communications and access and availability of providers and services.

Members receive information regarding providers, hours of operations, and the availability of transportation and translation services through Member Handbooks and Provider Directories. Materials are written in easily understood language and reading levels. Translation and TTD/TTY services are available free of charge to all enrollees. Written materials are available in prevalent non-English languages and in alternative formats for those with visual or hearing impairments.

An evaluation of the MCOs' operational systems relative to access found that all MCOs have procedures in place to conduct on-going analysis of the adequacy of provider networks, both for primary and specialty care. Member utilization of services and geo-access reports are used to identify providers with open networks to ensure that adequate numbers of providers are available to meet the needs of the population. Network assessments include ratio of provider specialty to members, travel distance, appointment scheduling, and after-hours coverage.

The MCOs have policies and procedures in place that promote access to women's health services and services for children with special needs through direct access to specialists. Case management and disease management programs are aimed at identifying members with special needs, or those who are non-compliant with care, to provide additional assistance in accessing needed services and improving health status. All MCOs provide for in-network access to a specialist for a second opinion and out-of-network access if an appropriate in-network specialist is not available.

Timeliness

Timeliness, as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation." The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of healthcare (*2014 Standards and Guidelines for the Accreditation of Managed Care Organizations*). In assessing MCO performance for the timeliness domain, Delmarva considered key areas of MCO operations where timeliness is likely to have the largest impact on access to services and health outcomes for individuals. Therefore, the timeliness domain focuses on timeliness of MCO decision making and notification to members.

An evaluation of the MCOs' operational systems relative to timeliness found that all MCOs monitor authorization decisions for timeliness. Provisions are made for both standard and expedited requests. Turn-around time is measured and documented with results summarized and reported to the designated committees. The MCOs also demonstrate that there are policies and procedures in place to address timeliness of appeal decisions and notification of determinations to the member.

Status of Prior Year (2013) Recommendations

Status of Recommendations from CY 2013 for MCOs

CY 2013 included substantial change; DHCF entered into contractual agreements with three new MCOs to provide health care services to the Medicaid eligible residents within the District. The compliance reviews completed during 2013 were considered desktop reviews and did not include an onsite assessment. Only electronic documents supporting compliance were reviewed. The assessment did not include interviews with MCO staff or file reviews, which typically include an audit of randomly selected grievances, appeals, denials, and credentialed providers.

The 2013 assessment was limited to a desktop review due to the interest of time, as contractual agreements were effective July 1, 2013. The review was completed during October and November of 2013. Additionally, the review was completed to provide DHCF with an assessment of MCO progress in implementing appropriate policies and procedures that demonstrate compliance with their contracts. Results of the desktop compliance review provided feedback to DHCF and the MCOs and identified opportunities for improvement (OFI). As a result of 2013 findings, MCOs were required to develop action plans to address any

opportunities for improvement noted in the 2013 ATR. Pertinent recommendations and the status of the MCOs' action plans related to each area are described below.

AmeriHealth District of Columbia

All 2013 opportunities for improvement were appropriately addressed by AHDC including:

- Revising its QAPI program description to include submission of annual performance measure data and results to DHCF and the EQRO.
- Establishing goals for performance measures noted in its work plan once baseline data is available.
- Revising its policy on member rights to include notification to the member at least 30 days prior to the effective date of any change to policies related to member rights.
- Revising its policy on utilization management decision response time to include more detail relative to enrollee notification, expedited decision making, and extensions.
- Revising its disenrollment policy to reflect reasons for which it may not request member disenrollment, requirements for effective dates of disenrollment and automatic approval of disenrollment.

Health Services for Children with Special Needs

HSCSN met all requirements of a CY 2013 focused review on coordination of care. There were no opportunities to follow-up on.

MedStar Family Choice

All 2013 opportunities for improvement were appropriately addressed by MSFC including:

- Revising its policy on member materials to reflect notification requirements: upon enrollment, annually, and at least 30 days prior to the intended date of change.
- Revising its appeals related policies to not only include the member right to present evidence and allegation of fact or law in writing, but also in person.
- Revising member materials, including the Notice of Action Letter, to no longer imply the member is required to cover the cost of continued benefits during the appeals or fair hearing process which is prohibited by DHCF.
- Editing its case management policy to include the specialist provider role in the development of an enrollee's treatment plan.
- Revising its member disenrollment policy to reflect procedures it follows when a member request for disenrollment is made directly to DHCF.

Trusted Health Plan

THP addressed a number of 2013 opportunities for improvement including:

- Drafting a policy on member access and availability that outlines communication requirements for essential enrollee information such as rights, benefits, emergency and post-stabilization services, provider demographics and facilities.
- Creating a policy on advance directives that requires the MCO to provide adult enrollees with information that reflects changes in state law no later than 90 days after the effective date of change.
- Revising member and provider materials to reflect that enrollees will not be held liable for the MCO's debts in the event of the MCO's insolvency and to include a statement that prohibits the MCO from restricting a health care professional from advising or advocating on behalf of an enrollee, within the lawful scope of practice.
- Developing a policy on emergency and post-stabilization services that addressed all issues identified during the 2013 review, with the exception of one requirement: the MCO may not refuse to cover emergency services based on the failure of the emergency room provider or hospital to notify the enrollee's provider or MCO of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
- Revising its policy on clinical guidelines to state that guidelines are provided to enrollees and providers upon request.
- Revising materials to inform members that they have a right to present evidence in person or writing during the appeals process.
- Revising its policy on appeals to state that it will pay for services if the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.
- Revising its Continuous Quality Improvement Program Description to indicate that measurements and reporting will be completed in a reasonable period to allow for aggregation and reporting so as to produce new information annually.

However, THP did not address all of its opportunities for improvement even though the MCO worked with DHCF and Delmarva and developed an action plan to address its opportunities. THP did not implement action plans for the following opportunities for improvement identified in 2013:

- Did not revise its Notice of Action Letter template to remove a statement that implies that the enrollee may be responsible for the cost of services during the appeal process. The District prohibits this recovery of payment in regard to the continuation of benefits during the appeal and fair hearing process.
- Did not revise the Member Handbook to explicitly state that providers must have the enrollee's written consent to file an appeal on their behalf. In another instance, Trusted revised the Member Handbook to explain that grievances may be filed either orally or in writing, according to requirements; but this

revision was not included in Trusted's policy on grievances, which requires a written statement for grievances.

- Did not modify enrollee materials/notifications or policies to reflect that MCOs are prohibited from recovering payment for the continuation of benefits during the appeals and fair hearing process.
- Did not address its appeal resolution timeline. Member and provider materials and the MCO policy reflect different resolution timelines, including 14, 15, and 30 day requirements, respectively. The District requires a 15 day resolution; however, the MCO may choose to hold itself to a higher standard. Additionally, a five day extension may be granted for appeals resolution; however, Trusted identified a 14 day extension in the Member Handbook.
- Did not make edits to its procedures for continuing enrollee benefits during an appeal or fair hearing to define specific requirements, such as being ordered by an authorized provider or until the enrollee withdraws the appeal.
- Did not indicate in the revised utilization management policy that the written notice of action for termination, suspension, or reduction of previously authorized services would be mailed at least 10 days before the date of action; it did not address an extension in the decision making process, in which enrollees have the right to file a grievance if they disagree with the decision to extend the time allowed for issuing an authorization decision; and it did not explicitly state that it will carry out determinations as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.
- Did not submit a revised policy on disenrollment that states that if DHCF fails to make a determination, in regard to a member's request for disenrollment, then the disenrollment is considered approved.

Status of Recommendations from CY 2013 for DHCF

The CY 2013 ATR noted that although DHCF had processes in place to monitor the quality of services provided to District residents, its Quality Strategy had not been updated to reflect planned initiatives to assure that District residents receive high quality care that is accessible and timely. Delmarva recommended that DHCF update its Quality Strategy to include measureable goals for the managed care program.

The DHCF, Division of Quality and Health Outcomes, began making revisions to its Quality Strategy in 2014 to serve as a framework for evaluating and monitoring quality improvement activities for Medicaid managed care programs. Specifically, during 2014, DHCF conducted an analysis and identified quality priorities. New priorities and initiatives have been recognized and are being incorporated into the revised Quality Strategy, which will be made available during FY 2015.

In 2014, DHCF completed its first District of Columbia's Managed Care Quarterly Performance Report. Through this report, DHCF evaluates MCO performance across a number of domains including the health plans' financial condition, administrative performance, care management outcomes, trends in beneficiary

utilization, and the MCOs' related medical care spending. DHCF anticipates that this quarterly performance evaluation will culminate in an annual report card on the performance of the District's MCOs.

2014 Opportunities for Improvement

Although the MCOs and the DHCF are committed to delivering high quality care and services to the District's Medicaid managed care enrollees, as a result of the CY 2014 evaluation activities and in the spirit of continuous quality improvement, Delmarva identified several opportunities for improvement. It is expected that the MCOs and DHCF will address these recommendations during CY 2015.

In addition to providing individualized MCO orientations prior to the initial EQR audits, Delmarva worked collaboratively with DHCF and provided technical assistance to the MCOs during 2014 as they completed their 2013 MCO Opportunities for Improvement (OFI) Action Plans. For example, the MCOs submitted action plans that were ultimately reviewed and approved by DHCF and Delmarva. In some instances, MCOs were required to revise and resubmit their OFI Action Plans. Conference calls were held with MCOs and written feedback was provided to ensure appropriate action plans. Final, revised documents were reviewed in October and November 2014 during the OSR.

Similar technical assistance will be provided in 2015, as the MCOs develop and implement their Opportunities for Improvement Action Plans. DHCF and Delmarva are requesting action plan submissions from the MCOs by 5/29/15. MCOs must then submit revised documentation, including applicable policies and procedures, by 6/30/15. Noncompliance may result in a formal Corrective Action Plan initiated through the DHCF Division of Managed Care.

2014 Recommendations for MCOs

AmeriHealth District of Columbia

Although AHDC addressed and resolved all 2013 recommendations, the 2014 review identified one new opportunity.

- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.

Health Services for Children with Special Needs

Although there were no 2013 opportunities for HSCSN to follow-up on, the 2014 review identified three new opportunities.

- The MCO must make information on providers available to the enrollees upon enrollment and annually thereafter, and give enrollees reasonable notice of any changes regarding providers.
- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.*
- The MCO must furnish services timely.

MedStar Family Choice

Although MSFC addressed and resolved all 2013 recommendations, the 2014 review identified two new opportunities.

- The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and timeframes in a state-developed or state-approved description.
- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.*

Trusted Health Plan

Although THP addressed a number of 2013 opportunities for improvement, a number of opportunities remained unresolved. The 2014 review identified the following opportunities, many of which were continued from 2013.

- The MCO must inform enrollees about grievance and fair hearing procedures upon enrollment, annually, and at least 30 days prior to any change.
- The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and timeframes in a state-developed or state-approved description.
- The MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system.
- The MCO's grievance process must be timely.
- The MCO must maintain written requirements regarding the filing of a grievance.
- The MCO must adhere to the state's regulations regarding the content of the notice of action.
- The MCO's written notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered service must be mailed timely.
- The MCO must handle grievances and appeals according to regulations.

* Subsequent to the 2014 review cycle, DHCF's Health Care Delivery Management Administration acknowledged that while federal and MCO contract language does not recognize "pre- and post-service appeals," the National Committee for Quality Assurance (NCQA) does acknowledge differences in the appeal types. The administration also recognizes that MCOs have interpreted contract language differently and plans to complete an internal review during 2015. Results of the review will include steps to provide clarification to MCOs. MCOs will not be required to develop an action plan to address this component.

- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.
- The MCO must notify any enrollee who has entered a grievance or appeal of the outcome of his or her case.
- The MCO must continue to provide benefits to the enrollee while the appeal and the state fair hearing are pending.
- The MCO may recover the cost of the services furnished to the enrollee while the appeal is pending if the final resolution of the appeal is adverse to the enrollee, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230.b. DHCF prohibits MCOs from recovering the cost of services in regard to the continuation of benefits.
- The MCO must furnish services timely.
- The MCO must cover and pay for emergency services and post-stabilization care services.
- The MCO must provide for timely disenrollment.
- The MCO must submit performance measurement data.

2014 Recommendations for DHCF

- Once baseline data are collected, DHCF should set specific performance goals for the selected quality measures for children and adults receiving Medicaid/CHIP services, regardless of whether a pay for performance initiative is implemented.
- To promote informed beneficiary choice, it is recommended that the MCO annual performance report card be made available to current and potential MCO enrollees both electronically and hard copy prior to the annual re-enrollment period.
- To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances.

CY 2014 District of Columbia Annual Technical Report

Introduction

The District of Columbia (the District) Department of Health Care Finance (DHCF) is the single state agency responsible for managing the District's Medicaid program which provides healthcare coverage to low-income children, adults, elderly, and persons with disabilities. As of December 2014, over 176,000 Medicaid enrollees were receiving healthcare services through one of three managed care organizations (MCOs) or one Child and Adolescent Supplemental Security Income Program (CASSIP) that contracts with DHCF to manage the healthcare of Medicaid beneficiaries.

For purposes of this report the MCOs and CASSIP are referred to collectively as the MCOs. Table 1 provides brief profiles of the health plans.

Table 1. Health Plan Profiles

Health Plan	Medicaid Enrollment (as of Dec. 2014)	Accreditation Status
AmeriHealth District of Columbia (AHDC)	103,780	NCQA Interim[6] Health Plan Accreditation - expires 1/10/16
Health Services for Children with Special Needs (HSCSN)	5,846	NCQA Certification[7] for Utilization Management and Credentialing - expires 3/13/15
MedStar Family Choice (MSFC)	38,663	NCQA Interim Health Plan Accreditation - expires 7/24/15
Trusted Health Plan (THP)	28,582	NCQA Interim Health Plan Accreditation - expires 3/5/16

As the single agency responsible for managing the District's Medicaid program, DHCF is charged with ensuring that Medicaid beneficiaries receive care that is of high quality, accessible, and timely. Furthermore, the Code of Federal Regulations (CFR) (42 CFR § 438.202(a) requires that each state contracting with an MCO or PIHP have a written strategy for assessing and improving the quality of managed care services.

[6] NCQA awards a status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a new review within 18 months to demonstrate they have executed those processes effectively. HEDIS and CAHPS measures are not considered in making a determination for interim status.

[7] Certification products represent a subset of the standards and guidelines for accreditation products and are appropriate for organizations that provide specific services but not comprehensive MCO programs.

DHCF's Strategic Plan for fiscal years 2012-2014 described its goals in support of its mission "to improve health outcomes for residents of the District of Columbia by providing access to a comprehensive and cost-effective array of quality health care services."[8] To ensure this, DHCF mandates that MCOs:

- Achieve 100% compliance with federal and contractual operational requirements;
- Conduct ongoing quality improvement initiatives and submit performance results;
- Calculate and submit valid and reliable Healthcare Effectiveness Data and Information Systems (HEDIS®)[9] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[10] data; and
- Attain National Committee for Quality Assurance (NCQA) accreditation[11].

Purpose

To ensure that managed care plans provide care and service that meets acceptable standards for quality, access, and timeliness, federal regulations require states contracting with managed care plans to perform an independent annual external review of each health plan for quality, timeliness, and access. In fulfillment of this requirement, DHCF contracts with Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This report will address: MCO performance on structural and operational standards representative of quality, access and timeliness; MCO quality improvement initiatives; MCO performance on CAHPS, and the status of NCQA accreditation for the MCOs.

This document is Delmarva's report to DHCF on the quality and timeliness of, and access to healthcare services that managed care plans provided to DC Medicaid enrollees during the period from January 1, 2014 through December 31, 2014.

Methodology

Federal regulations require that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the Centers for Medicare and Medicaid Services (CMS) for conducting the activities.[12] These protocols specify that the EQRO must conduct the following activities to assess managed care performance:

[8] Department of Health Care Finance FY 2012-2014 Strategic Plan available at:: http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStrategicPlanFY12-14.pdf

[9] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[10] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[11] HSCSN is excluded from this requirement; however, it does maintain NCQA certification in Utilization Management and Credentialing.

[12] The protocols can be downloaded at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

1) A review conducted within the previous three year period to determine the MCOs' compliance with standards established by DHCF to comply with the requirements of 42 C.F.R. § 438.204(g), as well as applicable elements of the MCOs' contracts with DHCF. The MCOs are responsible for addressing any recommendations or opportunities for improvement made by the EQRO.
2) Validation of DHCF required performance measures (PMV); and
3) Validation of DHCF required performance improvement projects (PIPs) that were underway during the previous 12 months.

CMS requires that information obtained through these activities be aggregated and analyzed to assess MCO performance in the areas of quality, access, and timeliness of services provided to Medicaid enrollees. During the period under review, the District's MCOs did not have data available to accurately and reliably calculate performance measures due to the limitations presented by continuous enrollment requirements for measure indicators. Therefore, this evaluation of quality, access, and timeliness of services for the period January through December 2014 is based on the data available from the MCOs' Operational Systems Reviews (OSRs), PIP proposal submissions, CAHPS results, and the information systems capabilities assessment.

In aggregating and analyzing the available data, Delmarva allocated OSR findings to standards or domains indicative of quality, access, or timeliness to care and services. The PIP and PMV validation activities are allocated to the quality domain. Delmarva has adopted the following definitions for quality, access, and timeliness in performing MCO assessments:

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (*Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003*).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA 2014 Health Plan Standards and Guidelines*).

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2014 Standards and Guidelines for the Accreditation of Managed Care Organizations*).

Operational Systems

The 2014 OSR was conducted as a full, comprehensive review of MCO policies, procedures, committee minutes, work plans, reports, and other written documentation submitted by the MCOs to demonstrate contractual and federal regulatory compliance. In addition, an intensive two day onsite visit was conducted to interview health plan representatives and to observe the manner in which the MCOs had implemented policies and procedures. The review was conducted by a team of healthcare professionals with experience in managed care and quality improvement systems.

The standards used to assess MCO performance were developed using the Balanced Budget Act (BBA), and the MCO's contractual requirements with DHCF, as a guide. The BBA governs all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and title 42 of the Code of Federal Regulations (CFR), part 438 et seq. Three key areas of the regulations are assessed:

- Enrollee Rights and Protections (ER) - 42 CFR § 438 Subpart C, Enrollee Rights and Protections, details requirements to ensure that managed care enrollees have the right to receive information about available healthcare services, how to access services, policies and procedures relative to obtaining services, and the right to make healthcare decisions.

- Grievance Systems (GS) - 42 CFR § 438 Subpart F, Grievance Systems, mandates that each MCO has in effect a grievance system that meets specific requirements to ensure notification of enrollees in a timely manner for all types of grievances and appeals. Access to a grievance system affords enrollees with the right to express dissatisfaction with care or services provided by the MCO or its providers and the ability for MCOs to potentially identify issues that need to be addressed (e.g. requesting payment from enrollees, inappropriate denial of payment or services).

- Quality Assessment and Performance Improvement (QA) - 42 CFR § 438 Subpart D, Quality Assessment and Performance Improvement, sets forth MCO specifications for quality strategies to ensure the delivery of high quality healthcare and customer service. MCOs must measure performance (e.g. immunization rates, preventive screening rate) and use their data to improve the quality of services provided to enrollees through quality of care studies and other activities. Standards for quality, access, and timeliness of care are defined and MCOs must monitor these to ensure enrollees receive the benefits and services to which they are entitled.

Prior to the onsite visits, Delmarva conducted orientation sessions for the MCOs, providing a description of the standards, elements, and components of each standard for review and a list of potential supporting documents. The MCOs submitted written policies and procedures to show evidence of compliance with the Federal regulations and the District's contractual requirements. A review of these documents took place prior to the onsite visits which were conducted in October and November 2014.

The Delmarva team completes its review and provides feedback to DHCF and each MCO with the goal of improving the care provided to Medicaid enrollees. Findings are documented for each standard by element and component. Following the Centers for Medicare and Medicaid Services Protocol, *Assessment of Compliance with Medicaid Managed Care Regulations*, Delmarva rates the level of compliance for each element and component with a review determination of met, partially met, or unmet as follows:

- Met – All required components and/or elements of a standard are fully met.
- Partially Met – Some, but not all, required components and/or elements of the standard are met.
- Unmet – None of the required components and/or elements of the standard have been met.
- Not Applicable – The component and/or element of a standard is not applicable.

Preliminary results of the OSR are compiled and submitted to DHCF for review. Upon the Department's approval, the MCO receives a report containing its individual review findings. Each element or component of a standard is of equal weight. An OFI Action Plan is required to address opportunities for improvement and recommendations for each component, element, or standard that did not meet the 100% minimum required compliance rate. The MCO must respond to Delmarva with any required OFI Action Plans within 45 days. The MCO may also respond to any other issues contained in the report at its discretion within this same time frame, and/or request a consultation with DHCF and Delmarva to clarify issues or ask for assistance in preparing its plan.

The content of the action plan is evaluated and a determination is made as to its adequacy in collaboration with DHCF. An action plan is determined to be adequate only if it addresses all required elements and components (timelines, action steps, etc.). Delmarva reviews any additional materials submitted by the MCO and monitors implementation of the OFI Action Plan. MCO noncompliance may result in a formal request for a Corrective Action Plan, which would also be monitored by DHCF and Delmarva.

Performance Improvement Projects

Delmarva's PIP review methodology is based on the CMS protocol, *Validating Performance Improvement Projects*. The validation is aimed at evaluating whether or not the PIPs are designed, conducted, and reported in a sound manner and the degree of confidence DHCF can have in the reported results.

Each MCO is required to provide the study framework and project description for each PIP at the onset of the projects. This information is reviewed to ensure that each MCO is using relevant and valid study techniques. CY 2014 PIP validation activities focused on the assessment of each MCO's project rationale, study questions, indicators, analysis of its own population, barrier analysis, planned interventions, and the

MCO's plan to evaluate progress and assess improvement. The 2015 PIP submissions will include the 2014 baseline data and will identify all interventions implemented for the PIPs.

The MCOs are required to provide updates on the progress of their PIPs in July of each year. The submissions include results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the MCO's data analysis plan as described in its PIP, as well as information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO decides to modify other portions of the project, updates to the submissions are permitted in consultation with Delmarva.

Delmarva's PIP reviewers evaluate each project submitted using a standard validation tool that employs the CMS validation methodology. This includes assessing each project in ten critical areas noted in Table 2.

Table 2. 10-Step PIP Review Process

Step	Description
1	Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.
2	Review the Study Question(s) - The study question should reference the study population, activity, and expected outcome. The study question guides the PIP and must be clear and answerable.
3	Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.
4	Review the Identified Study Population - The study population must reflect all individuals to whom the study questions and indicators are relevant.
5	Review Sampling Methods - The sampling method must be valid and protect against bias.
6	Review Data Collection Procedures - The data collection procedures must use a systematic method of collecting valid and reliable data.
7	Assess Improvement Strategies - The improvement strategies, or interventions, must be reasonable and address barriers on a system-level.
8	Review Data Analysis & Interpretation of Study Results - The study findings, or results, must be accurately and clearly stated.
9	Assess Whether Improvement is Real Improvement - Project results must demonstrate real improvement.
10	Assess Sustained Improvement - Sustained improvement must be demonstrated through repeated measurements.

As Delmarva conducts PIP reviews, each component within a step is rated as *Yes*, *No*, or *Not Applicable*. Components are then collectively reviewed to arrive at a determination of:

- Met – All required components are present.
- Partially Met – At least one, but not all components are present.
- Unmet – None of the required components are present.
- Not Applicable – None of the components are applicable.

Delmarva validated the MCOs' collaborative PIPs, *Improving Perinatal and Birth Outcomes* and *Adverse Outcomes of Chronic Diseases* for steps 1-6. The MCO reporting requirements and validation steps are limited for 2014 since the projects are new and 2014 is serving as the baseline year. As the PIPs progress, annual assessments will validate steps 7-10.

Performance Measures

The purpose of conducting the PMV activity is to evaluate the accuracy and reliability of the measures produced and reported by the MCO and to determine the extent to which the MCO followed specifications established by DHCF for calculating and reporting the measures. The accuracy and reliability of the reported rates is essential to ascertaining whether the MCO's quality improvement efforts have resulted in improved health outcomes. Further, the validation process allows DHCF to have confidence in MCO performance measure results and allows for accurate MCO comparisons.

Typically the annual PMV audit looks back and assesses the MCO's performance for the previous calendar year. However, since three of the MCOs implemented new contracts with DHCF on July 1, 2013 complete data are not available. Consequently, giving consideration to start up operations, the implementation of PIP collaborative activities new to the MCOs, and the limited data available, DHCF requested that Delmarva's PMV audit focus on the MCOs' readiness to report baseline data in 2015. Therefore, Delmarva conducted an information systems capabilities assessment (ISCA) of each MCO. The purpose of the assessment is to ensure that any identified information systems processes that might impact the MCO's ability to produce valid and reliable measures would be identified early and allow ample time for issues to be corrected. A full PMV audit will be conducted in 2015 to assess the reliability and validity of the MCOs' reported 2014 performance measure rates.

The validation activities for CY 2014 consist of two key activities:

- An overall assessment of the MCO's information systems capability to capture and process data required for reporting; and
- Review of the MCO's intended procedures to construct the measures.

Following the ISCA, the Delmarva auditor provides technical assistance to the MCOs regarding data sources, measure specifications, and reporting.

Findings

Quality

Quality, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." In assessing MCO performance for the quality domain, Delmarva considered key areas of MCO operations likely to have the largest impact on the quality of services and health outcomes for individuals. Therefore, the quality domain focuses on MCO Quality Assessment and Performance Improvement (QAPI) programs and performance improvement initiatives. The quality domain also includes an assessment of DHCF's progress in meeting its Quality Strategy goals.

DHCF Quality Strategy

Per 42 C.F.R. § 438.202(a), "each state contracting with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs." States are required to submit regular reports on the implementation and effectiveness of the quality strategy.

The DHCF, Division of Quality and Health Outcomes, began making revisions to its Quality Strategy in 2014 to serve as a framework for evaluating and monitoring quality improvement activities for Medicaid managed care programs. Although the Quality Strategy has not been finalized, it is intended to assess the effectiveness of programs and services as they relate to health outcomes for District MCO enrollees. The Quality Strategy objectives are in alignment with DHCF's Fiscal Year (FY) 2012-2014 Strategic Plan, which includes the following goals:

In 2014, DHCF completed its first District of Columbia's Managed Care Quarterly Performance Report. Through this report, DHCF evaluates MCO performance across a number of domains including the health plans' financial condition, administrative performance, care management outcomes, trends in beneficiary utilization, and the MCOs' related medical care spending.

- Improving Health Outcomes;
- Strengthening Program Integrity;

- Implementing Health Care Reform;
- Improving Medicaid Billing with Public Providers;
- Developing and Implementing a Comprehensive Health Information Technology Strategy;
- Enhancing Reporting Capabilities to Improve Outcomes and Performance Management; and,
- Enhancing DHCF Infrastructure.

Of the seven overarching strategic goals, the DHCF Division of Quality and Health Outcomes focus is on two specific goals: Improving Health Outcomes and Enhancing Reporting Capabilities to Improve Outcomes and Performance Management. To accomplish these goals, DHCF is exploring ways to drive improvement in MCO performance and ultimately enrollees' health outcomes. DHCF plans to raise expectations for MCOs' performance on select quality measures for children and adults receiving Medicaid/CHIP services and is considering a possible pay for performance incentive program.

In 2014, DHCF completed its first District of Columbia's Managed Care Quarterly Performance Report. Through this report, DHCF evaluates MCO performance across a number of domains including the health plans' financial condition, administrative performance, care management outcomes, trends in beneficiary utilization, and the MCOs' related medical care spending. DHCF anticipates that this quarterly performance evaluation will culminate in an annual report card on the performance of the District's MCOs.

Quality Assessment and Performance Improvement Programs

The MCOs must have QAPI programs in place to objectively monitor and evaluate the quality of services provided to enrollees. At a minimum the QAPI must demonstrate compliance with basic requirements for administrative structures and operations that promote quality of care. The organizational structure of the QAPI program must identify accountability within the organization for monitoring, evaluating, and making improvements to care and health outcomes for the MCO's members. Committees (credentialing, pharmacy and therapeutics, utilization management, etc.) are designated and comprised of appropriate professionals to provide oversight of the QAPI program activities with accountability to the governing body. The governing body is kept apprised of QAPI activities through regular written reports and, at least annually, a comprehensive evaluation of the QAPI is conducted and presented to the governing body for review.

Additionally, the MCO must demonstrate that it uses systematic processes to monitor quality of care and services and collects and reports data reflecting its performance. The QAPI demonstrates the MCO's ability to develop methodologically sound quality of care studies to capture and analyze data on demographics, health status, and utilization patterns of the enrolled members. There are written procedures for remedial action whenever inappropriate or substandard services are provided or services that should have been furnished were not and the MCO monitors the effectiveness of remedial actions.

AmeriHealth District of Columbia

AHDC has a comprehensive QAPI Program Description that describes its mission, goals, objectives, and scope of the program. The QAPI identifies the structure, roles, and responsibilities of the governing body, QAPI committee, and other AHDC committees. The QAPI committee evaluates the effectiveness of the QAPI program and directs QI and utilization management (UM) activities. An annual work plan is developed to identify QAPI deliverables and includes purpose/scope, frequency, responsible parties, committee reporting, and outcomes evaluation.

AHDC's 2014 QAPI program includes:

- Use of data about quality, clinical care and services, and health outcomes to identify improvement initiatives.
- Procedures to ensure adequate practitioner accessibility and availability to serve the membership.
- Credentialing/recredentialing processes to assure that the health plan's networks are comprised of qualified practitioners.
- Oversight of services provided by delegated entities.
- Coordination of services between various levels of care, network practitioners, and community resources to assure continuity of care and promote optimal physical, psychosocial and functional wellness, including for those with chronic illness or complex health needs.
- Utilization management procedures to ensure care rendered is based on established clinical criteria and clinical practice guidelines.
- Methods to ensure that assessment and appropriate interventions are taken to identify inappropriate, overutilization or underutilization.
- Use of results of member and practitioner/provider satisfaction measures when identifying and prioritizing quality activities.
- Communication of results of clinical and service measures and quality initiatives to practitioners, providers, and members.
- Documenting and reporting monitoring activities to appropriate committees.
- Facilitating the delivery of culturally competent healthcare to reduce healthcare disparities.
- Review of individual practitioner and provider performance on quality and utilization outcomes and application of clinical practice guidelines.

AHDC has developed a QAPI work plan. Although the work plan identifies specific performance measures with reporting cycles and goals for each measure, the measures are currently targeted to process more than outcomes. It is expected that as AHDC becomes more mature in performing data analysis, the MCO will add specific outcome measures with goals and timeframes for achieving them to the work plan.

Health Services for Children with Special Needs

HSCSN has an established QAPI program that measures, monitors, and reports on a variety of quality components and performance measures. The QAPI program is aligned with DHCF's goals and focuses on health outcomes by continuously assessing healthcare and service delivery processes. The QAPI indicates HSCSN's Board of Directors delegates authority for quality activities to the Chief Operating Officer, Chief Medical Officers, and the Performance Outcomes and Improvement Committee.

HSCSN's 2014 QAPI program addresses the following categories in establishing performance measures:

- Access and Availability
- Coordination/Continuity of Care
- Practice Guidelines
- Utilization Management
- Cultural Competency
- Member/Provider Satisfaction
- Regulatory Compliance

HSCSN has developed a comprehensive QAPI work plan that identifies performance measures/indicators corresponding to the categories above that identify benchmarks and thresholds HSCSN seeks to meet.

MedStar Family Choice

MSFC has a comprehensive QAPI program that describes its mission, goals, objectives, and scope of the program. The QAPI identifies the structure, roles, responsibilities, and qualifications of the governing body. MSFC's Board of Directors has delegated oversight of the QAPI program to the MSFC Executive Operations Team which has the authority to set and administer policy for the MCO. The MSFC QI/UM Committee works in conjunction with the Executive Operations Team to implement the MCO's QI and UM Plans. Other MSFC committees such as the Quality of Care/Peer Review Committee, Credentialing Committee, Pharmacy and Therapeutics Committee, Compliance/Privacy Committee, and Delegation Oversight Committee support the work of the QI/UM Committee. An annual work plan describes specific QAPI priorities for the year and includes purpose/scope, frequency, responsible parties, committee reporting, and outcomes evaluation.

Among the objectives of MSFC's 2014 QAPI program are to:

- Ensure and support efforts to remove any barriers to healthcare services and resources, including but not limited to language barriers.
- Create a review process that is consistent throughout the MSFC provider community and to provide a systematic approach for monitoring the quality, safety and appropriateness and effectiveness of patient care and services.
- Ensure the integration of information into the QI Plan.
- Include all participating practitioners in the MSFC network as appropriate in the QI Plan and QI process.
- Provide support and education to practitioners and providers to improve the safety of their practices.
- Provide integration, coordination and continuity of medical and behavioral health.
- Identify meaningful and relevant issues for assessment based on patient populations, demographics, care settings, types of services and case mix.
- Define quality indicators, measurements, and goals.
- Compare the quality of care and service against available benchmarks for standards of practice.
- Monitor the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening rates and ensure the completion of all components of the EPSDT screenings according to DHCF and the Salazar court order.
- Identify significant disparities in health services and health outcomes between racial and ethnic groups and develop a plan of action for measuring and evaluating efforts to remediate them.
- Develop, implement, and monitor corrective action plans (CAPs), where appropriate.
- Implement integrated improvement strategies and ensure follow up as appropriate by using collected data to identify, analyze, and trend problems.
- Comply with specific quality of care, access to care, documentation and performance standards adopted by DHCF and other regulatory agencies for the treatment of enrollees, especially those with special healthcare needs.
- Provide oversight of continuous and ongoing activities of delegated entities.
- Centralize and coordinate performance monitoring information.

MSFC's 2014 QAPI work plan focuses on compliance with DHCF, NCQA, and EQRO standards with goals set for activities corresponding with each body's requirements and the objectives identified above. The MCO also added activities related to HEDIS measures based on the MCO's performance in 2014.

Trusted Health Plan

THP has established a quality program that appropriately measures, monitors, and reports on a variety of quality components, programs, and performance measures. The MCO's QAPI program description provides a broad overview of its mission, goals, objectives, and program scope. Committee structure, roles and responsibilities, and governing body accountability are also described in the QAPI program description. THP's Board of Directors designated the Quality Executive Committee (QEC) as being responsible for all

the MCO's quality improvement, care coordination, utilization management, peer review and delegated functions. A number of subcommittees report to the QEC including: the Credentialing Committee, Grievance and Appeals Committee, Utilization Management Committee, Delegation Oversight Committee, Pharmacy and Therapeutics Committee, and the Member and Provider Advisory Committees.

THP's 2014 QAPI includes the MCO's quality indicators that address the following key components:

- Accessibility of Care
- Appropriateness and Efficiency of Care
- Continuity of Care
- Competency
- Safety/Risk Management
- Effectiveness of Care
- Timeliness of Care
- Customer Satisfaction

THP uses data collection and analysis to track clinical issues that are relevant to the MCO's population. The review of THP's performance on HEDIS measures and CAHPS results is a major activity within the QAPI program. THP developed an annual QAPI work plan based on key areas of performance for ongoing monitoring. Although THP was able to provide data and results to DHCF and the EQRO as requested, the MCO did not complete the required 2013 Quality Program Evaluation. Trusted must ensure that the quality evaluation is completed on an annual basis.

Performance Improvement Projects

As a component of the MCO QAPI program, the MCO must have performance improvement processes and systems in place to proactively identify areas for improvement and to test new approaches to fix underlying causes of persistent problems that may result in poor health outcomes. MCOs must exhibit use of sound methodologies to systematically gather information; identify problems; conduct root cause/barrier analyses; plan and implement interventions; and measure impact of these activities on enrollees. DHCF contractually requires all MCOs to actively participate in quality improvement initiatives.

MCOs have developed sound PIPs that include population analysis, barrier assessment, multifaceted interventions, and sound quantitative and qualitative analytic plans.

In 2009, recognizing the impact of chronic illnesses and poor birth outcomes on both cost and quality of life for District residents, DHCF and the then participating MCOs launched two collaborative quality

improvement projects. These multi-year projects are aimed at reducing adverse perinatal and birth outcomes and adverse outcomes of chronic diseases. In 2013, with the entrance of three new MCOs into the District's managed care program, a re-assessment of the topic areas and their relevance to the current Medicaid population was undertaken by DHCF, the MCOs, and other stakeholders. Collaborative goals and partners were re-assessed and it was determined that the perinatal and chronic conditions collaborative efforts remained important quality improvement initiatives within the District. In 2014, the MCOs and their collaborative partners focused on identifying joint and MCO specific interventions aimed at improving perinatal and birth outcomes and decreasing emergency department (ED) and acute inpatient hospital utilization by members with asthma.

Adverse Perinatal and Birth Outcomes

Improving perinatal and birth outcomes remains an important goal in the District. Therefore, the collaborative work group determined that it would be beneficial to Medicaid members residing in the District for the MCOs and other stakeholders to continue this effort. Goals for the perinatal collaborative are aimed at reducing adverse perinatal outcomes such as prematurity, low birth weight, and infant deaths. This PIP measures the rate of adverse outcomes per 1,000 eligible Medicaid enrollees and utilizes the following indicators to identify adverse events:

- Miscarriage or fetal loss.
- Neonates weighing <2500 grams.
- Neonates with a gestational age <37 weeks.
- Pregnancies for which the outcome is unknown.
- Lack of maternal HIV testing.
- Death of an infant age 0-365 days.

The collaborative work group confirmed the study topic, question, and chosen indicators. MCOs were instructed to develop individual written PIPs with a focus on assessing the current population and rationale for the PIP. MCOs submitted the written PIPs to Delmarva for validation activities. This validation assessed steps 1-6 of the CMS protocol. Performance on steps 1-6 can be found in Table 3. Steps 7-10 were assessed as not applicable (NA) during the 2014 assessment and will be evaluated in subsequent years of the PIP activities as the projects progress.

Table 3. Adverse Perinatal and Birth Outcomes PIP Validation Findings

Adverse Perinatal and Birth Outcomes PIP				
	AHDC	**HSCSN**	**MSFC**	**THP**
1) Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks)	Met	Met	Met	Met

Adverse Perinatal and Birth Outcomes PIP				
	AHDC	**HSCSN**	**MSFC**	**THP**
of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.				
2) Review the Study Question(s) - The study question should reference the study population, activity, and expected outcome. The study question guides the PIP and must be clear and answerable.	Met	Met	Met	Met
3) Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.	Met	Met	Met	Met
4) Review the study population - The study population must reflect all individuals to whom the study questions and indicators are relevant.	Met	Met	Met	Met
5) Review Sampling Methods - The sampling method must be valid and protect against bias.	NA	NA	NA	NA
6) Review Data Collection Procedures - The data collection procedures must use a systematic method of collecting valid and reliable data.	Met	Met	Met	Met
7) Assess Improvement Strategies - The improvement strategies, or interventions, must be reasonable and address barriers on a system-level.	NA	NA	NA	NA
8) Review Data Analysis & Interpretation of Study Results - The study findings, or results, must be accurately and clearly stated.	NA	NA	NA	NA
9) Assess Whether Improvement is Real Improvement - Project results must demonstrate real improvement.	NA	NA	NA	NA
10) Assess Sustained Improvement - Sustained improvement must be demonstrated through repeated measurements.	NA	NA	NA	NA

All of the MCOs conducted population and barrier analyses. Key barriers include lack of member education regarding the importance of prenatal care and failure of providers to complete and submit prenatal risk assessments to the MCOs. The MCOs and workgroup stakeholders agreed to jointly focus improvement efforts on educating providers regarding the importance of complete and timely submission of the Obstetrical (OB) Authorization Form for early identification of pregnant members who are at risk for poor outcomes. Planned interventions also focus on the use of community resources and programs to provide member education.

Each MCO has developed potential interventions to address its identified member barriers. These plans will be fully implemented in CY 2015 with on-going monitoring by the MCOs to gauge the effectiveness of the interventions. Baseline measure rates will be calculated in June 2015 using CY 2014 data.

MCO project rationales were completed during the first quarter of CY 2014 and were based on 2013 data. The MCOs were then expected to identify barriers and plan and design interventions to address the barriers. A snapshot of each MCO's population, identified barriers, and planned interventions follows.

AmeriHealth District of Columbia

AHDC reported that women comprise approximately 57% of its membership—of which 40-50% is of child bearing age. More than 48% of the MCO's membership is African American and many enrollees reside in Wards 6 and 7, where there are many social determinants that contribute to health disparities.

An initial barrier analysis was completed. The following barriers were identified:

- Members have limited access to services during non-business hours.
- Members lack understanding of recommended routine prenatal care.
- Members are transient with frequent changes in residence and telephone contact information.
- Members lack knowledge of what is required regarding infant care and health.
- Members do not keep prenatal appointments with providers and provider offices have limited resources to follow-up on members that do not keep appointments.
- The MCO struggles to obtain OB Authorization Forms from providers that allow for early identification of pregnant members.
- The MCO has limited resources to perform outreach on members without working telephones.

The MCO identified, or has already implemented, the following interventions:

- The MCO will identify pregnant members and proactively reach out to them and supply them with a cell phone and 250 free minutes per month, along with unlimited text messaging and calls to the MCO. MCO staff will assist members in scheduling prenatal appointments and will call and send text reminders as required.
- The MCO will send out notifications (via provider newsletters and fax-blasts) regarding the mandatory submission of the OB Authorization Form. The MCO is also considering completing a review to identify noncompliant providers in order to provide targeted follow up.
- The MCO will pilot a well-baby and postpartum visit coordination initiative. Due to members not keeping appointments, AHDC will work with pilot offices to schedule postpartum visits on the same day as the baby's one month well child visit.

- The Bright Star (Maternity) Program is managed by a team of Case Managers/Care Managers and Care Connectors. Based on pregnancy assessments, members are categorized into either a high risk or low risk intervention group. The maternity management program focuses on identifying and helping at risk pregnant women have a healthy, full-term pregnancy. The program focuses on promoting early identification of pregnancy and prenatal care; assisting pregnant mothers in adopting healthy behaviors and controlling risk factors; and educating the mother on infant care and health needs. The program was developed using prenatal care guidelines from the Institute for Clinical Systems Improvement.
- Bright Start Baby Shower, which is held every other month, provides an opportunity for expectant mothers to receive vital prenatal information in a celebratory environment. Educational information is provided via group discussions, games, and question and answer sessions. Members leave with educational materials and resources to help care for and support a newborn.

Health Services for Children with Special Needs

HSCSN's PIP adequately provides an analysis of its current population and rationale for the PIP based on plan demographics. HSCSN describes its membership as comprised of enrollees who are considered an at risk population due to qualifying criteria for plan participation. More than 64% of the health plan's enrollees have a behavioral health related diagnosis, which may impact the health and functioning of the enrollees. While HSCSN experiences few births, approximately 30% of the babies born to HSCSN's members were born at ≤32 weeks[13] of gestation and had a low birth weight of <2,500 grams.

HSCSN conducted an initial barrier analysis. The following list highlights barriers identified:

- Members seek prenatal care late in pregnancy due to low health literacy, lack of life skills, and uncertainty about pregnancy.
- Members have multiple children and do not have childcare options for prenatal visits.
- Members are desensitized to HIV status and lack understanding of risks and outcomes for the baby.
- Member socioeconomic factors including homelessness, multiple partners/failure to practice safe sex, food resources, substandard housing, etc.
- Members have cognitive disabilities.
- Providers submit late, incomplete, or no submission of the Obstetrics (OB) Assessment and Psychosocial Form.
- Prenatal care is sometimes provided at non-network providers, which creates barriers getting access to records.
- Provider claims are not coded correctly.

[13] At the time of project implementation, one of the PIP measures focused on gestational age of 32 weeks or less. The measure was subsequently revised to reflect gestational age of less than 37 weeks. The MCOs were not required to revise their project rationales based on this sole modification.

- MCO encounters delays in handing the pregnant member from Primary Case Manager/Care Manager to the OB Case Manager/Care Manager due to late notification from members and late notification via claims data.
- The MCO's inability to monitor all of the perinatal metrics electronically.
- The MCO has experienced OB Case Manager/Care Manager turnover.
- The MCO's inability to obtain HIV status for every pregnant member via claims, lab, or anti-retroviral medications.

HSCSN did provide a list of planned, or already implemented, interventions:

- An OB Multidisciplinary Team will conduct clinical rounds on all pregnancy cases and will prioritize and triage member care management intensity based on the clinical case reviews including medical, behavioral, and psychosocial needs. Additionally, the team will schedule, remind, and accompany members to their prenatal appointments. The team will also arrange transportation, follow-up after appointments, and provide health education regarding sexually transmitted infections and HIV. The baby's development/growth will be monitored and education regarding breast feeding will be provided. Contact will be made via the telephone or face to face. Also, a baby shower with Sudden Infant Death Syndrome (SIDS) training will be provided to pregnant members.
- The MCO is developing electronic tools to monitor perinatal care metrics and improve the timeliness of capturing data, including the OB Assessment and Psychosocial Form.
- The MCO plans to complete medical record reviews on pregnant members to obtain HIV status and perinatal visit information in an effort to gather complete and accurate information.
- The MCO will complete a mailing to the OB provider community to reintroduce the OB Assessment and Psychosocial Form. The Perinatal Collaborative will be explained and the importance of identifying and treating HIV positive pregnant women will be addressed.
- Revised the OB Program Description which includes the following changes:
  - clarified roles/responsibilities;
  - established timeframes for the handoff from Primary Case Manager/Care Manager to OB Case Manager/Care Manager;
  - implemented requirement of a transition meeting between the Primary Care and OB Case Manager/Care Managers;
  - developed, defined, and implemented processes for identifying pregnant members as early as possible; and
  - developed electronic monitoring and reporting for metrics.
- Initiated biweekly teleconference calls with Teen Alliance for Prepared Parenting (TAPP) to review previous referrals for updates and care coordination for new referrals.
- Initiated weekly lab reporting where lab results are provided to OB Care Management and the HEDIS Manager to assist in identifying pregnancies early and obtaining HIV testing results.

MedStar Family Choice

MSFC supported the project rationale with their plan-specific data. Based on a review of the MCO's 2013 reports of pregnancies, deliveries, and high risk newborns for the last two quarters of 2013, MSFC reported the following: 59 babies born with a low birth weight (<2,500 grams); 6 babies were born with a gestational age of ≤32 weeks; and 83 babies were admitted to the neonatal intensive care unit. The percentage outcomes for the population overall were not provided.

An initial barrier analysis was completed. The following list highlights some of the barriers identified:

- Members engage in high risk behaviors that contribute to adverse outcomes, such as cigarette smoking, drinking alcohol, or substance abuse. These members may be participating in these activities due to lack of knowledge or education about the impact of the high risk behaviors.
- Members do not have an understanding of what care is needed and may delay prenatal care while deciding whether or not to terminate the pregnancy.
- Members begin prenatal care visits, but do not complete all visits required.
- Members have diverse cultural backgrounds which may impact timeliness of prenatal care, if it is sought at all.
- Members do not have proper newborn care equipment/supplies, such as a pack and play which keeps babies confined and safe.
- Providers are not consistently submitting the OB Authorization Form; it is not tied to payment for prenatal services.
- Providers are not routinely screening pregnant members for drugs. Substance abuse may impact pregnancy outcomes.
- Providers may not effectively communicate with members with different cultural backgrounds, which may impact their approach to prenatal care.
- Lack of ability to influence providers to complete the OB Authorization Form and receive early notification of pregnant members.
- MCO encounters difficulty when scheduling prenatal care appointments with clinics (long telephone wait times, policies requiring in-person appointment scheduling, etc.), which some members rely on.

MSFC did provide a list of planned interventions. Interventions include:

- The system-wide collaborative intervention, use of the OB Authorization Form (and accompanying letter). The form collects information on new pregnancies, which allows for timely pregnancy notification and risk assessment. The accompanying letter to providers includes a summary of the form and expresses the value of its completion for the perinatal collaborative. The MCO plans to schedule appointments

with high-volume clinics to provide an educational session and explain the importance and value of completing the OB Authorization Form.

- Refer pregnant teens/youth to the Washington Hospital Center Teen Alliance for Prepared Parenting (TAPP) Program. The TAPP provides a full range of services that promote healthier living and improve the overall well-being of pregnant and parenting youth. Services include: obstetric and gynecologic services; prenatal and parenting education; family planning/contraceptive services; individual and group counseling; workshops in communication, conflict resolution, and other life-management skills; and support to ensure the continuation and completion of education.
- Refer pregnant members to the Department of Health (DOH) Safe Cribs Program which offers services and education designed to reduce infant mortality, sudden unexplained infant deaths (SUIDs), and suffocation. In addition to education and counseling, pack and plays are provided to the pregnant women.
- Distribute bi-annual provider newsletters, which will include tips/advice for practitioners regarding member prenatal care and recommendations on communicating with members with diverse cultural backgrounds.
- Contact and work with high volume clinics that prove to be difficult to work with when scheduling member prenatal care appointments. The Provider Relations Department will intervene on behalf of the Outreach Department and work with these clinics.

Trusted Health Plan

THP reviewed its 2013 pregnancy data to assess the relevancy of the PIP topic. Of the 168 pregnancies identified, only 63% had been tested for HIV. Additionally, 39% of deliveries were classified as high risk pregnancies and 19% resulted in a Newborn Intensive Care Unit (NICU) admission.

An initial barrier analysis was completed. The following barriers were identified:

- Lack of provider awareness regarding the MCO's obstetric case management program and community based partnerships.
- Lack of awareness regarding the importance of early prenatal and postpartum care.
- Incomplete or erroneous contact information makes enrollee contact difficult.
- Lack of documentation (concern identified: HIV screening is not identified via administrative data collection).
- OB Authorization Form is not submitted timely or completely.
- Lack of a systematic process to identify and manage pregnant members.
- Lack of ability to identify (early) and intervene on high risk pregnancies due to untimely and incomplete OB Authorization Forms.
- Lack of a process to monitor infant mortality.

THP did provide a list of planned interventions. Interventions include:

- The MCO's OB Case Manager/Care Manager will visit provider practices to educate providers on the collaborative, available educational programs, appropriate utilization and timely submission of the OB Authorization Form, HIV screening requirements, reporting birth weight in grams vs. pounds, etc.
- The OB Case Manager/Care Manager will work with the Customer Service, Utilization Review and Outreach Departments to identify alternate member contact methods for hard to reach members, including door-to-door contact, participation in utilization management rounds/monitoring daily census, regional information system, etc.
- The MCO will perform monthly queries utilizing the lab vendor's data link to review HIV screenings for known pregnant members. Noncompliant members will be followed up on via fax to confirm screening or remind the provider of the requirement.
- The MCO has subcontracted with an agency that will monitor high risk pregnancies, provide 48 hour assessments for NICU discharges, and assist in setting up the home post NICU discharge. The MCO indicated that risk factors for a high-risk pregnancy may include existing health conditions, such as high blood pressure, diabetes, or being HIV-positive, overweight, or obese. Additionally, pregnant teens and women aged 35 and over may be considered high risk.
- The MCO will use an assessment tool to monitor milestones during an infant's first year of life. The tool is based on milestones used by the Strong Start Program, which is an early intervention program in the District. Based on the score a referral may be made to Strong Start, which includes special needs case management, care coordination, home visitations/assessments, etc. Should a member not meet requirements for the Strong Start Program, they may be referred to THP's Case Management Team, which includes a Special Needs Case Manager/Care Manager, for intervention and monitoring. Case Management will monitor infants and record information (including infant mortality) in its care management system, Care Connect.
- The MCO is developing an OB Case Management Program, Healthy Beginnings. Education and outreach will be provided at the MCO's Outreach and Wellness Center within the District. The OB Case Manager/Care Manager will be stationed at the center and provide face-to-face contact and engagement with members. Educational materials will be distributed, including: information regarding the importance of prenatal care, awareness of bodily changes, and nutrition demands of pregnancy. THP's OB Case Management Program is also partnering with several organizations/programs to provide services at the Outreach and Wellness Center, including:
  - The Department of Health for training on Sudden Infant Death Syndrome (SIDS) prevention. The training will be provided once every six weeks and participants will receive a free Pack and Play.
  - Young Lives to provide training and assist teen moms with access to community resources. Training includes helping teen parents learn coping skills, newborn care, and family planning.
  - Women, Infants and Children (WIC) to provide WIC recertification.

- THP will also provide healthy cooking demonstrations for pregnant women and contract with lactation specialists to provide weekly breastfeeding training. Information on the activities and services available at the MCO's Outreach and Wellness Center will be distributed via fliers mailed to members and OB providers. Additionally, THP will share information telephonically and via face-to-face encounters.

Adverse Outcomes of Chronic Diseases

Multiple studies have consistently shown that asthma is a readily treatable condition that can be managed in an outpatient setting. The District's data has shown that members with asthma too frequently rely on the ED to manage their illness. Further, a recent study conducted by the Children's National Medical Center's Impact DC Program found that nearly 68% of ED visits for asthma were for children less than eight years of age. Consequently, the chronic condition collaborative work group concluded that the asthma collaborative should focus on children and young adults 2-20 years of age.

The Chronic Condition Collaborative goal is to reduce ED utilization and inpatient hospital admissions for children and young adults with asthma. It is believed that improving medication compliance for this population will result in better control and ultimately decrease ED utilization and acute hospital admissions. The PIP focuses on appropriate medication compliance and also measures the members' ED utilization and hospital admissions related to asthma.

Indicators were chosen with a greater focus on measures that would answer the study question and include:

- The number of children in the eligible population, ages 2 through 20 years, who had one or more ED visits with a principle diagnosis of asthma during the measurement year.
- The number of children in the eligible population, ages 2 through 20 years, who had one or more acute hospital inpatient admissions with a principle diagnosis of asthma during the measurement year.
- The Use of Appropriate Medications for People with Asthma - The number of members in the eligible population, ages 2 through 20 years, who were appropriately prescribed asthma medication during the measurement year.
- The number of members in the eligible population, ages 2 through 20 years, who were dispensed appropriate asthma controller medications that they remained on during the treatment period in the measurement year and who remained on an asthma controller medication for at least 50% of their treatment period.
- The number of members in the eligible population, ages 2 through 20 years, who were dispensed appropriate asthma controller medications that they remained on during the treatment period in the measurement year and who remained on an asthma controller medication for at least 75% of their treatment period.

The collaborative work group confirmed the study topic, question, and chosen indicators. MCOs were instructed to develop individual written PIPs with a focus on assessing the current population and rationale for the PIP. MCOs submitted the written PIPs to Delmarva for validation activities. This validation assessed steps 1-6 of the CMS protocol. Performance on steps 1-6 can be found in Table 4. Steps 7-10 were assessed as not applicable (NA) during the 2014 assessment and will be evaluated in subsequent years of the PIP activities as the projects progress.

Table 4. Adverse Outcomes of Chronic Diseases PIP Validation Findings

Adverse Outcomes of Chronic Diseases PIP (Asthma)				
	AHDC	**HSCSN**	**MSFC**	**THP**
1) Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.	Met	Met	Met	Met
2) Review the Study Question(s) - The study question should reference the study population, activity, and expected outcome. The study question guides the PIP and must be clear and answerable.	Met	Met	Met	Met
3) Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.	Met	Met	Met	Met
4) Review the study population - The study population must reflect all individuals to whom the study questions and indicators are relevant.	Met	Met	Met	Met
5) Review Sampling Methods - The sampling method must be valid and protect against bias.	NA	NA	NA	NA
6) Review Data Collection Procedures - The data collection procedures must use a systematic method of collecting valid and reliable data.	Met	Met	Met	Met
7) Assess Improvement Strategies - The improvement strategies, or interventions, must be reasonable and address barriers on a system-level.	NA	NA	NA	NA
8) Review Data Analysis & Interpretation of Study Results - The study findings, or results, must be accurately and clearly stated.	NA	NA	NA	NA

Adverse Outcomes of Chronic Diseases PIP (Asthma)				
	AHDC	**HSCSN**	**MSFC**	**THP**
9) Assess Whether Improvement is Real Improvement - Project results must demonstrate real improvement.	NA	NA	NA	NA
10) Assess Sustained Improvement - Sustained improvement must be demonstrated through repeated measurements.	NA	NA	NA	NA

All of the MCOs conducted data analyses of the eligible population to support the rationale for the study topic. Barrier analyses were also conducted as MCOs developed interventions to address the identified barriers. Key barriers include lack of member/guardian knowledge about asthma triggers and self-management and medication adherence. Interventions include use of community resources and programs for member education and identification of asthma triggers. Jointly, the MCOs are contracting with Impact DC, as the agreed upon system-wide collaborative intervention. Impact DC will conduct face-to-face asthma education with identified members in a series of extended visits in a healthcare setting. Members will be referred to the program based on specific criteria to be developed by the collaborative workgroup.

The expectation is that MCOs will calculate baseline measure rates in June 2015 using CY 2014 data. Implementation of planned interventions will occur in CY 2015 with on-going monitoring by the MCOs to gauge the effectiveness of performance improvement activities. Summaries of the MCOs' Chronic Condition PIPs follow.

AmeriHealth District of Columbia

AHDC reported that the District has the highest rate of asthma in the nation according to the American Lung Association. Approximately 2,500 members with asthma (ages 2 to 50) were identified by AHDC. During the second half of 2013, there were 607 ED visits for asthma and 54 asthma-related inpatient admissions—indicating a 25% ED utilization rate and a 2% inpatient admission rate for members with asthma. AHDC did not analyze data specific to the 2-20 years age range; however, the ED utilization rate presents an opportunity for improvement in asthma management.

An initial barrier analysis was completed. The following barriers were identified:

- Members lack education as it relates to asthma triggers.
- Members do not understand effective strategies for self-management.
- Members have limited access to services during non-business hours.
- Members lack understanding of recommended routine and preventive services for asthma.
- Members lack understanding of medication adherence.

- Members/caregivers are not engaged in the care process.
- Members do not make/keep their appointments with providers.
- Provider offices have limited resources to follow-up on members that do not keep their appointments.
- The MCO struggles to engage members due to outdated/inaccurate contact information.
- Members are using the ED instead of going to their PCP or an urgent care facility.

The MCO identified the following planned, or already implemented, interventions:

- The MCO is developing a "Breathe Easy. Start Today." (BEST) Program in conjunction with a partnering pharmacy system and participating AHDC providers. This program allows physicians to dispense asthma medications and related products directly from an automated unit within the office (that is maintained and filled by the pharmacy system). Units contain an inventory of spacers, masks, and medications for AHDC members and this allows patients to begin therapy immediately. Upon request, a Respiratory Therapist will be available for on-site training. The provider office will then teach the member/caregiver how to properly use the equipment. The goal is to ensure asthma medication adherence.
- The MCO has contracted with Impact DC, which is an asthma program that provides a comprehensive approach for asthma care that is consistent with national guidelines. The program aims to provide asthma education, short-term care coordination, and transitions patients to ongoing longitudinal care in their primary care medical home. The program is dedicated to improving asthma care and outcomes for children by educating patients and families about ways to manage the condition and connecting them with valuable community resources.
- The MCO has partnered with Healthy Hoops to provide an annual hands-on basketball event for children ages 3 to 18. The program teaches children/caregivers/families how to manage asthma through appropriate use of medication, proper nutrition, monitored exercise, and recreational activities. The program goal is to reduce ED visits and hospital stays related to asthma.
- The MCO has initiated a multi-team approach to improve asthma care. Children's National Medical Center identifies patients whose asthma is not well controlled and engages the patient in programs, such as Impact DC and Breathe DC where members are educated on asthma triggers and home assessments are completed. Breathe DC additionally educates members/caregivers on an electronic health tablet, maintained by AHDC's pharmacy benefits management company. The tablet involves an online portal with drug therapy management. The tool creates medication reminders, surveys members and completes member assessments, generates reports based on survey/assessment results, develops custom care plans, and tracks members' key health metrics.
- The MCO has engaged with Breathe DC to allow members with asthma to participate in a week long camping experience where the children learn to identify asthma triggers, recognize signs of an asthma attack, properly use medication and equipment, and perform breathing and relaxation exercises.

- The MCO is participating with the DC Healthy Homes Program in an effort to eliminate environmental asthma triggers in the member's home. This involves engagement from the District Department of Environment (DDOE) Case Workers. The Case Workers develop case-specific improvement plans, taking into consideration the ownership status of the member's home. For families that own their home, Case Managers/Care Managers provide free consultation on how to pursue safe hazard remediation and work with partners to secure grant funds for repair work. For families in public or subsidized housing, the DDOE works with the District's public housing agency and housing code enforcement agency to either make repairs or pursue regulatory action to bring landlords into compliance.
- The MCO has initiated a program, 4 Your Kids Care, that targets children ages 0-6 who have had low acuity ED visits in the last quarter for the purpose of: educating parents about appropriate ED utilization; connecting parents to a PCP, nurse call line, etc.; increasing PCP utilization and encouraging member-PCP relationships; providing appropriate case management referrals; reducing low acuity ED visits and program costs. Members are contacted by AHDC Community Outreach staff and are invited to events. Staff also survey members/caregivers to identify PCP utilization barriers.

Health Services for Children with Special Needs

HSCSN conducted a population analysis in relation to the incidence of asthma. Of the 5,690 enrollees, 1,303 have an ICD-9 asthma diagnosis; 538 have this diagnosis in the primary position and 535 have it in the secondary position. HSCSN also reported that 95% of its members are African American and noted that according to the Centers for Disease Control and Prevention, black children are 2-3 times more likely to be hospitalized and 5 times more likely to die from asthma. Although access to care may be a contributing factor, environmental exposures for children who live in substandard housing play an important role. HSCSN described the housing in the disadvantaged communities as old and poorly maintained, leading to increased exposures to many asthma triggers and toxins associated with asthma symptoms. HSCSN also noted that 64% of its enrollees reside within the three poorest wards within the District (Wards 6, 7, and 8). In conclusion, HSCSN stated that its membership is disproportionately affected by numerous social determinants such as poverty, substandard housing, poor education, single parent households, etc. This is in addition to the members existing complex conditions. All of these factors, HSCSN reported, adversely impact emergency room and inpatient utilization related to asthma.

An initial barrier analysis was completed. The following barriers were identified:

- Members may experience home infestations (rats, roaches, mice, bedbugs) which may exacerbate asthma.
- Members may have home environmental issues (standing water, mold, clutter, smoke, older housing stock) which may exacerbate asthma.
- Members/caregivers do not understand the importance of obtaining/following an asthma action plan.

- Members/caregivers believe that the member does not have asthma (instead they believe the member suffers from allergies).
- Members/caregivers do not understand the importance of using a spacer in conjunction with an inhaler.
- Members/caregivers do not understand the appropriate use of routine (maintenance) asthma medications and rescue asthma medications. Both medications are not always administered appropriately.
- Members/caregivers do not understand the importance of obtaining asthma medications—some members have no asthma medications and others do not routinely refill their asthma medications.
- Members/caregivers do not understand the importance of obtaining a flu shot.
- Members/caregivers do not understand the use of a Primary Care/Specialist Provider vs. using the ED as a main source of treatment.
- Members/caregivers require educational reinforcement in understanding asthma triggers in regard to their home environment (cigarette smoking, weather, exercise, stress, pets, strong odors, infestations, dust, and mold).
- Members experience unstable caregivers and a housing/home environment which may lead to increased exposure to environmental allergens.
- Multiple children in the home with special needs/mental health needs, domestic violence, and/or daily needs may not be met, all of which may interfere with seeking appropriate asthma treatment and/or asthma care.
- Members/caregivers may not have a working phone or are transient (or have provided incorrect phone numbers and addresses) making it difficult to locate members/caregivers which impacts follow up.
- Members/caregivers may experience access barriers which interfere with seeking appropriate treatment. Examples include: transportation, mental health issues, and inability to pick up medications from the pharmacy.
- Non-clinical Case Managers/Care Managers do not have the same clinical understanding of asthma as the clinical Case Managers/Care Managers, indicating a knowledge deficit.

HSCSN identified the following planned interventions:

- Impact DC—collaborative intervention. Members, meeting collaborative established criteria, will be referred to Impact DC for asthma management services. Specifically, a clinician will provide a comprehensive assessment of the member's asthma. Next, a trained asthma educator will provide individualized education on the pathophysiology of asthma, asthma self-care and monitoring, management of triggers/home exposures, the importance of ongoing asthma care in the primary care medical home, and use of asthma medications and appropriate devices, including a demonstration and practice with the devices. Impact DC staff will also call families by phone following discharge from the clinic.

- Back to school community event will be provided by HSCSN. Numerous health topics, including asthma, will be addressed. Specific to asthma, asthma triggers and trigger avoidance will be covered. Additionally, there will be asthmatic device demonstrations held.
- HSCSN Asthma Pilot Program, which uses a disease management team-based approach where members with asthma are assessed, educated, and receives regular in-person or telephonic contact. Inclusion criteria include: asthma diagnosis (primary or secondary), 3 ED visits with a primary asthma diagnosis and/or 2 inpatient hospitalizations with a primary asthma diagnosis. The pilot program interventions include:
  - Community partnership with Impact DC which services children whom have recently been to the ED, were hospitalized for asthma, or who generally have problems controlling their asthma. Members have been referred when it is determined that there is a need for individualized education specific to asthma, asthma medications, and proper spacer usage. Caregivers are also provided resources and educational information.
  - Breathe Easy Home Improvement Project (Breathe DC) provides home visits which serve children and their families struggling to control children's moderate to severe asthma. Program participants have a history of seeking asthma treatment in the ED or are hospitalized for asthma. Services include home visits to identify/reduce asthma triggers, assistance with pest management/infestations, reinforcement of dust mite reduction strategies, and member/caregiver smoking cessation services.
  - Asthma Pilot Rounds where the team meets weekly to discuss and review cases. Issues are addressed which may include a review of applicable community resources to address psychosocial issues such as food banks, shelters, utility assistance and discussion of applicable referrals to primary care, pulmonary specialist, or other specialists.
  - Children's Law Project (Healthy Together Program) which provides legal remedies to health problems. Legal services are provided pro bono. Examples of health related legal issues include enforcement of housing codes.
  - District's Department of the Environment (DDOE) Healthy Homes Project which aims to identify and end environmental health and safety threats in the home of families throughout the District. DDOE performs home assessments using a certified health home specialist. Members are referred to the program when environmental issues exist and contribute to the member's asthma exacerbations. Services include home assessments and code enforcement efforts.
  - Breathe DC Camp (Breathe Happy) is a weeklong camp for children with asthma. The MCO sponsors 5 members where the children learn to identify asthma triggers, recognize signs of an asthma attack, properly use medication and equipment, and perform breathing and relaxation exercises. Members chosen have high ED and inpatient utilization.
- The MCO holds mandatory training for all Care Management staff. The training provides education for professionals who educate and care for members with asthma and allergies. Case Managers/Care Managers learn the latest techniques in asthma care and receive current and reliable patient education information and materials. There are peak-flow meter training sessions where staff learns proper

techniques for using various medication devices. An additional training session provides a review of asthma physiology, explanations of HEDIS and collaborative asthma measure specifications, and interventions/care plans that are specific for asthma members.

MedStar Family Choice

MSFC reviewed its 2013 data to assess relevancy of the PIP topic and opportunity for improvement. As of January 2014, the MCO reported that it had 1,100 members with a primary diagnosis of asthma between the ages of 2 and 20. Additionally, for the last 6 months of 2013, there were 180 ED visits and 9 inpatient admissions for this population with a primary diagnosis of asthma.

An initial barrier analysis was completed. The following barriers were identified:

- Members are not monitoring/documenting their peak flow rates. When members don't record their rates, it makes it difficult for the PCP to assess how well controlled the member's asthma is.
- Members are not always aware of their specific asthma triggers within their home. Examples include: pests, mold, dust mites, cigarette smoke, etc.
- Providers are not consistent in their documentation of Asthma Action Plans. The MCO indicated that there may be an education gap on the correct use of the action plan, which does not optimize the value of the plan.
- The MCO currently lacks the ability to proactively identify members with asthma in an effort to provide intervention before ED or inpatient utilization. Reports currently being used are based on claims and capture information based on utilization.
- The MCO currently does not follow up with each member after one ED visit with an asthma diagnosis; Case Management contact is made after two ED visits. This missed opportunity delays follow up.

MSFC did provide a list of planned interventions. Some of the interventions include:

- The MCO is contracting with Impact DC, which is the system-wide collaborative intervention. Impact DC will conduct face-to-face asthma education with identified members in a series of extended visits at a healthcare setting. Members will be referred to the program based on specific criteria that is to be determined.
- The MCO is potentially going to partner with Breathe DC for the Breathe Easy Program. This program offers home visiting services for members with uncontrolled asthma. Home walkthroughs are completed to identify asthma triggers. Once the triggers are identified, the member receives help in reducing or eliminating the triggers as much as possible. If necessary, the member is provided equipment to help manage the triggers. Pest management services may also be provided.
- Provider and Member Newsletters will be distributed. The Provider Newsletter will include information on the Asthma Action Plans and convey that 100% of the membership with asthma should have a plan in place. The Member Newsletter will include information on peak flow meters, documentation on flow

rates, and how to identify asthma triggers and subsequently eliminate or reduce them. The letter will also address the importance of having an Asthma Action Plan in place.

- The MCO is going to make modifications/adjustments to its Pediatric Asthma Disease Management Program based on needs of the collaborative PIP and the Impact DC Program. Outreach criteria and report functionality will be addressed to ensure proper member identification.

Trusted Health Plan

THP assessed PIP relevancy by reviewing its 2013 data. The MCO identified 836 members with asthma, of which 400 were between the ages of 2-20. Of these members with asthma in the targeted age group, approximately 75% of them are participants in the MCO's case management program. THP indicated its interest in getting children more involved with asthma-management programs. Members that maintain control and manage their conditions are in a better position to avoid ED visits and inpatient hospitalizations.

An initial barrier analysis was completed. The following barriers were identified:

- Members have an over-reliance on acute care. An initial data analysis indicates that 35% of the study population was treated for asthma in the ED in 2013.
- Members are not self-managing and lack an understanding of asthma exacerbation events/triggers.
- Incomplete or erroneous contact information makes enrollee contact difficult.
- Primary Care Providers (PCPs) tend to not coordinate care among their patients' providers and lack awareness of the importance of this task.
- The MCO has had issues with its auto assignment of a PCP, when members do not select one on their own. Several pediatric groups were erroneously assigned to providers who don't serve the pediatric population. This resulted in these members seeking care in the ED vs. using a PCP.
- The MCO lacks a formal Asthma Disease Management Program.

THP did provide a list of planned interventions. Interventions include:

- The MCO is in the process of developing an Asthma Disease Management Program. Members will be referred via a variety of means (health risk assessments; claims and pharmacy data; interdepartmental, provider and member referrals). A pediatric asthma assessment is then completed where results determine stratification for intervention level. Members are introduced to the program and provided educational materials and resources. Education will be provided at the MCO's Health and Wellness Outreach Center. Members are informed of the educational seminars via the Asthma Welcome Packet and telephonic and face-to-face encounters. The Asthma Disease Manager will provide quarterly outreach to providers to determine if a member has an asthma care plan and if the member is compliant; assess

barriers to care; coordinate care with PCPs/specialists as necessary; and inform providers of any member referrals to asthma programs, such as Breathe DC or Impact DC.

- The MCO has contracted with Breathe DC which will provide home assessments for members with asthma. During the home assessments, there will be identification of and education regarding asthma triggers, suggestions regarding smoking cessation services, pest/rodent management, and a HEPA filter installation, if necessary. Additionally, members will participate in the Breathe DC summer camp. Campers will be taught how to identify their specific individual asthma triggers; how to recognize the signs and symptoms of an impending asthmatic episode; the importance and proper use of medications, spacers, and peak flow meters; breathing and relaxation exercises to help alleviate asthmatic symptoms; and how to communicate their illness more effectively.
- The MCO may partner with Let's Breathe, a Healthy Homes intervention. The program assists members with asthma identify their asthma triggers, provides home visits and follows up on instructions given by a service provider, mold remediation, and provision of free HEPA filters.
- The MCO is in the process of conducting a reassignment of members to pediatric panels and will develop a standard operating procedure to address inefficiencies in the auto-assignment process.
- The MCO plans to develop and distribute a pocket guide for physicians that will contain the MCO's formulary and clinical guidelines for the treatment of asthma. Additionally, a Case Management team member will visit practitioner offices (on a monthly basis) and educate the providers on the collaborative and the MCO's Asthma Disease Management Program.
- The MCO is also working to identify alternate contact information for hard to reach members by working with Customer Service, Utilization Review and Outreach Teams.

Performance Measures

The purpose of conducting the PMV activity is to evaluate the accuracy and reliability of the measures produced and reported by the MCO and to determine the extent to which the MCO followed specifications established by DHCF for calculating and reporting the measures. The accuracy and reliability of the reported rates is essential to ascertaining whether the MCO's quality improvement efforts have resulted in improved health outcomes. Further, the validation process allows DHCF to have confidence in MCO performance measure results and allows for accurate MCO comparisons.

Three of the four MCOs have data systems in place to accurately construct and report PIP measures. These three MCOs plan to utilize the services of certified HEDIS software vendors to assist in the construction and reporting of some or all of the PIP measures.

Typically the annual PMV audit looks back and assesses the MCO's performance for the previous calendar year. However, giving consideration to start up operations, the implementation of PIP collaborative activities

new to the MCOs, and the limited data that was available for 2014 measurement year, DHCF requested that Delmarva's PMV audit focus on the MCOs' readiness to report baseline data in 2015. Therefore, Delmarva conducted an information systems capabilities assessment (ISCA) of each MCO. The purpose of the assessment is to ensure that any identified information systems processes that might impact the MCO's ability to produce valid and reliable measures would be identified early and allow ample time for issues to be corrected.

Prior to initiating the ISCA activities, Delmarva provided an orientation and individual MCO teleconferences to explain the validation process and to answer any MCO staff questions. The MCO's information systems were reviewed and observations gathered to document the effect of information management practices on the measure reporting process. The validation focuses on certain aspects of the information systems (IS) that specifically influence the MCO's ability to accurately report the required measures. The MCO is required to demonstrate that it has the automated systems, information management practices, and data control procedures necessary to ensure that all required information for performance measure reporting is captured, translated, stored, analyzed, and reported.

The ISCA activity focused on three key areas:

1) Data integration and control – processes to ensure accuracy of data transfers, consolidations, extracts, repository structure and format, reporting software, and report production.
2) Data and processes used to produce the performance measures – assesses the MCO documentation and interpretation of measure specifications and data processes used to construct and calculate the measures.
3) Measure validation – determines if all relevant populations are identified according to the measure specifications.

Table 5 provides an overview of the MCO findings for the ISCA.

Table 5. Information Systems Capabilities Assessment Results

Information Systems Capabilities Assessment				
	AHDC	**HSCSN**	**MSFC**	**THP**
1) Accuracy of data transfers to assigned performance measure repository	Met	Met	Met	Met
2) Accuracy of file consolidations, extracts, and derivatives	Met	Met	Met	Partially Met
3) Accuracy of the performance measure data repository structure and format	Met	Met	Met	Met
4) Assurance of effective management of report production and of the reporting software	Met	Met	Met	Met

Information Systems Capabilities Assessment				
	AHDC	**HSCSN**	**MSFC**	**THP**
5) Measurement plans and policies which stipulate and enforce documentation of data requirements, issues, validation efforts and results	Met	Met	Met	Partially Met
6) Documentation of programming specifications for each measure	Met	Met	Met	Partially Met
7) For each performance measure, all members of the relevant populations identified in the performance measures specifications are included in the population from which the denominator is produced	Met	Met	Met	Met
8) Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures	Met	Met	Met	Met
9) Completeness and accuracy of the codes used to identify medical events has been verified and the codes have been appropriately applied	Met	Met	Met	Met
10) Specified time parameters are followed	Met	Met	Met	Met
11) Exclusion criteria included in the performance measure specifications have been followed	Met	Met	Met	Partially Met
12) Systems to estimate populations which cannot be accurately counted exist and are utilized when appropriate	Met	Met	Met	Met
13) All appropriate data are used to identify the entire at-risk population	Met	Met	Met	Met

Three of the four MCOs have data systems in place to accurately construct and report PIP measures. These three MCOs plan to utilize the services of certified HEDIS software vendors to assist in the construction and reporting of some or all of the PIP measures.

AmeriHealth District of Columbia

AHDC maintains a data warehouse for HEDIS and other performance measure reporting. Data from fourteen different sources are loaded weekly or monthly to the warehouse. All files are run through a comprehensive quality analysis process prior to being loaded to the warehouse. Reconciliations are conducted on every load and extract from the warehouse. The MCO maintains a reporting directory that includes an overview, data sources, steps required to generate data, and file reports. Data requirements for the collaborative measures include claims, laboratory, pharmacy, and member-level data. AHDC plans to utilize the services of a certified HEDIS software vendor for assistance in constructing the collaborative measure indicators.

Health Services for Children with Special Needs

During 2014, HSCSN successfully migrated and implemented new claims payment and case management systems. HSCSN is also constructing an internal data warehouse specifically for analytic and reporting needs. Currently, HSCSN actively manages data transfers from the transactional files to the data warehouse and uses daily audit reports to monitor file uploads. Data refreshes are sent to the certified HEDIS software vendor on a monthly basis. In 2014, HSCSN implemented a centralized decision support committee to oversee all data management activities. HSCSN plans to utilize the services of its certified HEDIS software vendor to construct and report the collaborative measures.

MedStar Family Choice

MSFC has a long-standing business relationship with a third party administrator (TPA). File transfers between the TPA and MSFC appear accurate and have appropriate edits and checks in place. Proper safeguards are in place to ensure that data is not lost or modified during transfers to the MSFC data warehouse. All data are loaded to a pre-staging area for validation before being loaded to the internal warehouse. MSFC will utilize the services of its certified HEDIS software vendor to construct the chronic conditions collaborative measures. The MCO will develop the programming internally for the adverse perinatal outcomes measures. An initial source code review during the onsite ISCA indicates that the MCO appears to have adequate reporting capabilities.

Trusted Health Plan

During the ISCA activities, THP provided flowcharts of its overall data system and initial source code. However, no measure-specific documentation or plan was provided. THP did not provide information regarding statistical testing or internal validation of measure results. A preliminary review of source code for the adverse perinatal outcomes measures noted that corrections were required for ICD and CPT codes related to exclusions and deliveries. Failure to correct the coding could result in undercounting of the denominator.

THP used the services of a certified HEDIS software vendor to calculate HEDIS 2014 rates. However, since THP is constructing its own internal data warehouse, THP plans to construct and calculate the collaborative performance measures in June 2015 using internal MCO resources. In order to be prepared to report measures, THP must:

- Develop procedures for coordinating the activities of vendors, particularly as this relates to uploading electronic data to the warehouse to ensure timely and complete integration of data.
- Document data file and field definitions for each measure.

- Document procedures for statistical testing and validation of measure results.
- Develop measure specific reporting flow charts or reporting plans. These should include data sources, data elements, staff roles, and critical milestones.
- Develop a policy for quality assurance of source code, including exclusion criteria to ensure that measure specifications appropriately exclude members from the denominator.

A full PMV audit will be conducted in 2015 to assess the reliability and validity of the MCOs' reported 2014 indicator rates for the Adverse Perinatal and Birth Outcomes and the Chronic Condition PIPs.

CAHPS Surveys

As a component of the MCO QAPI program, MCOs conducted Adult and Child surveys to assess member experiences with healthcare services, providers, and the health plans. Based on the 2014 survey results, District Averages were calculated and compared to NCQA Quality Compass benchmarks including the Medicaid Average and the Medicaid 75th Percentile. DHCF is requiring each MCO to develop an action plan for each measure that did not meet or exceed the Medicaid 75th Percentile. District Averages that met or exceeded the 75th Percentile include:

Adult Measures

- How Well Doctors Communicate Composite
- Rating of Personal Doctor (8+9+10)

Child Measures

- Shared Decision Making
- Health Promotion and Education
- Coordination of Care Composite
- Rating of Personal Doctor (8+9+10)

CAHPS Survey results, District Averages, and comparisons to NCQA Quality Compass Benchmarks can be found in Appendix I.

Access

Access (or accessibility) is defined by NCQA as "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." In assessing access, Delmarva considered information that is communicated to members, coordination of care and services, and availability of robust provider networks.

Member Communications

MCOs must provide notices to enrollees, informational materials, and instructional materials in a manner and format that may be easily understood. DHCF requires that enrollee materials be written at a fifth (5th) grade reading level. Written information must also be available in prevalent non-English languages and must be available in alternative formats for those who are visually or hearing impaired. In addition, interpretive services must be available free of charge to the enrollee for any language. Toll free numbers and TTY/TTD services are also required. MCOs are required to provide enrollees with information about:

MCOs use a variety of communication media to educate and inform members on benefits, their rights and responsibilities, and improving health outcomes. Communication is provided hardcopy, electronically and verbally, in alternative formats and languages.

- Availability of materials in alternative formats and availability of interpreter/translation services at no cost to the enrollee.
- Benefits covered by the MCO as well as those covered by the State plan.
- Complaints, grievance, appeal, and fair hearing procedures.
- The amount, scope, and duration of benefits and procedures for obtaining benefits, including family planning services from the provider of their choice regardless of network status.
- Changes in benefits or services.
- Policies on referrals for specialty care, how to access services available under the State plan but not under the MCO contract, and how transportation is provided.
- How after-hours coverage and emergency services are provided.
- Providers available to enrollees including names, locations, telephone numbers, non-English languages spoken, and whether the provider is accepting new patients.
- Member rights and responsibilities.
- Advance directives.

All of the MCOs include the required information in the member handbook and the provider directory. Additional information is disseminated to enrollees through monthly or quarterly newsletters and member specific letters.

AmeriHealth District of Columbia

AHDC publishes member handbooks and provider directories which are sent to members upon enrollment and annually. AHDC policies state that all written brochures and materials provided to members are written at the fourth (4th) grade reading level. AHDC policies also state that AHDC will provide printed copies of all vital documents and written materials in all prevalent non-English languages. AHDC defines prevalent non-English languages as any language spoken by three percent of the MCO's membership or 500 members,

whichever is less. Prevalent languages identified include: Spanish, Chinese, Vietnamese, Korean, Amharic, French, Braille, and any other language(s) identified by the District. The availability of language interpretation and TTD/TTY services, and how to access these services, is also described in the handbook. Interpretation services can be provided telephonically or in person at a hospital or doctor's office. The handbook also explains that translation services are free of charge and members with hearing impairments may call Member Services or the AmeriHealth DC TTY service toll-free. Members with visual impairments are also instructed to call toll-free to obtain information via an audiotape, in Braille, in large print or in another language. These instructions and toll free numbers are also provided on AmeriHealth DC's website.

The member handbook includes a listing of covered and non-covered services, authorization requirements, and describes the MCO's policies regarding access to primary care providers, specialists, women's health providers, family planning services, and second opinions. The handbook informs members that they may use any hospital or other setting for emergency care and defines routine, urgent and emergency care, along with explanations regarding the extent to which after-hours and emergency care are provided. Information on enrollee rights and responsibilities and procedures for how to file a complaint, grievance, or appeal are also detailed in the handbook. The provider directory includes the names, locations, and telephone numbers of network providers and identifies those who speak languages other than English as well as those not accepting new patients.

Health Services for Children with Special Needs

HSCSN publishes member handbooks and provider directories that are translated into Spanish and other prevalent non-English languages, including Chinese, Vietnamese, Amharic, French, and Korean. These publications are made available to members at enrollment and are written at a fifth grade reading level. HSCSN provides oral interpretation, translation, and/or sign language services free of charge and directs members to call HSCSN's Customer Care Department toll-free to access them. Members with hearing and visual impairments are also instructed to call the Customer Care Department to request materials in alternative formats.

The member handbook includes information on enrollee rights and responsibilities and procedures for how to file a complaint, grievance, or appeal. The member handbook includes a listing of covered and non-covered services, authorization requirements, and describes HSCSN's policies regarding access to primary care providers, specialists, and family planning services. The handbook also defines and describes HSCSN's procedures for routine, urgent and emergency care, along with how to access care when members are out of HSCSN's service area.

HSCSN's provider directory contains provider addresses and telephone numbers, available hours, whether or not providers are accepting new patients, and information regarding board certification, hospital privileges,

and non-English languages spoken. According to HSCSN staff the online provider directory located on the HSCSN's website is updated monthly; however, at the time of HSCSN OSR in November 2014, the most recent written provider directory was produced in 2012. Consequently, HSCSN must update its written provider directory to provide more current and accurate provider information to its members.

MedStar Family Choice

MSFC policies regarding member materials requires that all written brochures and materials provided to members are written at the fifth grade reading level. All materials are developed by the MSFC corporate marketing department to ensure that materials are culturally sensitive. Member materials are made available in prevalent non-English languages which the MCO defines as any language spoken by three percent or 500 members, whichever is less. Member materials requiring translation into other languages are sent to a vendor who is responsible for providing certification of their accuracy. MSFC's member handbook informs members of the availability of translation and TTY/TTD services free of charge to the enrollee and availability of member materials in alternative formats and languages. Members are instructed to call the MCO's Member Services toll-free number to obtain assistance.

MSFC's member handbook and provider directory are provided to members upon enrollment and annually. The member handbook informs members on how to select a PCP and how they can access the provider directory. Procedural steps to obtain specialty services, such as referrals and authorization requirements by PCPs before members may see a specialist are included in the handbook as are processes for filing complaints, grievances, or appeals. Information about the member's right to obtain access to a second opinion, direct access to women's health practitioners, and direct access to family planning services are also provided in the member handbook. Routine, urgent, and emergency care are defined and it is stated that in the event of an emergency, the member should call 911 or go to the nearest emergency room. The provider directory includes the names, locations, and telephone numbers of network providers and identifies those who speak languages other than English as well as those not accepting new patients.

Trusted Health Plan

THP provides members with an enrollment packet containing a welcome letter, provider directory, and member handbook within 10 days of enrollment into the MCO. THP's member materials policy states that materials are written at a fifth grade reading level. THP provides a language card to members at enrollment that informs them of their right to receive written translated materials in any prevalent language and oral interpretation services free of charge. THP identified non-English prevalent languages as Spanish, Amharic, Vietnamese, Chinese, Korean, and French. The language card informs members how to access translation and interpretation services and accompanies all written notices of denial, termination, reduction of services, denial of payment, or any other action upon which a member may file a grievance, or any other vital MCO document.

The THP member handbook informs members about their rights and responsibilities, procedures for authorization of services and how to file a complaint, grievance, or appeal. However, Trusted does not communicate the correct filing deadline for enrollees to request their benefits continue during an appeal or state fair hearing and must amend this filing requirement deadline. Additional information is provided on covered and non-covered services as well as direct access to women's health practitioners and family planning services.

The THP provider directory includes the names, locations, and telephone numbers of providers in the MCO's network. In addition, non-English languages spoken by providers are identified as well as those providers not accepting new patients. THP notifies members at least 30 days before the effective date of any change to the provider directory.

Care Coordination/Case Management

MCOs must ensure that each member has an ongoing source of primary care appropriate to his/her needs and designate a person or entity responsible for coordinating the services the member receives from the MCO with those the member receives from other providers or entities. The MCO must have mechanisms in place to assess Medicaid enrollees with special needs and to identify any special conditions that an enrollee may have which require on-going treatment and monitoring. For those members identified with special healthcare needs, the MCO must also ensure that a treatment plan is developed with input from the member, caregiver, PCP, and specialists involved in the member's care.

MCOs conduct initial member assessments in an effort to identify members with special needs or conditions that may require treatment or monitoring.

AmeriHealth District of Columbia

The AHDC Integrated Case Management (ICM) program uses various mechanisms to identify and coordinate care for members with complex special health care needs. The ICM program is "blended" meaning it integrates and addresses physical health, behavioral health and social/environmental aspects of the member's care. AHDC Case Managers/Care Managers screen members for multiple behavioral health conditions, including depression, anxiety, trauma exposure, suicide risk, substance abuse and autism (for children) and refers those who screen positive to clinical and behavioral health resources for further assessment and intervention.

Specific mechanisms for identifying members in need of chronic care management are employed by AHDC, including data mining, new member assessment, hospital discharge data, provider referrals, member requests, and health plan activity. Case Managers/Care Managers use the information collected during the assessment, input from the member/caregiver, and information and priorities identified by the PCP and treatment team to develop a comprehensive care plan. The Case Manager/Care Manager contacts the member's PCP to seek input in development of the care plan and to review questions and any suggested referrals regarding the plan. The Case Manager/Care Manager also seeks input and agreement from the member and other healthcare team members in the selection of the problems, issues, and cultural, physical, or psychological barriers or concerns that will be addressed.

Health Services for Children with Special Needs

Care management is an essential component of HSCSN's services given that all HSCSN members have special needs. All HSCSN members are assigned to a Case Manager/Care Manager for their entire period of enrollment based upon acuity and severity of their condition, diagnosis, and the anticipated complexity of care coordination needed to manage their treatment. Case Managers/Care Managers are licensed registered nurses, social workers, or practical nurses who consult with HSCSN's Chief Medical Officer and Chief Psychiatric Medical Officer on managing members care and treatment.

The Case Manager/Care Manager contacts members at least every 30 days to address treatment issues and compliance with HSCSN services and goals. Care management interventions are extensive and include an initial assessment; development of a treatment plan in collaboration with the member, family, PCP, and treating specialists; identification of educational, outreach, and resources needed by the individual; facilitation of transportation; transition services from early intervention programs and from pediatric to adult services; community referrals for food and housing needs; coordination of mental health services; and coordination of language interpretation/translation services. Care coordination is initiated by HSCSN and further developed by the enrollee's PCP, specialists caring for the enrollee, the enrollee, and the enrollee's caretaker or guardian as appropriate.

HSCSN recently contracted with the Congress Heights Life Skills Center, a behavior health clinic, located in Ward 8. HSCSN aims to offer additional behavioral health service options to members in need of these services.

MedStar Family Choice

MSFC's outreach program identifies members with special health care needs during welcome calls and refers them to case management. The MCO also utilizes a health risk questionnaire to identify members with special

health care needs within 60 days of enrollment. MSFC offers complex case management services to members who meet the following criteria:

- Transplants
- Multiple chronic illnesses with high utilization
- Catastrophic conditions/special needs
- Special needs populations defined by DHCF

MSFC uses claims and encounter data, pharmacy data, precertification and concurrent review data, and data received from DHCF to identify members for complex case management. MSFC uses health care professionals who specialize in diagnosing or treating special health care needs. The MCO allows members with special health care needs who require a course of treatment or regular care monitoring to directly access a specialist as appropriate for the member's condition and identified needs. MSFC's Care Management staff coordinates and supports direct access to specialty care when the member's health care needs warrant treatment by an appropriate specialist. MSFC develops a treatment plan for members identified as having special health care needs that addresses their physical, developmental, behavioral, and emotional conditions. The treatment plan is developed by PCPs with input from members and is reviewed and updated at least every 12 months.

Trusted Health Plan

THP employs the Health Risk Assessment (HRA) tool to help identify adult members with special health care needs. For members under 21 the MCO relies on the EPSDT process to identify those with special health care needs. Data from the HRA and EPSDT are used to stratify members into one of three categories; members with special health care needs are placed into Level III indicating they have complex needs. The MCO's Care Coordination Team comprised of THP Case Managers/Care Managers, members' PCPs and/or specialists works collaboratively with members to develop and implement treatment plans based on members' needs and barriers to care. Treatment plans are reviewed and updated at least annually and include specific member goals and expected outcomes and community resources.

THP Case Managers/Care Managers work with providers to communicate and share information needed to facilitate successful outcomes for members. Case Managers/Care Managers are responsible for implementation of member treatment plans and coordinates care including appropriate member education. THP's Information System assists with the tracking and monitoring of care coordination cases. Basic functionality includes the ability to:

- Facilitate Case Manager's/Care Manager's responsibilities for care planning, authorization of care and monitoring of receipt of planned services.

- Meet the requirements for EPSDT tracking.
- Allow the Case Manager/Care Manager to track and monitor other aspects of treatment planning.
- Protect health information in compliance with relevant privacy and confidentiality laws and regulations, so that only authorized staff can use it.
- Ensure medical record content is consistent with the utilization control requirements.

Selection and Retention of Providers

MCOs must have procedures in place for recruitment, selection, and retention of providers to ensure that members have access to a network of highly qualified practitioners. The MCO may not knowingly contract with individuals debarred, suspended, or otherwise excluded from participating in federal or state programs. Therefore, MCOs must have comprehensive credentialing programs that include processes for identifying debarred or suspended providers, reporting to the appropriate authorities any serious quality deficiencies, and use of performance data in making recredentialing decisions.

MCOs have credentialing and recredentialing procedures in place to ensure that members have access to highly qualified PCPs and specialists.

All of the MCOs have appropriate credentialing systems in place to ensure members receive care and services only from qualified healthcare professionals and that credentialing decisions are non-discriminatory. Credentialing programs describe the structure of the credentialing committee and accountability for decision making. Policies include appropriate verification of credentials and screening of applicants for sanctions and/or exclusions from federal or state programs.

AmeriHealth District of Columbia

AHDC has a comprehensive credentialing and recredentialing policy for both physicians and allied health practitioners. This policy details AHDC's process for primary source verification of provider qualifications: licenses, malpractice insurance coverage, liability and sanctions history, work history, and other information found in the application. AHDC credentials and recredentials practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed. Further, AHDC has policies in place that no provider shall be excluded or terminated from participation with AHDC due to the fact that the provider has a practice that includes a substantial number of patients with expensive medical conditions. AHDC's Provider Manual dedicates an entire section to informing providers about the MCO's credentialing and recredentialing process. The AHDC Credentialing Committee has ultimate accountability for the MCO's credentialing and recredentialing activities.

Practitioners must maintain a current DC unrestricted license, not subject to probation, suspension, proctoring requirements or other disciplinary actions in the state in which they practice and provide services to the health plan members. Practitioners must maintain a current unrestricted valid DC Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Providers are recredentialed every three years and information gathered from complaints and grievances is considered in the recredentialing review.

Health Services for Children with Special Needs

HSCSN maintains detailed credentialing and recredentialing policies and procedures that apply to all licensed practitioners and groups with an independent relationship with HSCSN who provide care to members, including: PCPs, medical, surgical, pediatric, and behavioral health specialists and subspecialties and allied health specialists including nutritionists, occupational and physical therapists, physician assistants, and speech and language pathologists and audiologists. HSCSN's Chief Medical Officer and Credentialing Committee, which includes licensed practicing providers, oversee credentialing and recredentialing activities.

HSCSN does not make credentialing and recredentialing decisions based on an applicant's race, ethnicity/nationality identity, gender, age, sexual orientation, types and/or cost of procedures or types of patients that the provider sees. HSCSN has also earned NCQA certification in credentialing and recredentialing.

MedStar Family Choice

MSFC has comprehensive policies in place for credentialing and recredentialing of practitioners that details the criteria used by the MCO. Although DHCF requires the credentialing process to be completed within 180 days, MSFC makes initial credentialing decisions within 120 days. MSFC conducts primary source verification of all licensed practitioners by using NCQA approved and/or industry recognized sources. Review of credentials includes verification of state licensure, professional training, and board certification and that the practitioner is professionally in good standing. MSFC queries the Excluded Parties List System (EPLS)/General Service Administration (GSA) monthly to identify any practitioners excluded from the Medicaid program. Any confirmed matches results in immediate termination of listed practitioners from the MCO's network.

MSFC's informs practitioners about the MCO's credentialing and recredentialing process in the Provider Manual. The MCO does not discriminate against practitioners who specialize in conditions that require costly treatments, who serve high-risk populations, or who act within the scope of their licenses or certifications.

Trusted Health Plan

THP's comprehensive 2014 Credentialing Plan contains the criteria, standards, and requirements established by the MCO for credentialing and recredentialing providers. The plan details policies and procedures for obtaining, reviewing, verifying, and approving the credentials of practitioners and providers for participation in the MCO's network and documents the role of the THP Credentialing Committee. THP's credentialing policies state that providers will not be discriminated against by the MCO on the basis of gender, race, color, religion, age marital status, national origin, sexual orientation, or disability. THP also does not discriminate against practitioners that serve high-risk populations or specialize in conditions that require costly treatment. THP's policies further state that practitioners must not have been excluded, expelled, or suspended from any federally funded programs, including Medicaid. Also, at the time of credentialing, practitioners must not be under sanction or prevented by a regulatory agency from participating in federal or state programs. In accordance with DHCF requirements, credentialing decisions are made within 180 days of receipt of a practitioner's application.

THP's recredentialing process includes a review of practitioner performance profile data including member complaints, quality audits, utilization information, and medical record review. THP requires all facilities the MCO contracts with to have a valid current license with the District of Columbia and/or necessary state licensure as well as valid accreditation by The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or other equivalent accrediting bodies.

Adequacy of Provider Networks

MCOs are contractually required to maintain and monitor a network of appropriate providers that are supported by written agreements and are sufficient in number to provide adequate access to all services covered under the contract. The MCOs must submit quarterly reports and geo-access maps showing participating PCPs by zip code of office locations to DHCF. Specifically, MCOs are required to meet access standards established by DHCF. These standards include:

MCOs exceed contractual requirements for provider ratios and travel distance.

- Member to Provider Ratio including:
  - At least 1 full time equivalent (FTE) PCP for every 1500 enrollees.
  - At least 1 FTE PCP with pediatric training and/or experience for every 1,000 members through the age of 20.
  - For enrollees through the age of 20, at least 1 active dentist for every 750 enrollees.
  - At least two hospitals that specialize in pediatric care.
  - Department of Behavioral Health core service agencies.

- A pharmacy network that includes:
- at least one (1) twenty-four (24) hour, seven (7) days a week pharmacy;
- at least one (1) pharmacy that provides home delivery service within four (4) hours; and
- at least one (1) mail-order service.

➢ Appointment Availability
- Initial appointments for pregnant women or enrollees desiring family planning services shall be provided within ten (10) calendar days of the enrollee's request.
- Appointments for initial EPSDT screens shall be offered to new enrollees within sixty (60) days of the enrollee's enrollment date or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child's case indicates a more rapid assessment or a request results from an emergency medical condition.
- The initial screen shall be completed within three (3) months of the enrollee's enrollment date, unless it is determined that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests, and immunizations shall take place within thirty (30) days of their scheduled due dates for children under the age of two (2) and within sixty (60) days of their due dates for children age two (2) and older.
- Periodic EPSDT screening examinations shall take place within thirty (30) days of a request.

➢ Travel Distance/ Time
- For all enrollees, at least 2 PCPs within 5 miles of an enrollee's residence or no more than 30 minutes travel time.
- Laboratories within 30 minutes travel time from a member's residence.
- At least two (2) pharmacies located within two (2) miles of enrollee's residence.

AmeriHealth District of Columbia

AHDC uses provider to member ratios, geographic access, appointment availability, and provider hours of operation to assess and anticipate Medicaid enrollment. On a quarterly basis, AHDC analyzes network adequacy and submits the required reports to DHCF. AHDC's quarterly report evaluates the composition of the provider network against the health status and needs of the MCO's members to identify any gaps or areas requiring expansion in primary care, specialty care, dental and mental health services. The documentation of network adequacy includes the geographic location of providers and members, distance, and travel time. AHDC also documents and reports the number of network providers not accepting new patients.

AHDC's September 2014 Managed Care Accessibility Analysis documented the MCO had a network of 513 PCPs at 108 locations. The report concluded that, based on provider numbers and geographic location, 99.9% of members had adequate access.

AHDC's policies allow female members direct access to women's health specialists. Second opinions may be obtained from within the network; however, if an in-network provider is not qualified, AHDC will arrange for the enrollee to obtain a second opinion from an out-of-network provider at no cost to members.

AHDC providers are required to meet the follow standards for member access to care:

- Emergency medical care – immediately at the nearest facility
- Urgent Medical Care – within 24 hours of request
- Routine primary or specialist care – within 30 days of request; initial appointments for new members ages 21 and older – within 30 days of request or within 45 days of becoming a member, whichever is sooner; initial appointments for pregnant women or family planning services – within 10 days of request
- Waiting time in a provider office – not to exceed 45 minutes for members arriving at the scheduled appointment time
- Use of free interpreter services – as needed upon member request during all appointments

AHDC's Provider Network Management (PNM) Department conducted an Access to Care survey covering the timeframe between January 1 through August 31, 2014, which demonstrated 100% access to care for pediatric members and 96% for adult members.

Health Services for Children with Special Needs

HSCSN maintains a sufficient number of service providers to ensure access to services in accordance with the DHCF access standards. HSCSN uses various data sources to monitor the number and geographic distribution of providers and to identify any network shortages including:

- Member feedback
- Geographic access data
- Feedback from HSCSN Team Leaders and staff
- External population data
- Comparisons of provider to enrollee ratios with relevant national standards for medical specialties

HSCSN's GeoAccess Report, dated January 6, 2014, indicated the following regarding the composition of the MCO's network:

- 1 PCP for every 10 enrollees
- 1 Dentist for every 47 enrollees
- 1 Mental Health Provider for every 17 enrollees

- 1 OB Provider for every 31 enrollees
- 1 Early Intervention Provider for every 86 enrollees

The GeoAccess Report also indicated that HSCSN had 100% access for the following provider types:

- PCPs
- Dentists
- Mental Health Providers
- OB Providers
- Early Intervention Providers

HSCSN's policies allow direct access to women's health specialists to female members and members are informed of their right to seek second opinions at no cost to them. If an HSCSN enrollee is in need of specialty services and no participating network providers are available to perform the needed service, HSCSN will authorize treatment by a non-participating provider. In these cases, HSCN provides out-of-network services at no cost to members.

Although HSCSN's policies and procedures regarding appointment access met DHCF standards and describe how access is monitored, HSCN's performance is inadequate. HSCSN's Secret Shopper survey results from June – September 2014 indicate that only 64.3% of members received appointments within the required timeframes. In a separate access survey performed by a vendor in the 1st Quarter of 2014, only 52% of HSCSN members were able to secure an appointment within 30 days. Consequently, HSCSN must improve the rate of members obtaining routine appointments within 30 days. Delmarva recommends achieving a 90% compliance rating in obtaining timely appointments within the required standards.

MedStar Family Choice

MSFC's Provider Relations Department is responsible for the MCO's network and recruits providers based on the following:

- Requests from Care Management
- Requests from Member Services
- GeoAccess Reports
- Privileges at participating hospitals

In establishing and maintaining the network, MSFC anticipates enrollment; expected utilization of services, including characteristics and health care needs; the number and type of providers required to furnish covered services; the number of network providers not accepting new patients; and the geographic location of the

providers and members which includes distance and travel time by normal means of transportation and whether provider locations are accessible to members with disabilities.

MSFC's June 2014 GeoAccess quarterly report contained the following data regarding provider numbers and types within the MCO's network:

- 1 Family Medicine Physician for every 238 members.
- 1 Internal Medicine Physician for every 194 members.
- 1 Pediatrician for every 92 members less than 21 years of age.
- 1 OB/GYN for every 256 women 18 years of age and older.

These statistics well exceed the District's requirement of 1 PCP for every 1,500 members and 1 Pediatrician for every 1,000 members under 21. In addition, the June 2014 GeoAccess Report documented that MSFC had 100% access, defined as at least two PCPs within 30 minutes travel or 5 miles radius of a member's residence, for the following provider types: Family Medicine, Internal Medicine, Pediatrics, and OB/GYN.

MSFC conducts a semiannual survey to collect and analyze data on the availability of PCP appointments for routine, urgent, after-hours, and initial prenatal care appointments in accordance with the standards set by DHCF. The results from the MCO's July 2014 found 100% of PCPs had urgent care availability within 24 hours of request as well as routine care availability within 30 days of request and 99% of PCPs had 24 hour access.

During any period in which MSFC does not have a specialist in the area, the member is permitted to utilize an out-of-network provider after obtaining the proper authorizations. MSFC also allows women to directly access a women's health specialist and direct access to specialist for those with special healthcare needs. Policies are in place permitting members access to a second opinion within the network. If a network provider cannot be identified, MSFC will assist in arranging a second opinion from an out-of-network practitioner.

Trusted Health Plan

THP uses GeoAccess reports and claims and encounter data to anticipate Medicaid enrollment. The MCO monitors provider accessibility and availability quarterly basis against established standards for geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours services. THP's monitoring activities include practitioner surveys, on-site visits, evaluation of member satisfaction and complaints, GeoAccess surveys, and monitoring of closed primary physician panels. Specific deficiencies are addressed with an improvement action plan with follow-up activity conducted to reassess compliance.

THP's January 2014 GeoAccess report indicated that the MCO maintained 1 PCP for every 64 members which exceeded the DHCF requirement of 1 PCP for every 1,500 members. This same report and another from September 2014 also indicated that THP achieved 100% compliance in meeting the standard that PCPs be accessible to members within a 30-minute travel time by public transportation or 5 mile radius of members' residences. The MCO reported that it had no closed panels.

THP policies allow for direct access to women's health specialists and family planning services. Policies are also in place allowing direct access to specialists for members with special needs. Second opinions may be obtained through a network provider; however, if a network provider is not available, THP will assist the enrollee in obtaining a second opinion from an out-of-network provider at no charge to members.

THP's appointment access standards for appointments states that members should have access to routine appointments within 30 days of request. However, in the MCO's 2014 Secret Shopper survey of network providers only 80% met this standard. Consequently, THP must improve its rate of members obtaining routine appointments within 30 days.

Timeliness

Timeliness is defined as whether the MCO makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of healthcare. In addition, MCOs must ensure that enrollees receive information regarding healthcare benefits, denials, and appeal procedures in accordance with regulatory timeframes. In assessing timeliness, Delmarva considered MCO processes for timely dissemination of information to members, timeliness of utilization management decisions, and timeliness of notification of decisions to enrollees.

Member Materials

Federal regulations require specific timeframes for dissemination of information to members. Information regarding member rights and responsibilities, covered and non-covered services, complaints, grievances, and appeals processes, and procedures for referrals and authorization of services must be provided to the member at the time of enrollment, annually, at least 30 days prior to the effective date of any change. The OSR for 2014 includes a thorough review of MCO policies and procedures related to member rights and communication. The focus of these reviews is on content of communications as well as timeliness of those communications.

Members receive timely communication regarding benefits, appeals, processes, and policy changes.

AmeriHealth District of Columbia

AHDC met all requirements for timeliness of member materials. In response to an opportunity identified in the CY 2013 OSR, the MCO revised its policy on member rights to include notification to the member at least 30 days prior to the effective date of any change to policies related to member rights.

Health Services for Children with Special Needs

HSCSN provides all enrollee materials, information, and notices in a timely manner. However, HSCSN's most recent written Provider Directory was outdated as it was produced in 2012 and contained incorrect addresses for over forty (40) percent of providers. Consequently, HSCSN must update its written Provider Directory to provide more current and accurate provider information to its members. An accurate Provider Directory must be provided to members upon enrollment and HSCSN must give members reasonable notice of any changes regarding providers. The Provider Director should also be updated at least annually.

MedStar Family Choice

MSFC provides all of the requisite member information upon enrollment and annually; however, there were conflicting timeframes documented for timely filing of appeals and state fair hearing requests in the member handbook and notice of action letter. The handbook indicates that benefits will continue if a member files an appeal or requests a fair hearing within 15 days of receipt of a notice of action of an adverse decision. However, the notice of action letter states the timeframe is 10 days. As a result, MSFC must revise its member handbook to comply with the 10 day DHCF requirement.

Trusted Health Plan

THP met most requirements for timeliness of member communications. However, the MCO did not meet requirements regarding informing members about grievances. THP's policies do not require communication of changes in grievance and fair hearing procedures within 30 days prior to the date of the change. In addition, THP's notice of action sent to members for appeals conflicts with a DHCF requirement prohibiting MCOs from recovering payment when members' benefits are continued during an appeal or District Fair Hearing process. THP must revise its policies to address these requirements.

Utilization Management

The MCO must have a comprehensive Utilization Management (UM) Program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement. The UM Program must specify criteria for UM decisions. The written UM Program must have mechanisms in place to detect over-utilization and under-utilization of services. For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that: preauthorization, concurrent review, and appeal decisions are made and supervised by appropriate qualified medical professionals; efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate; the reasons for decisions are clearly documented and available to the enrollee; there are well publicized and readily available appeal mechanisms for both providers and enrollees; preauthorization and concurrent review decisions are made in a timely manner as specified by the State; appeal decisions are made in a timely manner as required by the exigencies of the situation; and the MCO maintains policies and procedures pertaining to provider appeals. Adverse determination letters must include a description of how to file an appeal and all other required components. The MCO must also have policies, procedures, and reporting mechanisms in place to evaluate the effects of the UM Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

MCOs have procedures in place to ensure timeliness and tracking of authorization decisions, member complaints and appeals, and provider appeals processes are in place.

MCOs must meet the following requirements for utilization management:

- Standard authorizations must be completed, and a determination made, within 14 days of receipt of the request.
- Expedited authorization requests must be completed within 3 days.
- The MCO may extend the timeframe for issuing an authorization decision by up to 14 days.
- If the timeframe for decision making is extended, the MCO must notify the enrollee, make a decision as expeditiously as the enrollee's health condition requires, and make a decision no later than by the date the extension expires.
- In cases where services may be reduced, suspended, or terminated, the MCO must provide notice to the enrollee of the intended action at least 10 days prior to the effective date of the decision.

AmeriHealth District of Columbia

AHDC's policies and procedures provide clear explanations of how the MCO processes authorization requests and the timeframes for doing so. Standard and expedited requests are clearly defined as are reasons

for a possible extension. In response to an opportunity identified in the CY 2013 OSR, the MCO revised its policy on utilization management decision response time to include more detail relative to enrollee notification, expedited decision making, and extensions.

Health Services for Children with Special Needs

HSCSN's policies and procedures outline the process for authorizing initial and continuing services for its members according to required timeframes. HSCSN conducts medical necessity reviews, evaluation of patient-specific clinical information and outcomes, and analysis of utilization data to ensure services are provided in accordance with accepted norms of practice, criteria, and clinical guidelines.

MedStar Family Choice

MSFC policies and procedures conform to the timeliness requirements as stated in the MCO's contract with DHCF. Throughout the authorization review process, MSFC's Case Managers/Care Managers have access to a Physician Advisor who reviews service requests for medical necessity using nationally accepted criteria. Standard authorization decisions are made within 14 days of receipt and expedited decisions within 72 hours of receipt. In cases where an extension has been implemented, decisions are made as expeditiously as the enrollee's health condition requires or by the time the extension expires.

Trusted Health Plan

THP's utilization management policies detail the MCOs criteria for determining medical necessity. The policies also address application of the criteria in making authorization decisions by the MCO's Medical Director or another licensed THP physician. THP makes standard authorizations decisions within 7 days and expedited requests within 2 days which exceed contractual requirements of 14 days for standard authorizations and 3 days for expedited requests.

However, THP's policies:

- Do not state that the written notice of action for termination, suspension, or reduction of previously authorized services would be mailed at least 10 days before the date of action.
- Do not address an extension in the decision making process, in which enrollees have the right to file a grievance if they disagree with the decision to extend the time allowed for issuing an authorization decision.
- Do not state that it will carry out determinations as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.

- Do not address that the MCO may not refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
- Do not state if DHCF fails to make a determination regarding members' disenrollment requests in the federally-required timeframe that the disenrollment request is considered approved.

THP must revise its policies to address these requirements.

Grievance Systems

MCOs must have a grievance process in place and inform enrollees of how to file an MCO level grievance or appeal or request a state fair hearing. The MCO must provide a written notice of action for grievances and appeals. The Notice of Action (NOA) Letter must include: the action intended; the reason for the action; right to file an appeal or request a fair hearing, the procedures for exercising the rights of appeal; the circumstances under which expedited resolution may be requested; right to have benefits continue pending the outcome of the appeal; how to request continuation of benefits; and circumstances under which the enrollee may have to pay for continued benefits.

MCOs have procedures in place to monitor, track, and trend complaints and grievances.

DHCF holds the MCOs to the following timeliness requirements relative to grievances and appeals:

- Grievances must be resolved within 30 days.
- Appeals must be resolved within 15 days.
- Expedited appeals must be completed within 3 days.
- Written acknowledgement of receipt of grievance or appeal within 2 days.
- Standard or expedited appeals may be extended up to 5 days.

AmeriHealth District of Columbia

AHDC maintains comprehensive policies for resolution of complaints, grievances, and appeals. Policies define complaints, grievances, and appeals and set out specific timeframes for completion of key steps and activities. AHDC's policies and procedures meet all contractual requirements for timely decision making and notification to the member.

However, in a sample of AHDC grievances reviewed during the 2014 OSR, there was one instance where resolution of a grievance occurred, but a resolution letter was not submitted to the member. In another

instance, a computer glitch occurred that caused the case to be closed prematurely. Upon discovery, the case was reopened, but the origination date/date of receipt restarted when the case was reopened, which caused an untimely resolution letter. Consequently, the MCO must ensure that grievances are resolved and members are notified of their resolution within 30 days of receipt.

Health Services for Children with Special Needs

HSCSN maintains policies for resolution of complaints, grievances, and appeals. Policies define complaints, grievances, and appeals and include specific timeframes for completion of key steps and activities. However, HSCSN's policies and procedures do not meet all contractual requirements for timely decision making and notification to the member. The Appeal of Non-Certification Decisions Policy and Procedure states that a standard appeal process will be completed with a written NOA issued to members within 15 calendar days of the receipt of the request for a pre-service appeal, unless an extension is requested. This 15 day resolution meets the District's requirement, but this policy further states that post-service appeals are resolved within 30 calendar days. HSCSN's contract with the District does not differentiate between pre- and post-service appeals. It simply requires appeal resolution within 15 days after receipt. As a result, HSCSN must revise its policy to reflect the 15 day resolution timeframe for all standard appeals, regardless of type.*

In a review of a random sample of grievances during HSCSN's 2014 OSR, HSCSN frequently exceeded the 30 day resolution timeframe required by DHCF to inform members of the disposition of grievances. Consequently, HSCSN must implement actions to ensure it resolves grievances and notifies members of disposition within the required 30 day timeframe.

MedStar Family Choice

MSFC presents a systematic approach to handling complaints, grievances and appeals. Policies and procedures are compliant with contractual requirements with one exception. MSFC's appeal policy includes two types of standard appeals, pre-service and post-service, that set different timeframes for resolution. Under the policy, the MCO requires pre-service appeal resolution within 15 calendar days, which is in accordance with DHCF requirements. However, MSFC's policy requires post-service appeals to be resolved within 30 days. The MCO's contract with DHCF does not differentiate between pre-service and post-service appeals and requires appeal resolution within 15 days after receipt. Consequently, MSFC must revise its policy to reflect the 15 day resolution requirement mandated by DHCF for all standard appeals.*

* Subsequent to the 2014 review cycle, DHCF's Health Care Delivery Management Administration acknowledged that while federal and MCO contract language does not recognize "pre- and post-service appeals," NCQA does acknowledge differences in the appeal types. The administration also recognizes that MCOs have interpreted contract language differently and plans to complete an internal review during 2015. Results of the review will include steps to provide clarification to MCOs. MCOs will not be required to develop an action plan to address this component.

Trusted Health Plan

THP maintains policies detailing the MCO's processes for handling grievances and appeals. The policies address:

- Members' right to file a grievance and appeal.
- Assistance available to members to file a grievance and appeals.
- Timely filing requirements for grievances and appeals.
- Parties authorized, e.g. providers, caregivers, lawyers, etc., to file appeal or fair hearing requests on behalf of members.

THP's members are informed of their right to file grievances, appeals, and fair hearings and the process for doing so in the member handbook. The handbook also informs members of the MCO's process for resolving grievances and appeals.

THP's grievance and appeal policies contain numerous errors and omissions which result in the MCO not being fully compliant with DHCF requirements. These include:

- The appeals policy does not specify providers must have members' consent to file an appeal on their behalf and communicates an incorrect deadline (180 days vs. the required 90) for filing appeals.
- The grievances policy indicates grievances must be filed in writing which is contrary to federal requirements that they may be filed orally or in writing. THP's written requirement appears to have impacted and prevented members from completing the process as the MCO's staff reported instances when members who wished to file grievances were stymied by THP's requirement that they be filed in writing.
- The grievance and appeal policies do not explicitly state THP will acknowledge grievances upon receipt; do not state that it will use the date an oral appeal was received as the earliest possible filing date; and do not state that legal representatives of a deceased enrollee's estate may be included as a party to the appeals process.
- The appeals resolution timeframes in member and provider materials are inconsistent and do not meet DHCF's requirement of 15 days. THP's provider manual also erred in communicating a 72 business hour deadline, instead of the required 72 hours or three days, for the resolution of expedited appeals. The MCO's member handbook indicated the resolution timeframe for appeals may be extended for 14 days rather than the DHCF permitted 5 days.

THP must revise its policies to reflect these requirements.

Conclusions

The MCOs have quality systems and procedures in place to promote high quality care with well-organized approaches to quality improvement. The MCOs' QAPI programs include annual planning, participation from providers and MCO leadership, and provide for ongoing assessment of quality improvement activities. Additionally, the MCOs operate structured care management and disease management programs to improve access to services for members and have systems in place to identify enrollees with special healthcare needs. All MCOs incorporate the use of evidence-based guidelines in provider contracts and utilization management decisions, and collect, monitor, and report data related to quality of care. Credentialing systems ensure that only qualified medical professionals are selected to provide care to enrollees. Pertinent provider information is obtained through member complaints, satisfaction surveys, utilization and member appeals, and quality initiatives to assess providers for recredentialing.

Members receive information regarding providers, hours of operations, and the availability of transportation and translation services through the Member Handbooks and Provider Directories. Materials are written in easily understood language and reading levels. Translation and TTD/TTY services are available free of charge to all members. Written materials are also available for members in prevalent non-English languages and in alternative formats for those with visual or hearing impairments.

An evaluation of the MCOs' operational systems relative to access found that all MCOs have procedures in place to conduct ongoing analyses of the adequacy of provider networks, both for primary and specialty care. Member utilization of services and geo-access reports are used to identify providers with open networks to ensure that adequate numbers of providers are available to meet the needs of the population. Network assessments include ratio of provider specialty to members, travel distance, appointment scheduling, and after-hours coverage.

The MCOs have policies and procedures in place that promote access to women's health services and services for children with special needs through direct access to specialists. Care coordination and disease management programs are aimed at identifying members with special needs, or those who are non-compliant with care, to provide additional assistance in accessing needed services and improving health status. All MCOs provide for in-network access to a specialist for a second opinion and out-of-network access if an appropriate in-network specialist is not available.

An evaluation of the MCOs' operational systems relative to timeliness found that all MCOs monitor authorization decisions for timeliness. Provisions are made for both standard and expedited requests. Turn-around time is measured and documented with results summarized and reported to the designated committees. The MCOs also demonstrate that there are policies and procedures in place to address timeliness of appeals decisions and notification of determinations to the member.

Overall MCO performance in 2014 met DHCF requirements. However, Delmarva identified several opportunities for improvement, most of which were in the areas of grievances and appeals. MCOs must review their policies and procedures and revise them as needed to align their processes to better serve their members and meet DHCF requirements.

Status of 2013 Recommendations

Status of Recommendations from CY 2013 for MCOs

Although each health plan is committed to delivering high quality care and services to its managed care members, opportunities exist for continued performance improvement. As a result of CY 2013 findings, MCOs were required to develop action plans to address any opportunities for improvement noted in the CY 2013 ATR. Pertinent recommendations and the status of the MCOs' action plans related to each area are described below.

AmeriHealth District of Columbia

All 2013 opportunities for improvement were appropriately addressed by AHDC including:

- Revising its QAPI program description to include submission of annual performance measure data and results to DHCF and the EQRO.
- Establishing goals for performance measures noted in its work plan once baseline data is available.
- Revising its policy on member rights to include notification to the member at least 30 days prior to the effective date of any change to policies related to member rights.
- Revising its policy on utilization management decision response time to include more detail relative to enrollee notification, expedited decision making, and extensions.
- Revising its disenrollment policy to reflect reasons for which it may not request member disenrollment, requirements for effective dates of disenrollment and automatic approval of disenrollment.

Health Services for Children with Special Needs

HSCSN met all requirements of a CY 2013 focused review on coordination of care. There were no opportunities to follow-up on.

MedStar Family Choice

All 2013 opportunities for improvement were appropriately addressed by MSFC including:

- Revising its policy on member materials to reflect notification requirements: upon enrollment, annually, and at least 30 days prior to the intended date of change.
- Revising its appeals related policies to not only include the member right to present evidence and allegation of fact or law in writing, but also in person.
- Revising member materials, including the Notice of Action Letter, to no longer imply the member is required to cover the cost of continued benefits during the appeals or fair hearing process which is prohibited by DHCF.
- Editing its case management policy to include the specialist provider role in the development of an enrollee's treatment plan.
- Revising its member disenrollment policy to reflect procedures it follows when a member request for disenrollment is made directly to DHCF.

Trusted Health Plan

THP addressed a number of 2013 opportunities for improvement including:

- Drafting a policy on member access and availability that outlines communication requirements for essential enrollee information such as rights, benefits, emergency and post-stabilization services, provider demographics and facilities.
- Creating a policy on advance directives that requires the MCO to provide adult enrollees with information that reflects changes in state law no later than 90 days after the effective date of change.
- Revising member and provider materials to reflect that enrollees will not be held liable for the MCO's debts in the event of the MCO's insolvency and to include a statement that prohibits the MCO from restricting a health care professional from advising or advocating on behalf of an enrollee, within the lawful scope of practice.
- Developing a policy on emergency and post-stabilization services that addressed all issues identified during the 2013 review, with the exception of one requirement: the MCO may not refuse to cover emergency services based on the failure of the emergency room provider or hospital to notify the enrollee's provider or MCO of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
- Revising its policy on clinical guidelines to state that guidelines are provided to enrollees and providers upon request.
- Revising materials to inform members that they have a right to present evidence in person or writing during the appeals process.
- Revising its policy on appeals to state that it will pay for services if the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.

- Revising its Continuous Quality Improvement Program Description to indicate that measurements and reporting will be completed in a reasonable period to allow for aggregation and reporting so as to produce new information annually.

However, THP did not address the following opportunities for improvement identified in 2013:

- Did not revise its Notice of Action Letter template to remove a statement that implies that the enrollee may be responsible for the cost of services during the appeal process. The District prohibits this recovery of payment in regard to the continuation of benefits during the appeal and fair hearing process.
- Did not revise the Member Handbook to explicitly state that providers must have the enrollee's written consent to file an appeal on their behalf. In another instance, Trusted revised the Member Handbook to explain that grievances may be filed either orally or in writing, according to requirements; but this revision was not included in Trusted's policy on grievances, which requires a written statement for grievances.
- Did not modify enrollee materials/notifications or policies to reflect MCOs are prohibited from recovering payment for the continuation of benefits during the appeals and fair hearing process.
- Did not address its appeal resolution timeline. Member and provider materials and the MCO policy reflect different resolution timelines, including 14, 15, and 30 day requirements, respectively. The District requires a 15 day resolution; however, the MCO may choose to hold itself to a higher standard. Additionally, a five day extension may be granted for appeals resolution; however, Trusted identified a 14 day extension in the Member Handbook.
- Did not make edits to its procedures for continuing enrollee benefits during an appeal or fair hearing to define specific requirements, such as being ordered by an authorized provider or until the enrollee withdraws the appeal.
- Did not indicate in the revised utilization management policy that the written notice of action for termination, suspension, or reduction of previously authorized services would be mailed at least 10 days before the date of action; it did not address an extension in the decision making process, in which enrollees have the right to file a grievance if they disagree with the decision to extend the time allowed for issuing an authorization decision; and it did not explicitly state that it will carry out determinations as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.
- Did not submit a revised policy on disenrollment that states that if DHCF fails to make a determination, in regard to a member's request for disenrollment, then the disenrollment is considered approved.

Status of Recommendations from CY 2013 for DHCF

The CY 2013 ATR noted that although DHCF had processes in place to monitor the quality of services provided to District residents, its Quality Strategy had not been updated to reflect planned initiatives to assure

that District residents receive high quality care that is accessible and timely. Delmarva recommended that DHCF update its Quality Strategy to include measureable goals for the managed care program.

The DHCF, Division of Quality and Health Outcomes, began making revisions to its Quality Strategy in 2014 to serve as a framework for evaluating and monitoring quality improvement activities for Medicaid managed care programs. Although the Quality Strategy has not been finalized, it is intended to assess the effectiveness of programs and services as they relate to health outcomes for District MCO enrollees.

In 2014, DHCF completed its first District of Columbia's Managed Care Quarterly Performance Report. Through this report, DHCF evaluates MCO performance across a number of domains including the health plans' financial condition, administrative performance, care management outcomes, trends in beneficiary utilization, and the MCOs' related medical care spending. DHCF anticipates that this quarterly performance evaluation will culminate in an annual report card on the performance of the District's MCOs.

2014 Opportunities for Improvement

Although the MCOs and the DHCF are committed to delivering high quality care and services to the District's Medicaid managed care enrollees, as a result of the CY 2014 evaluation activities and in the spirit of continuous quality improvement, Delmarva identified several opportunities for improvement. It is expected that the MCOs and DHCF will address these recommendations during CY 2015.

2014 Recommendations for MCOs

AmeriHealth District of Columbia

Although AHDC addressed and resolved all 2013 recommendations, the 2014 review identified one new opportunity.

- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.

Health Services for Children with Special Needs

Although there were no 2013 opportunities for HSCSN to follow-up on, the 2014 review identified three new opportunities.

- The MCO must make information on providers available to the enrollees upon enrollment and annually thereafter, and give enrollees reasonable notice of any changes regarding providers.

- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.*
- The MCO must furnish services timely.

MedStar Family Choice

Although MSFC addressed and resolved all 2013 recommendations, the 2014 review identified two new opportunities.

- The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and timeframes in a state-developed or state-approved description.
- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.*

Trusted Health Plan

Although THP addressed a number of 2013 opportunities for improvement, a number of opportunities remained unresolved. The 2014 review identified the following opportunities, many of which were continued from 2013.

- The MCO must inform enrollees about grievance and fair hearing procedures upon enrollment, annually, and at least 30 days prior to any change.
- The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and timeframes in a state-developed or state-approved description.
- The MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system.
- The MCO's grievance process must be timely.
- The MCO must maintain written requirements regarding the filing of a grievance.
- The MCO must adhere to the state's regulations regarding the content of the notice of action.
- The MCO's written notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered service must be mailed timely.
- The MCO must handle grievances and appeals according to regulations.
- The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within state-established timeframes.

* Subsequent to the 2014 review cycle, DHCF's Health Care Delivery Management Administration acknowledged that while federal and MCO contract language does not recognize "pre- and post-service appeals," the National Committee for Quality Assurance (NCQA) does acknowledge differences in the appeal types. The administration also recognizes that MCOs have interpreted contract language differently and plans to complete an internal review during 2015. Results of the review will include steps to provide clarification to MCOs. MCOs will not be required to develop an action plan to address this component.

- The MCO must notify any enrollee who has entered a grievance or appeal of the outcome of his or her case.
- The MCO must continue to provide benefits to the enrollee while the appeal and the state fair hearing are pending.
- The MCO may recover the cost of the services furnished to the enrollee while the appeal is pending if the final resolution of the appeal is adverse to the enrollee, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230.b. DHCF prohibits MCOs from recovering the cost of services in regard to the continuation of benefits.
- The MCO must furnish services timely.
- The MCO must cover and pay for emergency services and post-stabilization care services.
- The MCO must provide for timely disenrollment.
- The MCO must submit performance measurement data.

2014 Recommendations for DHCF

- Once baseline data are collected, DHCF should set specific performance goals for the selected quality measures for children and adults receiving Medicaid/CHIP services, regardless of whether a pay for performance initiative is implemented.
- To promote informed beneficiary choice, it is recommended that the MCO annual performance report card be made available to current and potential MCO enrollees both electronically and hard copy prior to the annual re-enrollment period.
- To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances.

2014 CAHPS Survey Results

Measure	MCO A	MCO B	MCO C	MCO D	District Average	District Average Compared to Benchmark
Adult Measures						
Customer Service Composite	85.0%	87.0%	87.0%	NA	86.3%	♦
Getting Needed Care Composite	78.0%	76.0%	76.0%	72.0%	75.5%	♦
Getting Care Quickly Composite	78.0%	79.0%	75.0%	73.0%	76.3%	♦
How Well Doctors Communicate Composite	92.0%	92.0%	93.0%	94.0%	92.8%	♦ ♦ ♦
Shared Decision Making Composite (A lot/Yes)	50.0%	56.6%	49.7%	NA	52.1%	♦ ♦
Health Promotion and Education Composite	76.0%	76.0%	75.0%	69.0%	74.0%	♦ ♦
Coordination of Care Composite	77.0%	80.0%	84.0%	NA	80.3%	♦ ♦
Rating of Health Plan (8+9+10)	72.0%	77.0%	74.0%	71.0%	73.5%	♦
Rating of All Health Care (8+9+10)	70.0%	75.0%	74.0%	64.0%	70.8%	♦
Rating of Personal Doctor (8+9+10)	81.0%	82.0%	83.0%	81.0%	81.8%	♦ ♦ ♦
Rating of Specialist Seen Most often (8+9+10)	79.0%	81.0%	79.0%	NA	79.7%	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	79.0%	53.0%	63.0%	NR	65.0%	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	42.0%	29.0%	31.0%	NR	34.0%	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	42.0%	25.0%	27.0%	NR	31.3%	♦

Measure	MCO A	MCO B	MCO C	MCO D	District Average	District Average Compared to Benchmark
Aspirin Use and Discussion - Take daily aspirin/every other day	21.0%	9.0%	20.0%	NR	16.7%	^
Aspirin Use and Discussion - Discussed risks and benefits of using aspirin	35.0%	25.0%	34.0%	NR	31.3%	^
Flu measure - Had flu shot or spray in the nose since July 1, 2013	35.0%	42.0%	33.0%	NR	36.7%	^
Child Measures (General Population)						
Customer Service Composite	88.0%	91.0%	85.0%	79.0%	85.8%	♦
Getting Needed Care Composite	86.0%	82.0%	75.0%	72.0%	78.8%	♦
Getting Care Quickly Composite	83.0%	90.0%	85.0%	78.0%	84.0%	♦
How Well Doctors Communicate Composite	92.0%	93.0%	92.0%	89.0%	91.5%	♦
Shared Decision Making	55.0%	66.6%	57.0%	NA	59.5%	♦ ♦ ♦
Health Promotion and Education Composite	76.0%	81.0%	77.0%	71.0%	76.3%	♦ ♦ ♦
Coordination of Care Composite	83.0%	88.0%	83.0%	NA	84.7%	♦ ♦ ♦
Rating of Health Plan (8+9+10)	86.0%	82.0%	79.0%	80.0%	81.8%	♦
Rating of All Health Care (8+9+10)	86.0%	85.0%	88.0%	84.0%	85.8%	♦ ♦
Rating of Personal Doctor (8+9+10)	92.0%	92.0%	90.0%	88.0%	90.5%	♦ ♦ ♦
Rating of Specialist Seen Most often (8+9+10)	85.0%	86.0%	88.0%	NA	86.3%	♦ ♦
Child has a regular dentist	87.0%	90.0%	76.0%	64.0%	79.3%	^
Child has seen regular dentist for a check-up or routine care in the last 6 months	89.0%	85.0%	79.0%	65.0%	79.5%	^

Measure	MCO A	MCO B	MCO C	MCO D	District Average	District Average Compared to Benchmark
How often child received dental appointments with regular dentist as soon as you wanted	82.0%	89.0%	81.0%	63.0%	78.8%	^
If child does not have a regular dentist, child still got a check-up or other routine dental care in the last 6 months	23.0%	47.0%	30.0%	35.0%	33.8%	^

HSCSN used the Children with Chronic Conditions (CCC) survey; however, their results are included in the General Population and are used in the calculation of the District Average.
NA - Responses were less than 100.
NR - The MCO did not report the rate or the rate was biased.
^ - National benchmark is not available.
♦ - The District Average is below the NCQA Quality Compass National Medicaid Average.
♦ ♦ - The District Average is equal to or exceeds the NCQA Quality Compass National Medicaid Average, but does not meet the 75th Percentile.
♦ ♦ ♦ - The District Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid.
MCOs are required to identify an Opportunities for Improvement (OFI) Action Plan for all CAHPS Survey measures not meeting or exceeding the NCQA Quality Compass 75th Percentile for Medicaid. Action plans will be approved and monitored by DHCF and Delmarva during 2015.