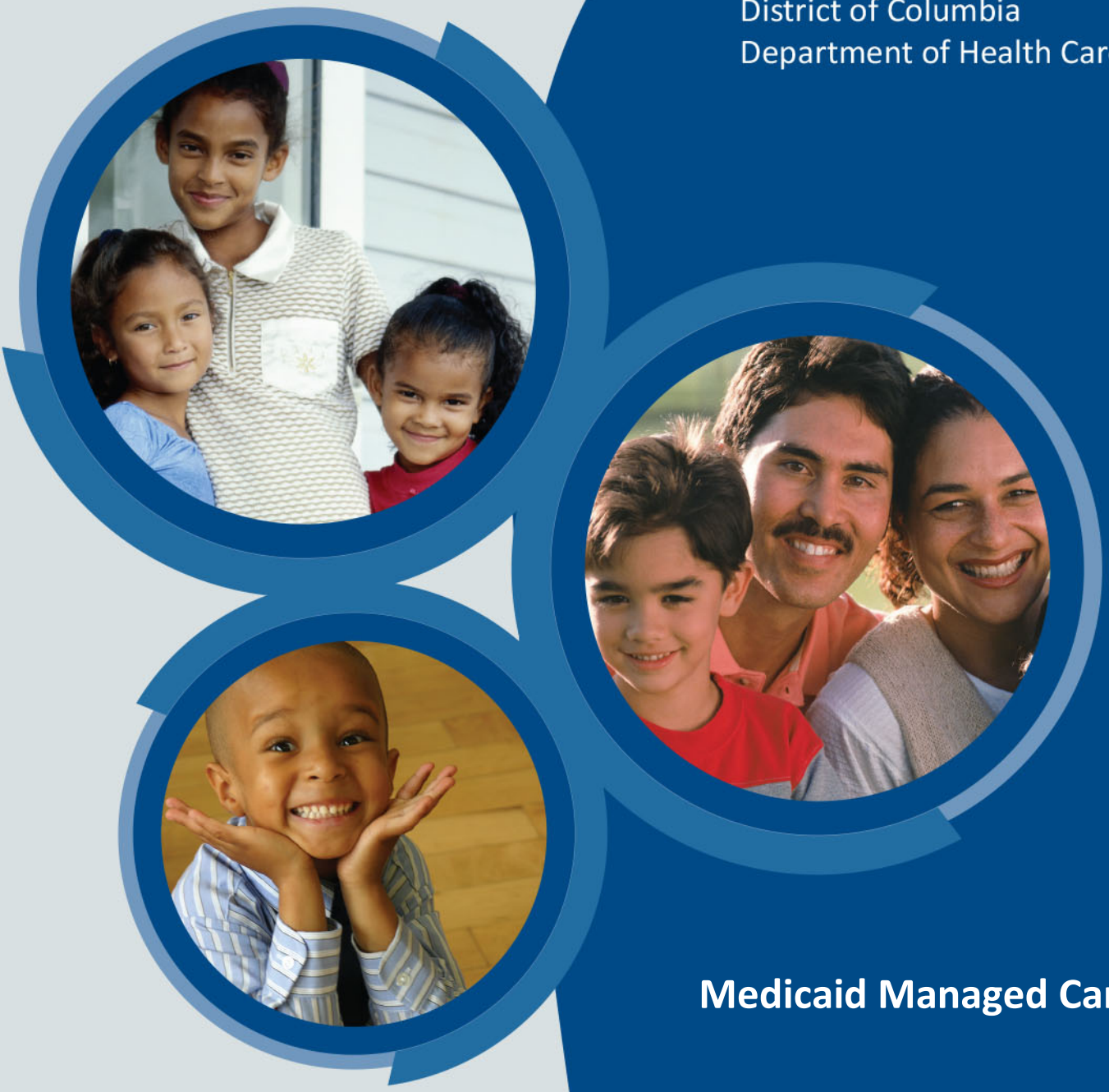
District of Columbia
Department of Health Care Finance



Medicaid Managed Care

2015 Annual Technical Report

Delmarva Foundation

A subsidieary of Quality Health Strategies

Submitted by:
Delmarva Foundation
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Table of Contents

District of Columbia - Department of Health Care Finance 2015 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 2015, approximately 180,237 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 began providing services to the District's Medicaid enrollees in July 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 Caritas District of Columbia (ACDC);
- Health Services for Children with Special Needs, Inc. (HSCSN);
- MedStar Family Choice (MFC); and
- Trusted Health Plan (THP).

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. To accomplish this, DHCF contractually requires 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 and maintain National Committee for Quality Assurance (NCQA) accreditation[4].

1 Health Services for Children with Special Needs, Inc. 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 (NCQ).
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.

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 MCO 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 to serve as the External Quality Review Organization (EQRO). This document is Delmarva Foundation's report to DHCF on the quality and timeliness of, and access to healthcare services provided to the District's Medicaid MCOs during the period from January 1, 2015 through December 31, 2015.

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 mandatory activities to assess managed care performance:

1) A review conducted within the previous three year period to determine MCO compliance with standards established by the State to comply with the requirements of 42 CFR § 438.204(g), as well as applicable elements of the MCOs' contracts.
2) Validation of State-required performance measures.
3) Validation of State-required performance improvement projects that were underway during the previous 12 months.

As the EQRO, Delmarva Foundation conducted each of the required activities in a manner consistent with the CMS protocols.

A comprehensive MCO Operational Systems Review (OSR) was conducted in 2014. Therefore, DHCF elected to have the 2015 external quality review (EQR) compliance review activities focus on evaluating the MCOs' Quality Assessment and Performance Improvement (QAPI) programs, case management procedures and documentation specific to services for pregnant women and children with asthma, and actions undertaken by the MCOs to address areas of non-compliance and recommendations for improvement from the 2014 findings.

In addition to the mandatory review activities, Delmarva Foundation conducted an analysis of MCOs' reported HEDIS and CAHPS measures, as well as an assessment of DHCF's progress in meeting its managed care Quality Strategy goals.

[5] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Information from these activities is aggregated and used to develop the Annual Technical Report (ATR) addressing the quality of, access to, and timeliness of services provided to Medicaid managed care enrollees in the District of Columbia. In aggregating and analyzing the data, Delmarva Foundation allocated standards and/or measures from each activity to domains indicative of quality, access, or timeliness to care and services.

Quality Findings

DHCF Quality Strategy

DHCF's Quality Strategy reflects both current and planned activities aimed at improving healthcare services and outcomes for Medicaid managed care enrollees. The Quality Strategy includes three broad goals:

1) Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members.
2) Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services.
3) Establish greater control and predictability over the District's spending on health care.

Beginning in FY 2014, in its efforts to achieve these goals, DHCF developed a proactive approach to early identification of areas for concern through quarterly monitoring and reporting of MCO performance. As a result of these efforts, DHCF published its first Annual Managed Care Performance Report Card in April 2015.[6] Report Card results identify satisfactory assessments for the following areas: financial condition, administrative performance, and utilization of physician care. Overall, care coordination is the biggest opportunity for improvement—including managing low acuity emergency department (ED) utilization, avoidable hospital admissions, and reducing hospital readmissions. To further quality improvement efforts on the part of the MCOs, DHCF plans to incentivize MCOs beginning in FY 2016 by implementing a pay-for-performance program.

In addition to the established Report Card measures, DHCF requires all MCOs to collect and submit annual audited HEDIS and CAHPS performance measures. DHCF has set performance goals for these measures at the national Medicaid 75th percentiles. However, for measurement year (MY) 2014 MCOs failed to meet the desired threshold for most HEDIS and CAHPS measures.

[6] District of Columbia's Managed Care Program End-of Year Performance Report Card; Contract Year 1 July 2013 – June 2014; Retrieved Nov. 12, 2015 from http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%20Program%20End-of%20Year%20Performance%20Report%20Card%20-%20DHCF.pdf

Quality Assessment and Performance Improvement Programs

The MCOs operate strong QAPI programs. Quality Program Descriptions and Work Plans are updated annually based on priority initiatives. The MCOs engage providers in quality program management and oversight. Performance is monitored via collaborative PIPs, HEDIS, CAHPS survey, provider satisfaction, NCQA, and EQRO findings. Quality teams are multidisciplinary and collaborate and prioritize to meet the needs of the membership.

Case Management

The MCOs operate case management programs that aim to engage complex and at risk members and to actively manage their care. Efforts are made to coordinate access to services and assist in the facilitation of appropriate and timely care and services. Additionally, goals include bringing noncompliant members into care and promoting self-management. Consistent with the collaborative PIPs, case managers attempt to identify high risk pregnant members as early as possible to coordinate appropriate prenatal care in an effort to reduce adverse perinatal and birth outcomes. Pediatric members are also engaged in case management to improve medication compliance and reduce ED utilization and inpatient admissions.

Performance Improvement Projects

The MCOs submitted methodologically sound PIPs for both collaborative projects: Improving Perinatal and Birth Outcomes and Pediatric Asthma. The submissions included thorough barrier analyses and interventions that directly target specific member, provider, and MCO barriers. Results were accurately and clearly presented, and baseline measurements were compared to internal goals and/or benchmarks when available. Delmarva Foundation recommends that MCOs continue with the current interventions in an effort to improve PIP performance. MCOs should collaborate with DHCF and each other on ways to improve the provider completion, return, and utilization of the OB Authorization/Assessment Form. Additionally, the MCOs should work with the collaborative work group to identify goals for the PIPs. Lastly, performance measure results should be monitored on a regular basis to ensure the interventions are achieving the desired impact.

MCO performance compared favorably to national and District-wide March of Dimes benchmarks for the Improving Perinatal and Birth Outcomes PIP. However, lack of documentation for HIV testing presented itself as an opportunity for improvement. The MCO weighted average for the No Maternal HIV Testing measure was 60.10%. In regard to the Pediatric Asthma PIP, results indicated that ED and inpatient hospital utilization was highest among children in the 2-4 years of age category. Appropriate medications were prescribed for 78.00% of members; however, only 59.29% were compliant with medication use for at least half of the prescribed period of treatment.

Performance Measure Validation

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. Although MCOs initially showed inconsistencies in interpretation of denominator specifications for the Perinatal and Birth Outcomes indicators, algorithmic compliance was eventually achieved by all MCOs after clarification from the auditor and DHCF. All measure indicators and final rates were deemed reportable for both collaborative PIPs.

HEDIS and CAHPS Performance Measures

The MCO weighted averages for the Comprehensive Diabetes Care indicators were below the national Medicaid averages. Results were similar for the Controlling High Blood Pressure performance measure. Based on the MCO averages, performance for all quality related CAHPS measures was below the 75th percentile benchmarks. Quality of care and services were scored higher for children. The following child survey measure results exceeded the national 75th percentile:

- Health Promotion and Education Composite
- Coordination of Care Composite
- Ration of Personal Doctor (8+9+10)

Access Findings

HEDIS and CAHPS Performance Measures

The MCOs had mixed results in child and adult access related measures. The District weighted average did not meet the Medicaid national average in adult and young children's access, as well as in childhood immunization measures. The District weighted average exceeded the Medicaid average in adolescent access, adolescent immunizations, and annual dental visits measures. The District MCO average exceeded the 75th percentile in lead screening, well-child visits (3-6 years of age), and adolescent well care measures.

In regard to member surveys, the MCO weighted average fell below the Medicaid national average in Getting Needed Care for both adults and children.

The District's MCOs must continue to focus on improving access to care for adults and children. Improved access can reduce emergency department utilization, improve or stabilize chronic conditions, and prevent childhood illness and associated complications.

Timeliness Findings

HEDIS and CAHPS Performance Measures

HEDIS measures for Timeliness of Prenatal Care and the Frequency of Ongoing Prenatal Care fell short of the national Medicaid averages. CAHPS results for satisfaction with Getting Care Quickly also did not meet the national averages. These measures present as opportunities for improvement.

Status of 2014 Recommendations

As a result of the 2014 review activities, several recommendations for improvement were made to the MCOs. The MCOs were expected to act on the recommendations during 2015. The MCOs developed and implemented Opportunities for Improvement Action Plans to address all 2014 recommendations. DHCF also addressed recommendations with one exception—the District did not provide separate and distinct definitions for member complaints and grievances. Delmarva Foundation continues to make this recommendation.

2015 MCO Opportunities for Improvement

Although each MCO is committed to delivering high quality care and services to its managed care members, opportunities exist for continued performance improvement. Delmarva Foundation recommends that all MCOs focus on improving performance for all PIP collaborative measures and all HEDIS and CAHPS measures that are not meeting the 75th percentile benchmark. Based on 2015 assessments, Delmarva Foundation developed the following MCO specific recommendations:

AmeriHealth Caritas District of Columbia

- The MCO should explore options for identifying HIV testing—specifically identifying the pregnancy profile blood test—so the organization can more accurately assess its compliance with testing. This is a critical component of the collaborative PIP and it is important for Case Managers to be aware of HIV positive members so they are able to monitor treatment.
- ACDC Case Managers should routinely monitor medication compliance in an effort to improve member self-management.

Health Services for Children with Special Needs, Inc.

- HSCSN's Case Managers should improve monitoring of and member compliance with postpartum visits.
- Case Managers should routinely monitor medication compliance and promote member self-management.

MedStar Family Choice

- MFC should include an explicit statement in its Continuous Quality Improvement Plan that addresses confidentiality and privacy and provide reference to the MCO's collection of privacy policies.
- To better demonstrate evidence of provider compliance in submitting the OB Authorization/Assessment Forms (PIP collaborative intervention), MFC should scan and save the documents rather than destroying the forms after extracting necessary information.

Trusted Health Plan

- Provide evidence of monitoring racial, socioeconomic, and ethnic disparities in health care utilization and in health outcomes and make efforts to reduce such disparities.
- Revise the Continuous Quality Improvement Program Description and provide explicit language to assure compliance with the requirement that the Chief Quality Officer is accountable for the continuous quality improvement activities for the MCO's own providers, as well as the subcontracted providers.
- Revise the Continuous Quality Improvement Program Description and provide explicit language to assure compliance with the requirement that the Chief Quality Officer must participate in monthly Continuous Quality Improvement meetings with DHCF and the EQRO.
- THP's Case Managers should improve monitoring of and member compliance with postpartum visits.
- THP should explore opportunities to more effectively obtain and track birth outcomes, such as birth weight and gestational age. These outcomes are critical components of the Improving Perinatal and Birth Outcomes PIP.
- THP Case Managers should ensure that all pediatric members with asthma that have a history of high utilization are contacted for case management services and no member meeting criteria "slips through the cracks."

2015 DHCF Recommendations

Considering all the results for measures of quality, access, and timeliness of care for the contracted MCOs, Delmarva Foundation developed the following recommendations for DHCF:

- Develop performance improvement goals for PIP collaborative performance measures. This will improve MCO accountability and engagement in collaborative efforts.
- Although DHCF set a performance goal at the 75th percentile for all HEDIS and CAHPS measures, Delmarva Foundation recommends that DHCF also set minimum performance goals for the MCOs on select HEDIS and CAHPS measures. Failure to meet these minimum performance levels may result in formal corrective action plans.
- Based on case management review findings and HEDIS performance measure results, add the Timeliness of Prenatal Care and Postpartum Care measures to the Improving Perinatal and Birth Outcomes Collaborative PIP. The District weighted averages for both measures fail to meet national Medicaid average.

- MCOs are all working to improve data collection for the Maternal HIV Testing measure. While it is important that MCOs improve data collection to accurately assess compliance, the ultimate goal should be to identify HIV positive members and ensure they are obtaining treatment to reduce risk of transmission to their unborn babies. DHCF should consider requiring MCOs initiate at least one intervention that aims to improve member awareness and understanding of one's HIV status and steps that can be taken to treat HIV positive members and reduce transmission.
- Determine if the District will allow MCOs to define and process appeals in a pre- and post-service manner with different resolution timeframe requirements. Some MCOs do not process "post-service" appeals according to the District's 15 day requirement.
- To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances.

District of Columbia Department of Health Care Finance 2015 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 October 2015, approximately 180,237 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)[7]. 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:

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- MedStar Family Choice (MFC); and
- Trusted Health Plan (THP).

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. To accomplish this, DHCF contractually requires 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®)[8] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[9] data; and
- Attain and maintain National Committee for Quality Assurance (NCQA) accreditation[10].

As noted, DHCF requires NCQA accreditation for the MCOs providing services to managed care enrollees. NCQA health plan accreditation includes two major components—an evaluation of the health plan's structure and processes to maintain and improve quality and an evaluation of the health plan's process and outcome measures related to clinical care (HEDIS) and member satisfaction (CAHPS). NCQA accreditation has been widely recognized by federal and state regulators as the gold standard for health plan operations. Information from the NCQA accreditation activities is often used to augment state strategies for assessing

[7] Health Services for Children with Special Needs, Inc. is the District's contractor for the CASSIP. It serves Supplemental Security Income eligible Medicaid members age 0-26 years.
[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[10] HSCSN is excluded from this requirement; however, it does maintain NCQA certification in Utilization Management.

health plan performance. Table 1 provides a brief overview of the contracted MCOs, including accreditation status.

Table 1. MCO Profiles

Health Plan	Medicaid Enrollment (as of Dec. 2015)	Accreditation Status
AmeriHealth Caritas District of Columbia	102,763	NCQA Health Plan Accreditation[11] - expires 12/8/18
Health Services for Children with Special Needs, Inc.	5,754	NCQA Certification[12] for Utilization Management - expires 4/13/17 (next scheduled review 1/17/17)
MedStar Family Choice	41,461	NCQA Health Plan Accreditation - expires 4/20/18
Trusted Health Plan	30,259	NCQA Health Plan Accreditation - expires 3/1/19

Purpose

Federal regulations (42 CFR Part 438 Subpart E) require that states contracting with managed care plans ensure that organizations, independent of the Medicaid agency and the managed care plans, perform an annual external review of the quality, timeliness, and access to health care services furnished by the MCOs. The Centers for Medicare and Medicaid Services (CMS) developed External Quality Review Organization (EQRO) Protocols[13] that describe procedures for conducting mandatory and optional activities to assess MCO performance. These protocols specify three mandatory activities that must be conducted to assess MCO performance. Mandatory activities include:

1) A review conducted within the previous three year period to determine MCO compliance with standards established by the State to comply with the requirements of 42 CFR § 438.204(g), as well as applicable elements of the MCOs' contracts. This activity is known as the Operational Systems Review (OSR) in the District.
2) Validation of State-required performance measures—known as the Performance Measure Validation (PMV) audit.
3) Validation of State-required performance improvement projects that were underway during the previous 12 months—known as the Performance Improvement Project (PIP) review.

[11] NCQA awards an accreditation status of Accredited to organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement.
[12] 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.
[13] The updated EQR Protocols are available for download at: https://www.cms.gov/Regulations-and Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html

To ensure that MCOs provide care and services that meet acceptable standards for quality, access, and timeliness, DHCF contracts with Delmarva Foundation to serve as the EQRO.

Federal requirements at 42 CFR § 438.202(a) also state 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." The DHCF, Division of Quality and Health Outcomes, is responsible for developing the framework for evaluating and monitoring the effectiveness of programs and services as they relate to improved health outcomes for the District's Medicaid MCO enrollees.

In addition, 42 CFR § 438.364 states that the EQRO must produce a detailed technical report that describes the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the MCOs and PIHPs. This document is Delmarva Foundation's report to DHCF on the quality and timeliness of, and access to healthcare services provided to DC Medicaid enrollees by MCOs for the period from January 1, 2015 through December 31, 2015.

Methodology

Operational Systems Review

The purpose of the OSR is to assess MCO performance against federal regulations and DHCF contractual requirements. In 2014, a comprehensive review of these requirements was conducted, including standards established by DHCF to comply with the requirements of 42 CFR § 438 Subpart C - Enrollee Rights (ER) and Protections; Subpart D - Quality Assessment and Performance Improvement (QAPI); and Subpart F - Grievance Systems (GS) as well as applicable elements of the MCOs' contracts with DHCF. The MCOs were responsible for addressing any recommendations or opportunities for improvement (OFIs) made by the EQRO as a result of the 2014 review.

In 2015, Delmarva Foundation conducted focused reviews of MCOs' structure and operations. Key areas of focus included:

- MCO contractual compliance with requirements for QAPI Plans. Standards for quality, access, and timeliness of care require that MCOs monitor services to ensure that enrollees receive the benefits and services to which they are entitled. The QAPI Plan requirements include specifications for the development of continuous quality improvement plans to ensure the delivery of high quality health care and customer service; health information systems capable of capturing MCO performance data (e.g. immunization rates, preventive screening rates) that can be used to improve the quality of services provided to enrollees; experienced and qualified quality improvement staff to conduct quality of care studies and other activities; and on-going monitoring of critical incidents and sentinel events.

- MCO Case Management procedures and documentation specific to services for pregnant women and children with asthma.
- MCO actions taken to address OFIs from 2014.

The annual structure and operational systems review is conducted in accordance with the EQRO Protocol, *Assessment of Compliance with Medicaid Managed Care Regulations,* using a systematic approach consisting of pre-site, on-site, and post-site activities. Standards used to assess compliance are developed based on Federal and contractual requirements.

Prior to the on-site visits, Delmarva Foundation 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 on-site visits. The pre-site document review gives the review team an opportunity to discuss MCO procedures and to develop questions necessary to clarify findings. This allows the review team to focus on MCO personnel interviews and observation of operational procedures while on-site.

An intensive on-site visit was conducted at each MCO during October and November 2015 to interview MCO representatives and to observe the manner in which the MCOs implemented written policies and procedures. The audit also included a concentrated case management file review. The review activities were conducted by a team of healthcare professionals with experience in managed care and quality improvement systems.

Upon completion of the OSR, the Delmarva Foundation team 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. Delmarva Foundation rates the level of compliance for each element and component with a review determination of met, partially met, or unmet as follows:

1) Met – All required components and/or elements of a standard are fully met.
2) Partially Met – Some, but not all, required components and/or elements of the standard are met.
3) Unmet – None of the required components and/or elements of the standard have been met.
4) 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 Foundation 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 Foundation 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 Foundation reviews any additional materials submitted by the MCO and monitors implementation of the OFI Action Plan at the discretion of the Department. MCO noncompliance may result in a formal request for a Corrective Action Plan, which would also be monitored by DHCF and Delmarva Foundation.

Performance Improvement Project Review

Delmarva Foundation's PIP review methodology is based upon 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.

The MCOs are 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. The MCOs are required to provide updates on the progress of their PIPs in July of each year. The annual 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 PIPs, 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 Foundation.

Delmarva Foundation'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 Foundation 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 Foundation validated the MCOs' collaborative PIPs: (1) Improving Perinatal and Birth Outcomes and (2) Pediatric Asthma. The MCO annual PIP reports submitted in 2015 reported baseline performance (measurement year (MY) 2014 data). Performance measures for each PIP are identified below.

Improving Perinatal and Birth Outcomes

- The number of neonates delivered during the measurement year with birth weight <2,500 grams.

- The number of neonates delivered during the measurement year with gestational age of less than 37 weeks.
- The number of women who did not receive an HIV test during the pregnancy prior to giving birth.
- The number of pregnancies ending in miscarriage or fetal loss (early or late).
- The number of pregnancies during the measurement year for which the birth outcome is unknown.
- The rate of adverse perinatal outcomes.
- The number of infant deaths (age 0-365 days) due to any cause during the measurement year.

Pediatric Asthma

- The number of children in the eligible population, ages 2-20, who had one or more emergency department (ED) visits with a principle diagnosis of asthma during the measurement year.
- The number of children in the eligible population, ages 2-20, 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 2-20, which were appropriately prescribed asthma medication during the measurement year.
- Medication management for people with asthma—the number of members in the eligible population, ages 2-20, who were dispensed appropriate asthma controller medications that they remained on during the treatment period during the measurement year. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
- Medication management for people with asthma—the number of members in the eligible population, ages 2-20, who were dispensed appropriate asthma controller medications that they remained on during the treatment period during the measurement year. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Performance Measure Validation

The validation of performance measures activity is conducted in accordance with the EQRO Protocol, *Validation of Measures Reported by MCOs*, using a systematic approach consisting of pre-site, on-site, and post-site activities. There are two primary objectives associated with the validation process:

1) To evaluate the accuracy of the performance measures reported by the MCO and
2) To determine the extent to which the MCO followed the specifications required by the District for calculating the performance measures.

Key validation activities include:

- Review of data systems and processes used by the MCO to construct the measure rates;
- Assessment of the calculated rates for algorithmic compliance to defined specifications; and
- Verification that the reported rates are based on accurate sources of information.

Pre-Site Review

The validation process begins with a conference call between the audit team, MCOs, and DHCF to confirm the measures and specifications to be used in the audit. Next, each MCO completes and submits its Information Systems Capabilities Assessment (ISCA), which describes the MCO's data systems for collecting valid, accurate data, and then calculating and reporting quality improvement data. The auditors evaluate the information in the ISCA for consistency with findings reported in previous assessments of the MCO's systems, and a site visit date is set. A tentative agenda is developed and a summary of ISCA issues is compiled.

On-Site Review

The validation team conducts an on-site visit to the MCO to investigate any potential issues identified through review of the ISCA document and to observe the systems and procedures used by the MCO to collect and produce measure data. The members of the validation team hold an entrance meeting with the MCO staff to describe the validation purpose, scope, necessary documentation, and to identify staff to be interviewed. These staff interviews provide insight into the accuracy and reliability of the reporting processes by allowing the health plan to clarify and provide more detail on any issues identified through the auditor's review of the ISCA.

During the on-site visit, the auditors review the information systems structure, protocols and procedures, and measure specific data collection methods. A preliminary review of the source code the MCO intends to use to produce the measures is also conducted. At the conclusion of these activities, the auditor meets with the MCO staff to review preliminary findings, request additional documentation if necessary, and provide guidance on areas requiring action.

Post-Site Review

Following the on-site visit, any action items are forwarded to the MCO in the form of a preliminary validation report. The MCO must demonstrate that it has the automated systems, information management practices, and data control procedures needed to ensure that all information required for performance measures reporting is adequately captured, translated, stored, analyzed, and reported. All outstanding issues must be resolved prior to the MCO calculating its final performance measures rates. A review and approval of the final source code is performed prior to the MCO calculating its final rates.

A final validation report is produced detailing MCO performance against information systems standards and measure specifications. Standards are assigned designations: Fully Compliant, Substantially Compliant, Not Valid, or Not Applicable to the MCO's measures. A final measure designation is assigned—Reportable or Not Reportable.

DHCF contracts with Delmarva Foundation to validate the accuracy and reliability of the MCOs' performance measures reported in conjunction with its mandated performance improvement projects (PIPs), *Improving Perinatal and Birth Outcomes* and *Pediatric Asthma.*

HEDIS and CAHPS Performance Measures

HEDIS and CAHPS measures have become an invaluable evaluation tool used by over 90% of health plans nationally. Because the District requires MCOs to report HEDIS and CAHPS measures and many health plans across the nation collect this data, it is possible to compare health plan performance among DHCF contracted health plans as well as to national Medicaid benchmarks.

HEDIS measures are designed to provide information to reliably compare the performance of health care plans across a wide array of clinical health care measures. These measures focus heavily on areas such as prenatal and postpartum care, child health preventive care such as well child visits and immunizations, management of chronic diseases, and access to care. CAHPS measures specifically address consumers' satisfaction and experience with Medicaid providers and systems of care. These measures can provide DHCF with data to comprehensively assess MCO performance in the areas of quality, access, and timeliness of healthcare services.

The District's contracted MCOs are required to submit validated results of their HEDIS and CAHPS measures to DHCF and Delmarva Foundation. To avoid duplicative efforts, Delmarva Foundation does not re-validate these measures, but does review the audit findings and uses MCO reported rates for the HEDIS and CAHPS measures in its analysis of MCO performance.

The full set of reported HEDIS and CAHPS rates can be found in Appendices 1 and 2.

Aggregation and Analysis of Results

Findings from the mandatory activities conducted by Delmarva Foundation, as well as the MCOs' HEDIS and CAHPS measures, are aggregated and analyzed by Delmarva Foundation to provide a comprehensive evaluation of the MCOs' performance. Information obtained through the EQR activities was aggregated and analyzed to assess MCO performance in the areas of quality, access, and timeliness of services. In aggregating and analyzing the data, Delmarva Foundation allocated standards and/or measures from each activity to domains indicative of quality, access, or timeliness to care and services. Delmarva Foundation has adopted the following definitions for quality, access, and timeliness in performing the 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 2015 Health Plan Standards and Guidelines*).

- **Timeliness**, the Institute of Medicine defines timeliness as "reducing waits and sometimes harmful delays" and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in physicians' offices or emergency rooms and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

Findings are compared across MCOs, to the District-wide weighted average, and to national Medicaid benchmarks where available.

Quality Findings

Quality, as it pertains to external quality review, is defined as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes for its enrollees (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Center for Medicare & Medicaid Services [CMS]).

This assessment of quality encompasses key areas of MCO operations likely to impact enrollee health outcomes, care delivery, and the experience of receiving care. Therefore, the quality domain focuses on MCO QAPI and Case Management programs, PIP initiatives, and HEDIS and CAHPS results indicative of quality systems. In addition, Delmarva Foundation assessed whether DHCF achieved its strategic goals pertinent to the managed care program. Delmarva Foundation also conducted an analysis of the MCOs' progress in resolving operational issues that were identified as opportunities for improvement from the prior year's structure and operational systems compliance review activities.

DHCF Quality Strategy

In addition to requirements that MCOs have quality programs in place, Federal requirements at 42 CFR § 438.202(a) state 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." The DHCF Division of Quality and Health Outcomes is responsible for developing the framework for evaluating and monitoring the effectiveness of programs and services as they relate to improved health outcomes for the District's Medicaid MCO enrollees.

DHCF's Quality Strategy reflects both current and planned activities aimed at improving healthcare services and outcomes for Medicaid managed care enrollees. The Quality Strategy includes three broad goals:

1) Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members.
2) Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services.
3) Establish greater control and predictability over the District's spending on health care.

Beginning in FY 2014, in its efforts to achieve these goals, DHCF developed a proactive approach to early identification of areas for concern through quarterly monitoring and reporting of MCO performance on:

- Financial condition
- Administrative performance
- Case management outcomes
- Network adequacy

- Enrollee utilization of health plan services
- Medical care expenditures and loss ratios

As a result of these efforts, DHCF published its first Annual Managed Care Performance Report Card in April 2015. Report Card results identify satisfactory assessments for the following areas: financial condition, administrative performance, and utilization of physician care. Overall, care coordination is the biggest opportunity for improvement—including managing low acuity ED utilization, avoidable hospital admissions, and reducing hospital readmissions.

To further quality improvement efforts on the part of the MCOs, DHCF plans to incentivize MCOs beginning in FY 2016 by implementing a pay-for-performance program. Performance measures will be based on existing measures currently collected for the quarterly MCO monitoring. As indicated, care coordination requires significant improvement.

In addition to the established Report Card measures, DHCF requires all MCOs to collect and submit annual audited HEDIS and CAHPS performance measures. DHCF has set performance goals for these measures at the National Medicaid 75th percentiles. However, MY 2014 reported rates show that the District weighted average was below the 75th percentile for nearly all HEDIS and CAHPS measures.

Quality Assessment and Performance Improvement Programs

42 CFR § 438 Subpart D, Quality Assessment and Performance Improvement, sets forth MCO specifications for quality strategies to ensure the delivery of high quality health care and customer service. At a minimum the QAPI must demonstrate compliance with basic requirements for administrative structure and operations that promote quality of care. The organizational structure of the QAPI must identify accountability within the organization for monitoring, evaluating, and making improvements to care and health outcomes for the MCO's members. Appropriate professionals must be designated for QAPI program oversight with ultimate accountability of the program to the MCO governing body. The governing body must be kept apprised of the QAPI activities through regular written reports and an annual comprehensive evaluation of the program.

The MCO contractual QAPI requirements include specifications for the development of continuous quality improvement plans to ensure the delivery of high quality health care and customer service; health information systems capable of capturing MCO performance data (e.g. immunization rates, preventive screening rate) that can be used to improve the quality of services provided to enrollees; experienced and qualified quality improvement staff to conduct quality of care studies and other activities; and on-going monitoring of critical incidents and sentinel events. There must be written procedures in place for remedial action whenever substandard care or services are provided or when care or services that should have been provided, were not. The MCO must monitor the effectiveness of any remedial action.

AmeriHealth Caritas District of Columbia

ACDC was compliant with all QAPI Plan requirements. The MCO maintains a QAPI Program Description that is updated annually and identifies priority initiatives. The MCO participates in collaborative PIPs and collects and reports on a variety of performance measures. ACDC focuses on chronic diseases and members who are assessed as being high risk for utilization of services. Furthermore, the MCO has various ongoing clinical initiatives related to childhood immunizations, obesity in children and adults, hypertension, and diabetes. On an annual basis, the MCO assesses in initiatives for effectiveness as ACDC aims to drive improvement. Barriers, quality of care, and utilization of services are assessed and results are reported in the annual QAPI Program Evaluation. ACDC maintains a Quality Management Department that consists of clinical, quality improvement, and community health staff that is sufficient to meet the goals and objectives of the QAPI Program.

Health Services for Children with Special Needs, Inc.

HSCSN was compliant with all QAPI Plan requirements. The CASSIP's QAPI Program Description requires the organization to analyze performance measures and survey results to improve health care quality. The program aims to ensure quality of care; provide service and access in a timely, appropriate, and cost effective manner; and to improve the health status of the members. HSCSN monitors effectiveness throughout the year using various performance measure results such as collaborative PIPs, HEDIS, CAHPS survey, provider satisfaction survey, NCQA, and EQRO findings. Results are reported in its annual QAPI Program Evaluation. HSCSN maintains a Quality and Accreditation Department that consists of clinical, quality improvement, and analytic staff that work together to meet the goals and objectives of the QAPI Program.

MedStar Family Choice

MFC was compliant with all QAPI Plan requirements. The MCO's Quality Improvement (QI) Plan identifies health care quality goals and objectives and priority initiatives for improving MCO performance. MFC strives to provide the highest quality of care compared to District and national benchmarks. The MCO also aims to monitor and improve health care quality based on a review and analysis of HEDIS, CAHPS, collaborative PIPs, and other performance measures. MFC annually reports results of its initiatives and performance measures in its QI Appraisal. Furthermore, the evaluation includes goals for the next annual year. The MCO maintains a QI Department comprised of clinical, analytical, quality improvement, compliance, among other supporting staff, that meet program requirements.

Trusted Health Plan

THP was compliant with most QAPI Plan requirements. The MCO's Continuous Quality Improvement (CQI) Program Description is used to facilitate a coordinated, multidisciplinary approach to objectively and systematically monitor and evaluate the quality, appropriateness, and outcomes of medical care and services and the processes by which they are delivered to members. THP measures and monitors collaborative PIPs, HEDIS, CAHPS survey, and other relevant performance measure results. The MCO aims to improve health care quality within the District of Columbia and meet and exceed national 75th percentile benchmarks. The

results of quality initiatives and performance are reported in the MCO's annual QI Program Evaluation. The THP QI Department consists of clinical, quality improvement, and compliance staff that work together to meet the needs of the program.

THP's opportunities for improvement include (1) monitoring and reporting on racial, socioeconomic, and ethnic disparities in health care utilization and (2) providing more explicit Chief Quality Officer responsibilities including accountability for CQI activities for providers and participation in monthly CQI meetings with DHCF and the EQRO.

Case Management

The Case Management Society of America defines case management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes." The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner. The optimal case management environment allows direct communication between the case manager, the enrollee, and appropriate service personnel. Timely and appropriate case management of the District's managed care enrollees can potentially improve timeliness and access to primary preventive services, improve health outcomes for people with chronic conditions, decrease costs associated with inappropriate utilization of ED visits and readmissions to acute hospitals.

Delmarva Foundation conducted a case management review that focused on members participating in active case management for high risk pregnancy and pediatric asthma to be consistent with the quality focus of the collaborative PIPs. A total of 60 files were reviewed for each MCO—30 for each area of study. Based on the specific PIP performance measures and the uniqueness of each MCO's case management procedures and systems, results were largely qualitative rather than quantitative.

Perinatal and Birth Outcomes Case Management File Review

The high risk pregnancy case management file review concentrated on assessing whether or not MCOs are receiving an Obstetrics (OB) Authorization/Assessment Form from providers, which is the collaborative intervention in which all MCOs are aiming to improve performance. Not only do the forms provide notification of pregnant members, but providers also complete an initial assessment in which the MCOs are able to gain valuable insight into possible risks for the women. The earlier an MCO receives notification of a pregnant member, the sooner the organization can reach out and engage the member in critical case management activities with the goal of reducing adverse perinatal events and birth outcomes. The case management file review also assessed these adverse events and outcomes. Results are documented in Table 3.

Table 3. Perinatal and Birth Outcomes Case Management File Review

Perinatal and Birth Outcomes Case Management File Review+				
Element	ACDC %	HSCSN %	MFC %	THP %
Obstetrical Assessment Forms received from providers (collaborative intervention).	60	70	*	80
Evidence of a care plan	100	89	87	95
Birth outcome: low birth weight (<2,500 grams)	17	20	30	25
Birth outcome: <37 weeks gestational age	17	33	17	25
Birth outcome: No evidence of an HIV test	97	6	3	20
Birth outcome: Pregnancies ending in miscarriage or fetal loss	0	3	6	0
Birth outcome: Infant deaths (0-365 days)	0	0	0	0
Member participation in prenatal care	87	93	100	80

* The MFC Case Manager's process was to extract necessary information from the forms and then destroy the forms. Therefore, form receipt cannot accurately be assessed. MFC agreed to change the practice and will scan and save the forms electronically.
+ A total of 30 files were reviewed for each MCO.

All MCOs should continue efforts to engage high risk pregnant members in case management activities. ACDC should explore options for identifying HIV testing—specifically identify the pregnancy profile blood test since the MCO reports that the profile captures the HIV testing. While postpartum visit results are not displayed in Table 3 due to a lag in claims at the time of the file review, it was clear that HSCSN and THP both had an opportunity for improvement in the measure. Members should be closely followed to ensure completion of the postpartum visit. If the scheduled visit is not completed, the appointment should be rescheduled. Lastly, THP Case Managers had a difficult time identifying birth outcomes such as birth weight and gestational age and should explore opportunities to more effectively obtain and track this information as the outcomes are critical components of the PIP collaborative.

Pediatric Asthma Case Management File Review

The pediatric asthma case management file review concentrated on ensuring the development of care plans based on member assessments and monitoring medication compliance among other measures. The goal of the collaborative is to improve member self-management, including medication compliance, and to reduce asthma related emergency department and inpatient hospitalizations for these members. The collaborative intervention aims to engage members in a program entitled IMPACT DC. The program's goal is to steer children away from episodic use of the emergency department for their asthma management, and towards more effective primary long-term asthma care and management. Results are documented in Table 4.

Table 4. Pediatric Asthma Case Management File Review

Pediatric Asthma Case Management File Review+				
Element	**ACDC**	**HSCSN**	**MFC**	**THP**
Evidence of a care plan	100%	87%	100%	100%
Evidence of monitoring of medication compliance	Yes*	Yes*	Yes	Yes
Referrals/participation in IMPACT DC	Yes	Yes^	Yes	Yes
Member engagement with primary care provider	Yes	Yes	Yes	Yes

*** Medication compliance is monitored, but not consistently.**
^ While members have been referred to IMPACT DC, the sample of members reviewed elected not to participate in the program. However, there was evidence of engagement with primary care providers.
+ A total of 30 files were reviewed for each MCO.

All MCOs should continue to strive to engage high risk children with asthma in case management activities and promote primary care provider encounters. ACDC and HSCSN should more actively assess medication compliance. Lastly, THP should establish a procedure that ensures that *all* pediatric members with high utilization are contacted for case management services.

Performance Improvement Projects

Each MCO is required to annually conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant improvement in clinical or non-clinical care areas that are expected to have a favorable effect on health outcomes. The MCOs' PIPs must include measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. The validation activity is performed to assess whether the MCOs' PIPs are designed, conducted, and reported in a sound manner, and the degree of confidence DHCF can have in the reported results.

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 performance improvement projects. These multi-year projects are aimed at reducing adverse perinatal and birth outcomes and adverse outcomes of chronic diseases. In July 2013, the District implemented managed care contracts with three new MCOs and the returning CASSIP plan. After re-convening the collaborative work groups, it was determined that the perinatal collaborative remained relevant to the District's managed care population. The chronic disease collaborative was determined to be too broad to have a significant impact on the managed care population. Therefore, after analysis of data, it was decided to focus the chronic disease collaborative on improving outcomes for children with asthma where MCOs are able to concentrate their efforts.

The collaborative stakeholders continue to meet on a monthly basis. Both collaborative work groups have sought community participation to solicit input from providers and consumers and to expand their influence

beyond the formal membership. Each MCO documents its individual progress as a component of its PIP reporting. Delmarva Foundation aggregates the MCO indicator rates to create District-wide weighted averages for the key indicators annually.

Improving Perinatal and Birth Outcomes

DHCF, in collaboration with the District's MCOs and other stakeholders, embarked on a multiyear initiative to improve perinatal birth outcomes for District residents. The specific goal of the collaborative is to reduce the rate of adverse perinatal events that occur for pregnancies in the measurement year, as well as among infants, ages 0-365 days, in the same measurement year. Data from MY 2014 were used to calculate baseline rates for each MCO and Delmarva Foundation calculated a District weighted average for each indicator. Results are reported in Table 6.

Table 5 provides findings for each MCO against the 10 validation steps for the Adverse Perinatal and Birth Outcomes PIP.

Table 5. Improving Perinatal and Birth Outcomes PIP Validation Results

Adverse Perinatal and Birth Outcomes PIP				
Element	**ACDC**	**HSCSN**	**MFC**	**THP**
1) Assess the Study Topic	Met	Met	Met	Met
2) Review the Study Question(s)	Met	Met	Met	Met
3) Review the Selected Study Indicator(s)	Met	Met	Met	Met
4) Review the study population	Met	Met	Met	Met
5) Review Sampling Methods	NA	NA	NA	NA
6) Review Data Collection Procedures	Met	Met	Met	Met
7) Assess Improvement Strategies	Met	Met	Met	Met
8) Review Data Analysis & Interpretation of Study Results	Met	Partially Met	Met	Met
9) Assess Whether Improvement is Real Improvement	NA	NA	NA	NA
10) Assess Sustained Improvement	NA	NA	NA	NA

NA denotes that the element could not be assessed. Data are not yet available to assess improvement, as only baseline data has been reported.

The MCOs met all requirements with one exception. HSCSN received a partially met finding for Step 8, Review Data Analysis and Interpretation of Study Results. While the CASSIP completed an analysis of findings, the organization did not document its planned follow up activities that will be conducted based on results. Subsequently, HSCSN has stated that interventions will continue and follow up activities will be reported in the next annual report per requirements.

Several steps were not applicable. Step 5, Review Sampling Methods, was not applicable as the entire population was studied; sampling was not completed. Step 9, Assess Whether Improvement is Real Improvement, was not applicable as the PIP submission included an assessment of baseline data only. This

step will be assessed after remeasurement data is available, which will be reported in 2016. Finally, Step 10, Assess Sustained Improvement, cannot be assessed until at least two years of remeasurement data is available.

Prenatal care is one of the most effective interventions for improving birth outcomes. Regular prenatal care, early and on-going throughout pregnancy, is a key factor in preventing prematurity and low birth weight. By using early risk assessment tools, providers can improve and sometimes prevent costly outcomes. The cost of care for premature and low birth weight infants not only puts a strain on current budgets, but also impacts costs associated with long-term care for children born with developmental delays.

More than 1.2 million people in the United States are living with HIV infection, and almost 1 in 8 (12.8%) are unaware of their infection. HIV increasingly affects women of childbearing age with most women diagnosed between the ages of 25-44. Women accounted for 20% of estimated new HIV infections in 2010 and 23% of those living with HIV infection in 2011. For an HIV-positive woman not taking HIV medications, the chance of passing the virus to her child ranges from about 15 to 45% during pregnancy, labor, and delivery. [14]

Perinatal HIV cases are defined as those in which transmission occurs during pregnancy, labor, delivery, or breastfeeding. Among the mothers of HIV-infected infants reported to the Centers for Disease Control and Prevention (CDC) from 2003–2007, only 62% had at least one prenatal visit, 27% were diagnosed with HIV after delivery, and only 29% received some antiretroviral medication during pregnancy. Since the introduction of guidelines for perinatal testing and use of anti-retroviral medications in women testing positive for HIV, the mother-to-infant transmission has decreased to less than 2% in the United States. The most recent District HIV surveillance data (2013) indicate that there have been 15 cases of perinatal transmission of HIV between 2009 and 2015.[15]

In addition to the validation activity, Delmarva Foundation conducted analysis and aggregation of indicator results. Baseline rates for adverse perinatal outcomes can be found in Table 6.

Table 6. Perinatal Collaborative Indicator Rates

Performance Measures	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
Neonates with weight <2500 grams	7.12	12.69	7.08	1.03	5.96

[14] Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, Sexual Transmitted Diseases and Tuberculosis Prevention, Centers for Disease Control and Prevention; Retrieved Nov. 9, 2015 from http://www.cdc.gov/hiv/statistics/overview/ataglance.html

[15] Annual Epidemiology and Surveillance Report; District of Columbia, Dept. of Health, HIV/AIDS, Hepatitis, STD, and TB Administration; Retrieved Nov. 9, 2015 form http://doh.dc.gov/page/annual-report-2014

Performance Measures	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
Neonates <37 weeks gestational age	1.05	14.93	8.40	1.86	4.10
No maternal HIV testing	55.22	5.97	59.85	77.56	60.10
Miscarriage or fetal loss	13.45	15.67	12.57	5.07	11.42
Birth outcome unknown	0.00	15.67	0.00	0.00	0.46
Infant death rate	0.34	0.98	0.09	0.13	0.26
Rate of adverse perinatal outcomes (includes No Maternal HIV Testing)	14.37	20.45	27.54	25.28	19.78

Comparison of rates between MCOs is not advised as no population risk adjustment has been conducted.

- The MCO weighted average for the rate of Adverse Perinatal and Birth Outcomes for the baseline year (January 1, 2014 – December 31, 2014) is 19.78%. The largest contributing factor to this rate is lack of HIV testing prior to delivery. Just over 60% of women did not have a documented HIV test prior to delivery.
- The District's weighted average for Adverse Perinatal and Birth Outcomes, excluding lack of HIV testing, is 5.4%, showing the significant impact of HIV testing on the rate.
- MCO indicator rates compare favorably to national and District-wide March of Dimes benchmarks[16]:
  - The District's MY 2014 MCO weighted average of 5.96% compares favorably to the MY 2013 national rate of 8.0% and the District-wide rate of 9.4% for low birth weight (<2500 grams) infants.
  - Preterm births among MCO enrollees for MY 2014 averaged 4.10%. This compares favorably to the MY 2013 national rate of 11.4% and the District-wide rate of 13.3%.
  - The infant death rate (age 0-365 days) for the District's MCOs for MY 2014 was 2.6 per 1,000 live births. The March of Dimes national rate for MY 2013 was 6.0 per 1,000 live births and 6.7 per 1,000 District-wide.

The MCOs submitted methodologically sound PIPs aimed at improving birth outcomes. All of the MCOs conducted barrier analyses and developed interventions to address the specific member, provider, and MCO barriers. All of the MCOs identified lack of provider compliance with completion and submission of the OB Authorization/Assessment Form as an ongoing problem that severely limits the MCOs' ability to identify

[16] National Center for Health Statistics, final natality data. Retrieved November 04, 2015, from www.marchofdimes.org/peristats.

pregnant members. Early identification of pregnancies and early initiation of prenatal care are essential to good birth outcomes. Additional barriers include:

- Limited member-access to after hour services.
- Member educational needs regarding recommended prenatal care and importance of keeping appointments.
- Transient membership with frequent address and telephone contact changes.
- Member lack of knowledge surrounding infant care and health.
- Members fail to keep perinatal appointments and provider practices have limited resources to pursue follow-up on members who miss appointments.
- The MCO has limited resources to perform outreach to members without working telephones.
- The MCOs struggle with members' risky behaviors such as smoking and alcohol/substance use throughout pregnancy in spite of educational efforts.
- Members wait to seek care until late in pregnancy due to low health literacy.
- Members with multiple children lack childcare resources and are therefore noncompliant with prenatal visits.
- Members are desensitized to HIV risks and potential outcomes for the newborn.
- MCO inability to identify and monitor HIV testing status through claims, laboratory data, and anti-retroviral medication prescribing.
- Socioeconomic factors such as homelessness, multiple partners, food resources, substandard housing, etc. impact health outcomes.
- Diverse cultural backgrounds and beliefs impact member behaviors and communication.
- Incorrect claims coding and access to care at out-of-network providers limits the MCO's early identification and access to records for pregnant members.
- OB care/case manager turn-over rate in the MCOs.

The MCOs have agreed to participate in one joint intervention related to improving birth outcomes. Since early identification of members is important to prevention of poor outcomes and all MCOs have identified poor provider compliance with the completion of the OB Authorization/Assessment forms, the MCOs are jointly working to improve provider completion and submission of the forms. The MCOs are also working with DHCF to make the form more meaningful and user friendly, including exploring the opportunity of implementing an electronic reporting process.

Individual MCO interventions include:

- Identifying pregnant members without telephones and supplying them with cell phones and 250 free minutes per month, along with unlimited text messaging and calls to the MCO. The MCO assists in scheduling appointments and sends text message reminders for appointments.
- Coordinating the scheduling of the 30 day well-baby visit and post-partum visit on the same date for selected pediatric and obstetric practices.

- Implementing the Bright Star (maternity) Program to identify, assess and manage the care of at-risk pregnant women using prenatal guidelines from the Institute for Clinical Systems Improvement.
- Holding a baby shower every other month to provide a venue and opportunity for pregnant women to receive vital prenatal information in a celebratory environment.
- Holding biweekly calls with Teen Alliance for Prepared Parenting (TAPP) to monitor prior referrals and collaborate in care coordination for new referrals.
- Added a support person to the OB Team to assist in collection of OB Authorization/Assessment Forms and to track pharmacy fills for prenatal vitamins. The support staff member is also available to attend prenatal appointments with members if additional support is needed.
- Developed a claims and OB lab panel report to capture "possible" pregnancies.
- Referring members to the Safe Cribs Program for services and education designed to reduce infant mortality.
- Sending newsletter tips to providers with advice for managing communication with members from diverse cultural backgrounds.
- Working with high volume clinics to facilitate member scheduling.
- Using multiple means to identify contact information for members, including outreach to customer service, utilization management, and outreach departments; door-to-door visits; daily census monitoring and tracking and; access to Maryland's CRISP data (the regional health information exchange known as Chesapeake Regional Information System for Our Patients) to identify members admitted to a Maryland facility.
- Contracting with a specialty case management agency that monitors high-risk pregnancies, provides 48 hour assessments for newborn intensive care unit (NICU) discharges, assists in preparing the member's home in preparation to meet the newborn's needs.
- Developed an OB case management program, Healthy Beginnings, to provide education and outreach to pregnant members. An OB Case Manager is stationed at the MCO's Outreach and Wellness Center to provide face-to-face interaction and engagement of members.
- Encouraging participation of members in the Department of Health's educational program on Sudden Infant Death Syndrome.
- Providing access to a lactation specialist and weekly breast feeding training sessions.
- Providing healthy cooking demonstrations.

Adverse Outcomes of Pediatric Asthma

While there is evidence that asthma can be treated in an outpatient setting, data suggests that the ED has typically been used to manage this illness. Multiple studies have consistently shown that asthma is a readily treatable condition that can be managed in an outpatient setting. National asthma guidelines recommend early treatment and special attention to patients who are at high risk of asthma-related death.

ED visits or acute hospital admissions for an asthma exacerbation are key indicators of poorly controlled asthma and risk for future asthma exacerbations. Predictors of death due to poor asthma control include three or more ED visits for asthma in the past year, an asthma hospitalization or ED visit in the past month, overuse of short-acting beta agonist (short-term relief medication), a history of intubation or stay in an intensive care unit for asthma, difficulty perceiving asthma symptoms, lack of a written asthma action plan, certain patient characteristics (low socioeconomic status, female, nonwhite, current smoker, or major psychosocial problems), and the presence of other medical conditions such as cardiovascular disease. Racial disparities in asthma hospitalizations and deaths have been historically large, two to three times higher among black persons compared with white persons.[17]

Routine visits to a physician office or hospital outpatient clinic for preventive asthma care is a key component of asthma management. There are specific recommendations for patient education to help prevent future ED visits, including focused and targeted patient education in the physician office and ED setting (assessing inhaler technique, instructions for medication, and steps to follow for worsening symptoms) and referral for follow-up asthma care.

ED utilization rates for people living with asthma are high for children and adults within the District. 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. DHCF, recognizing the impact of pediatric asthma, on both costs to the Medicaid program and health outcomes for the District's Medicaid residents, embarked on a multi-year collaborative effort to improve asthma self-management and reduce asthma related utilization. The PIP focuses on measuring changes in the health outcomes of children 2-20 years of age with a diagnosis of asthma.

The Pediatric Asthma PIP indicators measure asthma medication compliance and the rate of occurrence of emergency room visits and hospitalizations for Medicaid managed care plan enrollees with a principle diagnosis of asthma. These measures were identified based on the belief that people with asthma who are well managed and have an ongoing source of medical care will have fewer ED visits or hospitalizations.

Each MCO's Pediatric Asthma PIP was reviewed against all components contained within the 10 step review process used to evaluate the validity of the MCOs' PIP activities. Validation results for the Pediatric Asthma PIP can be found in Table 7.

Table 7. Pediatric Asthma PIP Validation Results

Pediatric Asthma PIP				
Element	ACDC	HSCSN	MFC	THP
1) Assess the Study Topic	Met	Met	Met	Met
2) Review the Study Question(s)	Met	Met	Met	Met

[17] Moorman JE, Akinbami LJ, Bailey CM, et al. National Surveillance of Asthma: United States, 2001–2010. National Center for Health Statistics. Vital Health Stat 3(35). 2012; http://www.cdc.gov/nchs/data/series/sr_03/sr03_035.pdf

Pediatric Asthma PIP Element	ACDC	HSCSN	MFC	THP
3) Review the Selected Study Indicator(s)	Met	Met	Met	Met
4) Review the study population	Met	Met	Met	Met
5) Review Sampling Methods	NA	NA	NA	NA
6) Review Data Collection Procedures	Met	Met	Met	Met
7) Assess Improvement Strategies	Met	Met	Met	Met
8) Review Data Analysis & Interpretation of Study Results	Met	Met	Met	Met
9) Assess Whether Improvement is Real Improvement	NA	NA	NA	NA
10) Assess Sustained Improvement	NA	NA	NA	NA

NA denotes that the element could not be assessed. Data are not yet available to assess improvement.

All MCOs met requirements and were assessed as fully met. Similar to the Perinatal PIP Collaborative validation, several steps were not applicable and require additional remeasurement data before they can be evaluated.

In addition to the PIP validation activities, Delmarva Foundation conducted analysis of reported rates for baseline MY 2014. The utilization and medication compliance indicator rates for members with asthma fluctuated widely among MCOs. Table 8 provides baseline rates for the Pediatric Asthma PIP.

Table 8. Baseline Pediatric Asthma PIP Rates

Performance Measures	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
ED Asthma Visits (Total Ages 2-20 Years)	26.62	28.98	35.04	89.35	32.44
Inpatient Admissions for Asthma (Total Ages 2-20 Years)	5.87	3.00	5.02	10.97	5.69
Use of Appropriate Medications for People with Asthma (Total Ages 2-20 Years)	87.41	76.86	59.14	45.48	78.00
Medication Management for People with Asthma 50% Compliance (Total Ages 2-20 Years)	65.57	76.86	45.98	6.45	59.29
Medication Management for People with Asthma 75% Compliance (Total Ages 2-20 Years)	41.89	75.44	33.13	6.45	41.74

Comparison of rates between MCOs is not advised as no population risk adjustment has been conducted.

An analysis of the MCO specific PIP results found that:

- Of the members with asthma, the asthma related ED visit rate was 32.44%; utilization was highest in the 2-4 years of age category with a rate of 47.86%.
- Acute hospital admissions were also highest in the 2-4 years of age group at 9.11%, compared to the 5.69% District weighted average for total members 2-20.
- Appropriate medications were prescribed for 78.00% of MCO enrollees with asthma. However, only 59.29% were complaint with medication use for at least half of the prescribed period of treatment.
- The 5-11 years of age group was most compliant with medication treatment—63.81% compliant for at least half of the prescribed treatment period and 45.61% compliant for at least 75% of the treatment period.

The MCOs submitted methodologically sound PIPs aimed at improving health outcomes for children with asthma. All of the MCOs conducted barrier analyses and developed interventions to address the specific member, provider, and MCO barriers. Lack of member knowledge regarding asthma triggers and the importance of medication adherence were the most frequently identified barrier. Additional barriers include:

- Limited member access to services during non-business hours.
- Member lack of understanding of effective self-management strategies and routine preventative care.
- Members do not make/keep appointments for ongoing preventative care, relying on emergency department or urgent care for treatment.
- Providers have limited resources to follow-up on members who do not keep appointments.
- MCOs struggle to engage members in care due to outdated or inaccurate contact information.
- Environmental issues (standing water, mold, second-hand smoke, pets, rodent infestation) may exist in the home which exacerbate asthma symptoms.
- Psychosocial barriers to care may exist such as unstable caregiver/home environment, domestic violence, or other children with special needs in the home may inhibit member access to care.
- Members do not document or monitor peak flow rates making it difficult for the PCP to assess asthma control.
- Providers do not consistently document asthma action plans.
- MCOs lack the ability to proactively identify asthmatics before a claim is filed.

Recognizing that lack of education is a key factor in improving health outcomes for children with asthma, the MCOs have all contracted with a pediatric asthma education program, IMPACT DC, to increase member and caretaker knowledge of asthma triggers and management. IMPACT DC is a pediatric asthma program that provides a comprehensive approach to asthma care that is consistent with national practice guidelines. The program aims to provide asthma education, short term care coordination, transition of asthma patients to a primary care medical home for on-going care, and connecting members to community resources. The goal is to reduce emergency department visits and acute hospital admissions.

Individual MCO interventions include:

- Implementation of an electronic health management tablet maintained by the pharmacy benefits manager. The tablet includes an online portal for drug therapy management, including medication reminders, member surveys and self-assessments, custom care plans, and tracking members' key health metrics.
- Partnering with Breathe DC to allow members to participate in a week long camping experience focused on education of children regarding asthma triggers, medication use, and breathing and relaxation exercises.
- Participating with the DC Healthy Homes Program in an effort to identify and eliminate environmental asthma triggers found in the member's home.
- Targeting parents/caregivers of children age 0-6 years who have had low acuity ED visits for education about appropriate ED use, importance of connecting with a PCP for preventative care, and referral to case management.
- Development of a program, in partnership with the pharmacy benefits manager, to allow physicians to dispense asthma medications and related products from an automated unit within the office. This allows members to begin therapy immediately and to receive instruction in proper use of equipment.
- Developed an asthma pilot program using a disease management team to provide assessment, education, and regular in-person or telephonic contact with members identified with an asthma diagnosis and 3 ED visits or 2 inpatient hospitalizations.
- Conducting weekly asthma rounds for team discussion and review of individual cases. Issues addressed include community resources, food banks, shelters, utility assistance, and referrals to specialists.
- Referring members to the Children's Law Project which provides legal remedies to health problems through pro bono assistance with enforcement of housing codes.
- Conducted a mandatory training for all care management staff to educate and reinforce staff knowledge about asthma treatment and proper use of medication devices such as spacers. Training also included smoking cessation and available resources.
- Participating in the Asthma Air Buddies Program, a school-based asthma management program. The program includes an awareness assembly and mobile van consultations.
- Distributing provider and member newsletters which include educational articles about asthma triggers, monitoring peak flow rates, and the importance of having an asthma action plan.
- Developed an Asthma Disease Management Program using a variety of means to identify asthmatic members including health risk assessments, claims and pharmacy data, and provider referrals.
- Conducting quarterly outreach to providers to determine if asthmatic members have an asthma action plan, to assess barriers to care, coordinate PCP/specialist care, and notify providers of member referrals/participation in educational or other asthma management programs.
- Partnering with Healthy Hoops to provide an annual hands-on event for children 3-18 years of age. The program provides education on medication, proper nutrition, monitored exercise, and recreational activities.

Performance Measure Validation

Given that the MCOs are required to submit audited HEDIS/CAHPS rates, the District chose to direct EQRO activities to auditing and validating the MCOs' information systems and processes for collecting data and reporting collaborative PIP measurement results as these are not validated as a component of the MCOs' NCQA audit activities. Delmarva Foundation conducted validation activities for all four MCOs.

The goal of conducting the performance measures validation activity is to evaluate the accuracy and reliability of the measures produced and reported by the MCOs and to determine the extent to which the MCOs followed specifications established by DHCF for calculating and reporting the collaborative performance measure rates. The accuracy and reliability of the reported rates is essential to ascertaining whether the MCOs' quality improvement efforts have resulted in improved health outcomes.

Three key validation activities are conducted:

- Review of data systems and processes used by the MCO to construct the measure rates;
- Assessment of the calculated rates for algorithmic compliance to defined specifications; and
- Verification that the reported rates are based on accurate sources of information.

Information from several other sources is also used to satisfy validation requirements. These sources include, but are not limited to the MCOs':

- Information Systems Capabilities Assessment (ISCA);
- Claims systems and processes (including lab, dental, and pharmacy data);
- Data warehouse overview;
- Documentation (e.g., IS specifications, data dictionaries, program source code, data queries, record review tools, policies and procedures) for review prior to or during the on-site validation;
- Observations resulting from on-site information system queries and MCO staff interviews;
- Source code review; and
- Information provided subsequent to the on-site visit to address any deficiencies and/or outstanding issues.

The ISCA tool was reviewed and used to assess the MCOs on factors essential in the performance measure process, including data integration, data control, and calculation of rates. Based on the information provided, the MCOs have a satisfactory process for data integration, appropriate data control, and adequate interpretation of measures specifications.

Source code was reviewed which included an assessment and validation of the diagnosis, procedure, pharmacy, and revenue codes to ensure these codes were correctly applied. Additionally, the source code review determined that members of the denominators were correctly selected from the populations, time parameters were accurate, and numerators included appropriate parameters and members.

Table 9 provides the MCOs' validation of systems and processes for constructing the collaborative PIP measures: Improving Perinatal and Birth Outcomes and Pediatric Asthma.

Table 9. Audit Designation Table for Collaborative PIP Performance Measures

Collaborative PIP Measures: Perinatal and Birth Outcomes and Pediatric Asthma					
Validation Component	Audit Element	Validation Results			
		ACDC	HSCSN	MFC	THP
Documentation	Data integration and control procedures are assessed to determine whether the MCO has the appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. Measurement procedures and programming specifications including data sources, programming logic, and computer source codes are documented.	Met	Met	Met	Met
Denominator	Validation of the denominator calculations for the performance measures is conducted to assess the extent to which the MCO used appropriate and complete data to identify the entire population and to the degree to which the MCO followed the measures specifications for calculating the denominator.	Met	Met	Met	Met
Numerator	The validation of the numerator determines if the MCO correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and followed the measure specifications for calculation of the numerator.	Met	Met	Met	Met
Reporting	Validation of reporting assesses whether the MCOs followed the District's requirements for reporting the measures rates and followed specifications. The District requires the MCOs to report the denominator, specific numerator events, and calculated final rates. A final determination is made as to whether the MCO is fully compliant (FC), substantially compliant (SC), or non-compliant (NC).	FC	FC	FC	FC

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. Although MCOs initially showed inconsistencies in interpretation of denominator specifications for the Perinatal and Birth Outcomes PIP indicators, algorithmic compliance was eventually achieved by all MCOs after clarification from the auditor and DHCF. Numerator and denominator compliance was met for both the Perinatal and Birth Outcomes and the Pediatric Asthma PIPs. All measure indicators and final rates were deemed reportable.

HEDIS and CAHPS

As previously noted, all District Medicaid MCOs are required to calculate and submit audited HEDIS and CAHPS measures to DHCF. Delmarva Foundation selected and analyzed results from HEDIS effectiveness of care measures and CAHPS measures reported by the MCOs to assess quality. The full set of reported HEDIS and CAHPS rates can be found in Appendices 1 and 2.

Managing chronic disease is a complex matter requiring care coordination between the MCO and the servicing providers. Research has shown that following evidence-based health care guidelines for treatment and monitoring of these individuals can improve health status. HEDIS measures provide information on the health status of the MCOs' chronic diseases populations and can be used in conjunction with the MCOs' chronic diseases adverse event rates to assess how well the MCOs are performing in improving health status for those living with a chronic illness.

Comprehensive Diabetes Care

Diabetes can lead to significant health complications such as heart disease, kidney disease, blindness and amputations. Controlling levels of blood glucose, blood pressure, and cholesterol are key to preventing these diabetes related complications. In 2014, diabetes ranked as the sixth leading cause of death in the District of Columbia. According to 2014 estimates by the CDC, nearly 29.1 million (9.3%) people in the United States have diabetes. In the District of Columbia, 8.3% of residents reported having been diagnosed with diabetes.[18]

As noted in Table 10, the District's MCO weighted averages were below the National Medicaid Averages for all indicators.

[18] National Center for Chronic Disease Prevention and Health Promotion, Retrieved Nov. 4, 2015, from http://www.cdc.gov/diabetes/data/statistics/2014statisticsreport.html.

Table 10. Comprehensive Diabetes Care

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Comprehensive Diabetes Care - Blood Pressure Control (<140/90) - % members 18–85 years of age with HTN whose BP was adequately controlled	57.12	55.00	61.50	10.61	51.76	♦
Comprehensive Diabetes Care - Eye Exams - % of members who had a retinal eye exam	49.13	45.00	47.08	38.49	47.11	♦
Comprehensive Diabetes Care - HbA1c Testing - % members 18–75 years of age with Hemoglobin A1c (HbA1c) testing	83.85	82.50	81.57	77.34	86.2	♦
Comprehensive Diabetes Care - HbA1c Control <7%	31.40	NA	30.66	4.85	27.66	♦
Comprehensive Diabetes Care - HbA1c Control <8%	47.05	40.00	45.07	6.83	40.92	♦
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	43.92	52.50	46.53	91.91	51.30	♦
Comprehensive Diabetes Care - Medical Attention for Nephropathy (Kidney Disease)	80.21	62.50	78.65	76.98	79.26	♦

NA - Denominator too small to calculate reliable rate.
♦ - 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.

Controlling High Blood Pressure

Approximately 1 in 3 adults in the United States has hypertension and approximately 52% of people with hypertension have their blood pressure under control (<140/90).[19] Lifestyle modifications such as increased exercise and reduced salt intake can help individuals control their blood pressure. In addition, antihypertensive pharmacotherapy is effective in controlling blood pressure and has been associated with reduced incidence of stroke, heart attack, heart failure, and kidney disease.

According to the CDC, cardiovascular disease is the number one cause of death among District residents (27.8 % of total deaths in 2010), and the second leading cause of hospitalizations (5,583 hospitalizations in 2010). African American residents are almost three times more likely to die from heart disease than their white counterparts (333.0 deaths per 100,000 compared to 116.6 deaths per 100,000). Death rates are also significantly higher among residents of Wards 5 and 7, with these two wards accounting for 35 percent of all deaths. Hypertension is a major contributing factor to the morbidity and mortality associated with heart disease. An estimated 41.5 percent of Ward 7 residents and 39.3 percent of Ward 5 residents have high blood pressure.

As seen in Table 11, the District's MCO weighted average for controlling blood pressure did not meet the National Medicaid Average.

Table 11. HEDIS Controlling High Blood Pressure

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Controlling High Blood Pressure	47.89	59.46	53.28	6.50	43.75	♦

♦ - 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.

Use of Appropriate Medication for People with Asthma

According to the CDC approximately 1 in 12 adults and 1 in 10 children in the United States had asthma in 2009. It is one of the most common chronic diseases in childhood and accounts for about $50 billion in associated medical costs annually. The overall prevalence of asthma in the District is estimated to be 18.0%.[20]

[19] "High Blood Pressure Facts". Centers for Disease Control and Prevention. Available at: www.cdc.gov/bloodpressure/facts.htm
[20] "Asthma Fact Sheet", American Lung Association. Available at: www.lung.org/lung-disease/asthma/resources/facts-and-figures/asthma-children-fact-sheet.html.

Asthma is a chronic lung disease that can be life-threatening if not properly managed. However, research has shown that the use of evidence-based guidelines can significantly improve management of the disease. These guidelines recommend specific pharmacotherapy aimed at controlling asthma exacerbations in the long-term as well as medications for quick relief of acute asthma symptoms.

The HEDIS indicator, Use of Appropriate Medications for People with Asthma, measures how well providers are adhering to these treatment guidelines. The HEDIS measure for Medication Management for People with Asthma provides an indication of how compliant asthmatics are with use of prescribed asthma control medications.

The MCOs' and the District's weighted averages for MY 2014 are found in Table 12.

Table 12. HEDIS Appropriate Medications for People with Asthma

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Use of Appropriate Medications for People with Asthma – (Total)	NA	88.05	82.89	NA	86.99	♦ ♦
Medication Management for People with Asthma – Medication Compliance 50% (Total)	NA	62.40	58.73	NA	61.68	^
Medication Management for People with Asthma – Medication Compliance 75% (Total)	NA	35.66	28.57	NA	34.27	♦ ♦

NA - Denominator too small (<30).
^ - 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.

Key findings related to asthma care include:

- The District's weighted average for Use of Appropriate Medications for People with Asthma exceeded the national Medicaid average.
- The District's weighted average for Medication Management for People with Asthma – Medication Compliance 75% exceeded the national Medicaid average.

CAHPS

Adult enrollees and parents/guardians of child enrollees are asked annually to rate the quality of care and services provided by MCOs in which they are enrolled. MCOs are required to assess consumer satisfaction using a standardized instrument, the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Tables 13 and 14 provide results from the adult and child CAHPS surveys for 2015 on measures representative of quality. For comparison purposes, 2014 averages are also included.

Table 13. Adult CAHPS (Experience with Care) Representative of Quality

CAHPS Measure	ACDC 2015 %	HSCSN 2015 %	MFC 2015 %	THP 2015 %	MCO Average 2014 %	MCO Average 2015 %	2015 MCO Average Compared to 2015 Benchmarks
Customer Service Composite	87.9	83.9	82.5	NA	86.3	84.8	♦
How Well Doctors Communicate Composite	94.0	93.3	92.5	88.7	92.8	92.1	♦♦
Shared Decision Making Composite (A lot/Yes)	76.2	76.7	77.7	NA	52.1	76.9	♦♦
Health Promotion and Education Composite	76.9	73.8	77.0	64.9	74.0	73.2	♦♦
Coordination of Care Composite	80.1	89.8	58.0	74.3	80.3	75.5	♦
Rating of Health Plan (8+9+10)	78.6	76.0	75.0	70.6	73.5	75.0	♦
Rating of All Health Care (8+9+10)	76.5	79.2	71.0	69.3	70.8	74.0	♦♦
Rating of Personal Doctor (8+9+10)	87.0	78.3	82.0	77.7	81.8	81.2	♦♦
Rating of Specialist Seen Most often (8+9+10)	87.3	79.4	75.0	NA	79.7	80.6	♦♦

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 fell below the 75th percentile for all satisfaction ratings by adults.

- Among adults Customer Service, Coordination of Care, and Rating of Health Plan were scored below the national Medicaid average.
- The District's MCOs met the Medicaid national average for How Well Doctors Communicate, Shared Decision Making, and Health Promotion and Education.
- MCOs met the national Medicaid average for Ratings of Health Plan, Personal Doctors, and Specialists.

Table 14. Child CAHPS (Experience with Care) Representative of Quality

CAHPS Measure	ACDC 2015 %	HSCSN 2015 %	MFC 2015 %	THP 2015 %	MCO Average 2014 %	MCO Average 2015 %	2015 MCO Average Compared to 2015 Benchmarks
Customer Service Composite	87.8	86.0	86.5	78.2	85.8	84.6	♦
How Well Doctors Communicate Composite	92.6	93.3	90.5	89.2	91.5	91.4	♦
Shared Decision Making	82.1	81.4	78.3	NA	59.5	80.6	♦ ♦
Health Promotion and Education Composite	76.7	77.6	79.0	71.0	76.3	76.1	♦ ♦ ♦
Coordination of Care Composite	85.5	86.1	84.0	NA	84.7	85.2	♦ ♦ ♦
Rating of Health Plan (8+9+10)	85.5	81.8	85.0	82.2	81.8	83.6	♦
Rating of All Health Care (8+9+10)	83.9	86.0	89.0	83.1	85.8	85.5	♦ ♦
Rating of Personal Doctor (8+9+10)	89.2	88.9	91.0	90.5	90.5	89.9	♦ ♦ ♦
Rating of Specialist Seen Most often (8+9+10)	87.3	79.3	78.0	NA	86.3	81.5	♦
Child has a regular dentist	87.4	93.9	80.0	NR	79.3	87.1	^
Child has seen regular dentist for a check-up or routine care in the last 6 months	86.5	85.8	78.0	NR	79.5	83.4	^

CAHPS Measure	ACDC 2015 %	HSCSN 2015 %	MFC 2015 %	THP 2015 %	MCO Average 2014 %	MCO Average 2015 %	2015 MCO Average Compared to 2015 Benchmarks
How often child received dental appointments with regular dentist as soon as you wanted	85.6	90.2	81.0	NR	78.8	85.6	^
If child does not have a regular dentist, child still got a check-up or other routine dental care in the last 6 months	37.7	77.1	22.0	NR	33.8	45.6	^

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.

In general, consumers were more satisfied with care and services provided to children than for adults.

- MCOs met or exceeded the Medicaid national 75th percentile for Health Promotion and Education, Coordination of Care, and Rating of Personal Doctor.
- MCOs met or exceeded the Medicaid national average (but below the 75th percentile) for Shared Decision Making and overall Rating with Health Care.
- Customer Service, How Well Doctors Communicate, Rating of Health Plan, and Rating of Specialists fell below the Medicaid national average.

Access Findings

An assessment of access considers the degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. Factors influencing this ability include geographic, architectural, transportation, and financial considerations, among others. 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, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services."

Access to healthcare is the foundation of good health outcomes. Factors influencing access include provider availability, geographic proximity, transportation, and policies that enhance access. Availability is the extent to

which the organization provides the appropriate types and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas.

Delmarva Foundation evaluates access to care and services for MCO enrollees through analysis of HEDIS measures of access (such as preventive care and well visits), and analysis of CAHPS survey results regarding member satisfaction with access.

HEDIS Performance Measures

Preventive health care measures provide information about how well a health plan provides services that maintain good health and prevent illness in adults and children. Children's access to health care is an important determinant of better health outcomes as well as readiness to learn. A regular source of care is vitally important in terms of providing appropriate preventive services and/or diagnosing and treating acute/chronic conditions in a timely manner. From a cost perspective, regular access to preventive services can decrease the need for emergency and specialized services.

Table 15 provides information on the MCOs' performance on measures of access.

Table 15. Access to Preventive Care

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Adults' Access to Preventive/ Ambulatory Health Services (20-44 Years)	71.63	78.64	64.36	57.04	67.59	♦
Adults' Access to Preventive/ Ambulatory Health Services (45-64 Years)	79.98	NA	73.60	68.06	76.29	♦

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Childhood Immunization Status - Combo 2 - % of children with 4 diphtheria, tetanus and pertussis (DTaP), 3 polio (IPV), 1 measles, mumps and rubella (MMR), 2 H influenza type B (Hib), 3 hepatitis B (HepB), and 1 chicken pox (VZV) vaccines by 2nd birthday	75.69	80.00	74.84	14.99	68.08	♦
Childhood Immunization Status - Combo 3 - % of children with Combo 2 and 4 PCV vaccines by 2nd birthday	73.84	77.86	72.29	14.00	66.26	♦
Lead Screening in Children - % of members aged 1-5 years with a lead screening	86.63	86.21	78.03	59.21	82.27	♦ ♦ ♦
Children and Adolescents' Access To PCP (12-24 Months)	94.17	93.44	89.96	86.00	91.86	♦
Children and Adolescents' Access To PCP (25 Months-6 Years)	88.37	91.69	82.56	81.43	86.81	♦
Children and Adolescents' Access To PCP (7-11 Years)	NA	94.95	84.03	NA	93.37	♦ ♦

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Children and Adolescents' Access To PCP (12-19 Years)	NA	92.75	79.14	NA	91.47	♦ ♦
Well-Child Visits in the first 15 Months of Life (6 or more visits) - % of members who had six or more well-child visits with a PCP during their first 15 months of life	53.47	64.94	60.58	34.69	53.21	♦
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - % of members 3-6 years who had 1 or more well-child visits with a PCP	83.14	85.71	76.89	70.83	80.76	♦ ♦ ♦
Adolescent Well-Care Visits - % of members 12-21 who had at least 1 well-care visit with a PCP or an OB/GYN	61.95	71.39	55.23	45.83	60.40	♦ ♦ ♦
Immunizations for Adolescents - Combination 1	82.11	83.91	74.77	18.18	78.10	♦ ♦
Annual Dental Visit (Total-Age 2-21 Years)	67.37	69.79	9.94	59.10	57.99	♦ ♦

***NA denotes that the MCO did not have a large enough population to report on this measure.**
♦ - 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.

In the area of access to preventive/ambulatory care:

- The District weighted average did not meet the Medicaid national average in the following measures:
  - Adults Access to Preventive/Ambulatory Health Services – 20-44 and 45-64 years of age
  - Childhood Immunization Status – Combo 2 and Combo 3
  - Children and Adolescents' Access to PCP – 12-24 months and 25 months-6 years
  - Well-Child Visits in the First 15 Months of Life (6 or more visits)
- The District weighted average exceeded the Medicaid average, but did not meet the 75th percentile in the following measures:
  - Children and Adolescents' Access to PCP (7-11 years)
  - Children and Adolescents' Access to PCP (12-19 years)
  - Immunizations for Adolescents (Combo 1)
  - Annual Dental Visit (ages 2-21)
- The District weighted average exceeded the Medicaid 75th percentile in the following measures:
  - Lead Screening
  - Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
  - Adolescent Well-Care Visits (ages 12-21)

The District's MCOs must continue to focus on improving access to care for children and adults. Improved access can reduce emergency department utilization, improve or stabilize chronic conditions, and prevent childhood illness and associated complications.

CAHPS Performance Measures

Table 16 provides a comparison of 2014 and 2015 performance on the CAHPS measure related to getting needed care. This measure gauges the member's or parent/guardian's perceptions and satisfaction with access to care and services.

Table 16. Adult and Child CAHPS Satisfaction with Access to Care

CAHPS Measure	ACDC 2015 %	HSCSN 2015 %	MFC 2015 %	THP 2015 %	MCO Average 2014 %	MCO Average 2015 %	2015 MCO Average Compared to 2015 Benchmarks
Getting Needed Care Composite (Adult)	80.7	81.5	75.0	73.2	75.5	77.6	♦
Getting Needed Care Composite (Child)	80.7	83.0	78.5	75.0	78.8	79.3	♦

♦ - 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.

Analysis of CAHPS results related to access found that:

- Satisfaction with access to Needed Care for adults improved only slightly over 2014, from 75.5% to 77.6%.
- Satisfaction with access to Needed Care for children also improved slightly over 2014, from 78.8% to 79.3%.
- Adult and Child rates for Getting Needed Care were below the national Medicaid average indicating an opportunity for continued improvement.

Timeliness Findings

The Institute of Medicine (IOM) considers timeliness to be one of the six domains of healthcare quality. The IOM defines timeliness as "reducing waits and sometimes harmful delays." Standards for timeliness are incorporated into MCO contracts and define the length of time in which an enrollee would be able to schedule or receive an appointment. Timeframes are based on the urgency of need and the presence or absence of health symptoms.

Timeliness of care can affect utilization, including both appropriate care and over- or underutilization of services and contribute to enrollee complaints and dissatisfaction. Presumably, the earlier an enrollee sees a medical professional, the sooner he or she can receive necessary healthcare services. Postponing needed care may result in adverse health outcomes and increases in hospitalization and emergency room utilization.

Timeliness can also be a marker for the adequacy and effectiveness of policies and procedures that promote health outcomes through communication and resolution of complaints and grievances so as to not disrupt or delay healthcare services.

HEDIS Performance Measures

Prenatal visits in the first trimester provide an opportunity for early risk assessment, health promotion, and medical, nutritional, and psychosocial interventions that can promote good clinical outcomes for both mother and child. Ongoing prenatal care visits provide opportunities for early identification of complications and reduce risks for poor outcomes.

Delmarva Foundation chose the timeliness and frequency of prenatal care as key measures of timeliness important to the District in achieving its goals to reduce adverse perinatal and birth outcomes. Table 17 provides MCOs' performance on timeliness of prenatal care for pregnant women and the frequency at which women receive prenatal care visits.

Table 17. Timeliness and Frequency of Prenatal Care

Measure HEDIS 2015 (MY 2014)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Timeliness of Prenatal Care - % of deliveries where a prenatal care visit occurred in the first trimester or within 42 days of enrollment in the health plan	64.34	77.66	81.75	62.57	69.42	♦
Frequency of Ongoing Prenatal Care (>= 81%)	30.30	26.60	54.74	28.27	36.82	♦

♦ - 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.

Analysis of HEDIS measures related to timeliness of services found that:

- The District's weighted average fell short of the national Medicaid average for Timeliness of Prenatal Care.
- The District's weighted average for the frequency with which women obtain Ongoing Prenatal Care (at least 81% of the recommended prenatal care visits) fell short of the national Medicaid average.

CAHPS Performance Measures

CAHPS surveys query adults and parents/guardians of children regarding satisfaction with how quickly they can get needed care. Table 18 provides information regarding members' satisfaction with getting care quickly.

Table 18. Adult and Child CAHPS Satisfaction with Timeliness of Care

CAHPS Measure	ACDC 2015 %	HSCSN 2015 %	MFC 2015 %	THP 2015 %	MCO Average 2014 %	MCO Average 2015 %	2015 MCO Average Compared to 2015 Benchmarks
Getting Care Quickly Composite (Adult)	83.5	80.8	77.0	71.9	76.3	78.3	♦
Getting Care Quickly Composite (Child)	83.8	88.3	57.0	79.4	84.0	77.1	♦

♦ - 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.

Consumer satisfaction with how quickly care could be obtained fell below the National Medicaid average for both adults and children.

- Adult satisfaction increased from 76.3% in 2014 to 78.3% in 2015.
- Child satisfaction decreased significantly from 84.0% in 2014 to 77.1% in 2015.

Summary of Findings

Quality

DHCF Quality Strategy

DHCF's Quality Strategy reflects both current and planned activities aimed at improving healthcare services and outcomes for Medicaid managed care enrollees. The Quality Strategy includes three broad goals:

1) Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members.
2) Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services.
3) Establish greater control and predictability over the District's spending on health care.

Beginning in FY 2014, in its efforts to achieve these goals, DHCF developed a proactive approach to early identification of areas for concern through quarterly monitoring and reporting of MCO performance. As a result of these efforts, DHCF published its first Annual Managed Care Performance Report Card in April 2015.[21] Report Card results identify satisfactory assessments for the following areas: financial condition,

[21] District of Columbia's Managed Care Program End-of Year Performance Report Card; Contract Year 1 July 2013 – June 2014; Retrieved Nov. 12, 2015 from http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%20Program%20End-of%20Year%20Performance%20Report%20Card%20-%20DHCF.pdf

administrative performance, and utilization of physician care. Overall, care coordination is the biggest opportunity for improvement—including managing low acuity emergency department (ED) utilization, avoidable hospital admissions, and reducing hospital readmissions. To further quality improvement efforts on the part of the MCOs, DHCF plans to incentivize MCOs beginning in FY 2016 by implementing a pay-for-performance program.

In addition to the established Report Card measures, DHCF requires all MCOs to collect and submit annual audited HEDIS and CAHPS performance measures. DHCF has set performance goals for these measures at the national Medicaid 75th percentiles. However, for measurement year (MY) 2014 MCOs failed to meet the desired threshold for most HEDIS and CAHPS measures.

Quality Assessment and Performance Improvement Programs

The MCOs operate strong QAPI programs. Quality Program Descriptions and Work Plans are updated annually based on priority initiatives. The MCOs engage providers in quality program management and oversight. Performance is monitored via collaborative PIPs, HEDIS, CAHPS survey, provider satisfaction, NCQA, and EQRO findings. Quality teams are multidisciplinary and collaborate and prioritize to meet the needs of the membership.

Case Management

The MCOs operate case management programs that aim to engage complex and at risk members and to actively manage their care. Efforts are made to coordinate access to services and assist in the facilitation of appropriate and timely care and services. Additionally, goals include bringing noncompliant members into care and promoting self-management. Consistent with the collaborative PIPs, case managers attempt to identify high risk pregnant members as early as possible to coordinate appropriate prenatal care in an effort to reduce adverse perinatal and birth outcomes. Pediatric members are also engaged in case management to improve medication compliance and reduce ED utilization and inpatient admissions.

Performance Improvement Projects

The MCOs submitted methodologically sound PIPs for both collaborative projects: Improving Perinatal and Birth Outcomes and Pediatric Asthma. The submissions included thorough barrier analyses and interventions that directly target specific member, provider, and MCO barriers. Results were accurately and clearly presented, and baseline measurements were compared to internal goals and/or benchmarks when available. Delmarva Foundation recommends that MCOs continue with the current interventions in an effort to improve PIP performance. MCOs should collaborate with DHCF and each other on ways to improve the provider completion, return, and utilization of the OB Authorization/Assessment Form. Additionally, the MCOs should work with the collaborative work group to identify goals for the PIPs. Lastly, performance measure results should be monitored on a regular basis to ensure the interventions are achieving the desired impact.

MCO performance compared favorably to national and District-wide March of Dimes benchmarks for the Improving Perinatal and Birth Outcomes PIP. However, lack of documentation for HIV testing presented itself as an opportunity for improvement. The MCO weighted average for the No Maternal HIV Testing measure was 60.10%. In regard to the Pediatric Asthma PIP, results indicated that ED and inpatient hospital utilization was highest among children in the 2-4 years of age category. Appropriate medications were prescribed for 78.00% of members; however, only 59.29% were compliant with medication use for at least half of the prescribed period of treatment.

Performance Measure Validation

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. Although MCOs initially showed inconsistencies in interpretation of denominator specifications for the Perinatal and Birth Outcomes indicators, algorithmic compliance was eventually achieved by all MCOs after clarification from the auditor and DHCF. All measure indicators and final rates were deemed reportable for both collaborative PIPs.

HEDIS and CAHPS Performance Measures

The MCO weighted averages for the Comprehensive Diabetes Care indicators were below the national Medicaid averages. Results were similar for the Controlling High Blood Pressure performance measure. Based on the MCO averages, performance for all quality related CAHPS measures was below the 75th percentile benchmarks. Quality of care and services were scored higher for children. The following child survey measure results exceeded the national 75th percentile:

- Health Promotion and Education Composite
- Coordination of Care Composite
- Ration of Personal Doctor (8+9+10)

Access

HEDIS and CAHPS Performance Measures

The MCOs had mixed results in child and adult access related measures. The District weighted average did not meet the Medicaid national average in adult and young children's access, as well as in childhood immunization measures. The District weighted average exceeded the Medicaid average in adolescent access, adolescent immunizations, and annual dental visits measures. The District MCO average exceeded the 75th percentile in lead screening, well-child visits (3-6 years of age), and adolescent well care measures.

In regard to member surveys, the MCO weighted average fell below the Medicaid national average in Getting Needed Care for both adults and children.

The District's MCOs must continue to focus on improving access to care for adults and children. Improved access can reduce emergency department utilization, improve or stabilize chronic conditions, and prevent childhood illness and associated complications.

Timeliness

HEDIS and CAHPS Performance Measures

HEDIS measures for Timeliness of Prenatal Care and the Frequency of Ongoing Prenatal Care fell short of the national Medicaid averages. CAHPS results for satisfaction with Getting Care Quickly also did not meet the national averages. These measures present as opportunities for improvement.

Status of 2014 Recommendations

MCOs

As a result of the 2014 review activities several recommendations for improvement were made to the MCOs. The MCOs were expected to act on the recommendations during 2015. The status of each recommendation is described below.

AmeriHealth Caritas District of Columbia

2014 Opportunity for Improvement:

- 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.

Follow Up Activity and 2015 Finding:

- Based on a sample of grievances reviewed during the 2014 OSR site visit, there were two instances where the MCO was not timely in resolving grievances and providing notification to members. To address the issue, the Member Services Supervisor now reviews a weekly report that tracks the status of each grievance and member notification. As a result, there have not been any timeliness issues in 2015.

Health Services for Children with Special Needs, Inc.

2014 Opportunities for Improvement:

- The CASSIP 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 CASSIP 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 CASSIP must furnish services timely.

* 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 recognized that MCOs have interpreted contract language differently and planned to complete an internal review during 2015 with the intent of providing clarification to the MCOs. MCOs were not required to develop an action plan to address this component.

Follow Up Activity and 2015 Finding:

- HSCSN was using and distributing an outdated Provider Directory; the last update was completed in 2012. The CASSIP was tasked with refreshing the Provider Directory to ensure accurate and current information was being distributed to members. During the 2015 OSR site review, HSCSN staff explained that the Provider Directory was updated in June 2015 to demonstrate compliance and provide enrollees with current provider contact information.
- Per requirements, enrollees should be notified of any complaint/grievance resolution within 30 days of HSCSN receiving the complaint/grievance. Based on a review of randomly selected files in 2014, the EQRO determined that the 30 day resolution and notification requirement was not consistently met. To address requirements, HSCSN developed a peer review tool and process to ensure timely resolution and notification. During the site review, HSCSN reported 100% compliance since initiating the intervention.
- HSCSN members are not always able to obtain routine provider appointments within 30 days of requesting the appointment, as evidenced by the CASSIP's 2014 secret shopper results (64.3% compliant). HSCSN conducted provider education regarding scheduling requirements and also posted access requirements on the provider website, as well as within the provider newsletter. Based on an analysis of secret shopper survey results through September 2015, compliance had improved to 79.3% - a 15 percentage point improvement. HSCSN should continue efforts to further improve compliance.

MedStar Family Choice

2014 Opportunity for Improvement:

- 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.*

Follow Up Activity and 2015 Finding:

- The 2014 Member Handbook was found to have an inaccurate deadline (15 days) for a member to file an appeal or request a fair hearing in order to have their benefits continue after an adverse action. During the 2015 site visit, the MCO provided evidence of the correction (10 days). The 2015 Member Handbook was revised to state, "If you want to continue receiving the benefit during your fair hearing or appeal, you must request the fair hearing or appeal with the later of the following: within 10 days [of notice]…"

Trusted Health Plan

2014 Opportunities for Improvement:

- 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 systems in place for enrollees that include 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.
- 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.

Follow Up Activity and 2015 Finding:
THP had numerous policies and procedures that required clarification and/or additional language to meet requirements. The MCO developed and submitted an action plan to address the required policy and procedure revisions. The action plan was approved and indicated that all policies and procedures would be revised and approved by June 2015. During the site review, THP provided evidence that its Quality Executive Committee had signed off on the revised policies on June 30, 2015.

DHCF

2014 Opportunities for Improvement and Follow Up Activities:

1) Once baseline data are collected, DHCF should set specific performance goals for the selected quality measures for children and adults receiving Medicaid services, regardless of whether a pay for performance initiative is implemented. *In 2015, DHCF set performance goals for HEDIS and CAHPS measures at the 75th percentile.*

2) 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. *DHCF makes the Annual Managed Care Performance Report available to stakeholders and enrollees on the District's website.*
3) To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances. *DHCF acknowledged this recommendation and is in agreement; however, DHCF decided to maintain current definitions until the new managed care regulations are finalized.*

2015 Opportunities for Improvement

MCO Opportunities for Improvement

Although each MCO is committed to delivering high quality care and services to its managed care members, opportunities exist for continued performance improvement. Delmarva Foundation recommends that all MCOs focus on improving performance for all PIP collaborative measures and all HEDIS and CAHPS measures that are not meeting the 75th percentile benchmark. Based on 2015 assessments, Delmarva Foundation developed the following MCO specific recommendations:

AmeriHealth Caritas District of Columbia

- The MCO should explore options for identifying HIV testing—specifically identifying the pregnancy profile blood test—so the organization can more accurately assess its compliance with testing. This is a critical component of the collaborative PIP and it is important for Case Managers to be aware of HIV positive members so they are able to monitor treatment.
- ACDC Case Managers should routinely monitor medication compliance in an effort to improve member self-management.

Health Services for Children with Special Needs, Inc.

- HSCSN's Case Managers should improve monitoring of and member compliance with postpartum visits.
- Case Managers should routinely monitor medication compliance and promote member self-management.

MedStar Family Choice

- MFC should include an explicit statement in its Continuous Quality Improvement Plan that addresses confidentiality and privacy and provide reference to the MCO's collection of privacy policies.
- To better demonstrate evidence of provider compliance in submitting the OB Authorization/Assessment Forms (PIP collaborative intervention), MFC should scan and save the documents rather than destroying the forms after extracting necessary information.

Trusted Health Plan

- Provide evidence of monitoring racial, socioeconomic, and ethnic disparities in health care utilization and in health outcomes and make efforts to reduce such disparities.
- Revise the Continuous Quality Improvement Program Description and provide explicit language to assure compliance with the requirement that the Chief Quality Officer is accountable for the continuous quality improvement activities for the MCO's own providers, as well as the subcontracted providers.
- Revise the Continuous Quality Improvement Program Description and provide explicit language to assure compliance with the requirement that the Chief Quality Officer must participate in monthly Continuous Quality Improvement meetings with DHCF and the EQRO.
- THP's Case Managers should improve monitoring of and member compliance with postpartum visits.
- THP should explore opportunities to more effectively obtain and track birth outcomes, such as birth weight and gestational age. These outcomes are critical components of the Improving Perinatal and Birth Outcomes PIP.
- THP Case Managers should ensure that all pediatric members with asthma that have a history of high utilization are contacted for case management services and no member meeting criteria "slips through the cracks."

DHCF Recommendations

Considering all the results for measures of quality, access, and timeliness of care for the contracted MCOs, Delmarva Foundation developed the following recommendations for DHCF:

- Develop performance improvement goals for PIP collaborative performance measures. This will improve MCO accountability and engagement in collaborative efforts.
- Although DHCF set a performance goal at the 75th percentile for all HEDIS and CAHPS measures, Delmarva Foundation recommends that DHCF also set minimum performance goals for the MCOs on select HEDIS and CAHPS measures. Failure to meet these minimum performance levels may result in formal corrective action plans.
- Based on case management review findings and HEDIS performance measure results, add the Timeliness of Prenatal Care and Postpartum Care measures to the Improving Perinatal and Birth Outcomes Collaborative PIP. The District weighted averages for both measures fail to meet national Medicaid average.
- MCOs are all working to improve data collection for the Maternal HIV Testing measure. While it is important that MCOs improve data collection to accurately assess compliance, the ultimate goal should be to identify HIV positive members and ensure they are obtaining treatment to reduce risk of transmission to their unborn babies. DHCF should consider requiring MCOs initiate at least one intervention that aims to improve member awareness and understanding of one's HIV status and steps that can be taken to treat HIV positive members and reduce transmission.

- Determine if the District will allow MCOs to define and process appeals in a pre- and post-service manner with different resolution timeframe requirements. Some MCOs do not process "post-service" appeals according to the District's 15 day requirement.
- To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances.

Appendix 1
HEDIS 2015 - Measurement Year (MY) 2014

The HEDIS performance measure result tables include MY 2014 results. Individual MCO performance rates, the District weighted average, and a comparison of the District weighted average to the HEDIS 2015 (MY 2014) NCQA Quality Compass benchmark are provided for each measure. Comparisons to the benchmarks are made via a diamond rating system.

National Medicaid Percentile Ranges	Diamond Rating
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.	♦♦♦

Effectiveness of Care Domain

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	43.71	^	29.85	^	39.5	♦
Adult BMI Assessment	^	79.51	90.51	^	85.8	♦♦
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	70.61	0.00	87.52	80.83	75.8	♦
Annual Monitoring for Patients on Persistent Medications - Digoxin	^	^	^	^	^	
Annual Monitoring for Patients on Persistent Medications - Diuretics	67.48	^	84.54	76.24	72.5	♦

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Annual Monitoring for Patients on Persistent Medications - Total	69.05	87.88	85.98	78.83	74.2	♦
Antidepressant Medication Management - Effective Acute Phase Treatment	45.94	17.65	53.09	49.09	46.9	♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	33.69	8.82	37.45	31.82	33.6	♦
Appropriate Testing for Children With Pharyngitis	79.44	70.00	84.82	^	79.5	♦♦
Appropriate Treatment for Children With Upper Respiratory Infection	97.12	95.73	95.56	99.52	97.2	♦♦♦
Asthma Medication Ratio (5-11)	^	60.00	0.00	^	60.0	♦
Asthma Medication Ratio (12-18)	^	51.02	0.00	^	51.0	♦
Asthma Medication Ratio (19-50)	^	61.82	42.86	^	54.4	♦♦♦
Asthma Medication Ratio (51-64)	^	0.00	0.00	^	^	
Asthma Medication Ratio (Total)	^	57.29	57.89	^	57.4	♦
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	31.30	0.00	37.67	62.82	37.1	♦♦♦
Breast Cancer Screening	^	^	^	^	^	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	^	^	^	^	^	
Cervical Cancer Screening	74.39	64.61	62.29	28.54	65.0	♦♦
Childhood Immunization Status - Combo 2	75.69	80.00	74.84	14.99	68.1	♦
Childhood Immunization Status - Combo 3	73.84	77.86	72.29	14.00	66.3	♦
Childhood Immunization Status - Combo 4	73.84	77.86	71.02	14.00	66.1	♦♦
Childhood Immunization Status - Combo 5	60.88	44.29	56.69	11.55	53.4	♦
Childhood Immunization Status - Combo 6	48.15	47.14	46.82	10.81	43.2	♦
Childhood Immunization Status - Combo 7	60.88	44.29	55.73	11.55	53.3	♦
Childhood Immunization Status - Combo 8	47.92	47.14	46.50	10.81	43.0	♦♦

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Childhood Immunization Status - Combo 9	41.90	26.43	37.90	9.09	36.6	♦
Childhood Immunization Status - Combo 10	41.90	26.43	37.58	9.09	36.6	♦♦
Childhood Immunization Status - DTaP	81.48	83.57	76.43	17.44	72.9	♦
Childhood Immunization Status - Hepatitis A	90.28	93.57	87.58	56.76	85.9	♦♦
Childhood Immunization Status - Hepatitis B	89.35	92.86	88.54	19.41	80.5	♦
Childhood Immunization Status - HiB	92.59	90.71	88.22	22.60	83.2	♦
Childhood Immunization Status - Influenza	56.48	58.57	52.55	25.55	52.3	♦♦
Childhood Immunization Status - IPV	90.74	91.43	85.67	20.64	81.4	♦
Childhood Immunization Status - MMR	91.90	96.43	90.45	55.77	87.4	♦
Childhood Immunization Status - Pneumococcal Conjugate	81.71	85.00	79.62	17.20	73.4	♦
Childhood Immunization Status - Rotavirus	71.76	49.29	64.65	14.99	62.8	♦
Childhood Immunization Status - VZV	91.44	95.71	88.54	56.02	86.8	♦
Chlamydia Screening in Women (Lower Age Stratification)	76.81	75.96	75.00	64.97	75.6	♦♦♦
Chlamydia Screening in Women (Upper Age Stratification)	74.68	73.68	73.20	69.37	73.6	♦♦♦
Chlamydia Screening in Women - Total	75.73	74.87	74.07	68.09	74.5	♦♦♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	57.12	55.00	61.50	10.61	51.8	♦
Comprehensive Diabetes Care - Eye Exams	49.13	45.00	47.08	38.49	47.1	♦
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	31.40	0.00	30.66	4.85	27.7	♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	47.05	40.00	45.07	6.83	40.9	♦
Comprehensive Diabetes Care - HbA1c Testing	83.85	82.50	81.57	77.34	82.4	♦

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Comprehensive Diabetes Care - Medical Attention for Nephropathy	80.21	62.50	78.65	76.98	79.3	♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) (Lower score is better)	43.92	52.50	46.53	91.91	51.3	♦
Controlling High Blood Pressure	47.89	59.46	53.28	6.50	43.8	♦
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.67	0.00	0.00	0.00	66.7	♦
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	62.00	72.50	82.05	64.58	67.5	♦
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	75.71	^	^	^	75.7	♦♦♦
FU Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	0.00	23.33	0.00	0.00	23.3	♦
FU Care for Children Prescribed ADHD Medication - Initiation	33.52	28.21	0.00	0.00	31.0	♦
FU After Hospitalization For Mental Illness - 7 days	16.53	18.02	12.25	26.79	17.5	♦
FU After Hospitalization For Mental Illness - 30 days	29.46	38.37	24.51	40.48	31.5	♦
Human Papillomavirus Vaccine for Female Adolescents	38.89	37.68	32.18	6.90	36.2	♦♦♦
Immunizations for Adolescents - Meningococcal	87.01	87.83	77.85	24.55	82.7	♦♦
Immunizations for Adolescents - Tdap/Td	83.82	88.26	78.77	20.91	80.5	♦
Immunizations for Adolescents - Combination 1	82.11	83.91	74.77	18.18	78.1	♦♦
Lead Screening in Children	86.63	86.21	78.03	59.21	82.3	♦♦♦
Medication Management for People With Asthma: Medication Compliance 50% (5-11 Years)	^	63.28	^	^	63.3	
Medication Management for People With Asthma: Medication Compliance 50% (12-18 Years)	^	55.95	^	^	56.0	

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Medication Management for People With Asthma: Medication Compliance 50% (19-50 Years)	^	71.74	^	^	71.7	
Medication Management for People With Asthma: Medication Compliance 50% (51-64 Years)	^	0.00	^	^	^	
Medication Management for People With Asthma: Medication Compliance 50% (Total)	^	62.40	58.73	^	61.7	
Medication Management for People With Asthma: Medication Compliance 75% (5-11 Years)	^	33.59	^	^	33.6	♦♦♦
Medication Management for People With Asthma: Medication Compliance 75% (12-18 Years)	^	30.95	^	^	31.0	♦♦♦
Medication Management for People With Asthma: Medication Compliance 75% (19-50 Years)	^	50.00	^	^	50.0	♦♦♦
Medication Management for People With Asthma: Medication Compliance 75% (51-64 Years)	^	0.00	^	^	^	
Medication Management for People With Asthma: Medication Compliance 75% (Total)	^	35.66	28.57	^	34.3	♦♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5 Years) 1st Year	^	^	^	^	^	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (6-11 Years)	13.04	25.81	0.00	0.00	20.4	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (12-17 Years)	28.18	42.07	^	^	36.5	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	22.98	37.72	0.00	0.00	31.6	
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) (Lower score is better)	4.21	2.06	1.27	1.43	3.3	♦♦
Persistence of Beta-Blocker Treatment after a Heart Attack	70.59	0.00	0.00	0.00	70.6	♦
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.02	0.00	87.50	23.08	77.5	♦

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	67.94	0.00	72.73	7.69	60.5	♦
Use of Appropriate Medications for People with Asthma (5-11 Years)	^	93.43	0.00	^	93.4	♦♦♦
Use of Appropriate Medications for People with Asthma (12-18 Years)	^	84.85	0.00	^	84.9	♦
Use of Appropriate Medications for People with Asthma (19-50 Years)	^	80.70	71.43	^	77.2	♦♦
Use of Appropriate Medications for People with Asthma (51-64 Years)	^	0.00	0.00	^	^	
Use of Appropriate Medications for People with Asthma - Total	^	88.05	82.89	^	87.0	♦♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-5 Years)	0.00	0.00	0.00	0.00	^	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6-11 Years)	33.33	0.00	0.00	0.00	33.3	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Years)	28.04	22.89	0.00	0.00	25.8	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	30.57	25.66	0.00	0.00	28.5	
Use of Imaging Studies for Low Back Pain	86.71	0.00	82.91	91.74	86.6	♦♦♦
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1-5 Years)	0.00	0.00	0.00	0.00	^	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6-11 Years)	0.00	0.00	0.00	0.00	^	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12-17 Years)	0.00	0.90	0.00	0.00	0.9	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	0.00	0.63	0.00	0.00	0.6	

Effectiveness of Care Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 Years)	80.48	79.10	78.63	20.58	74.1	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 Years)	82.14	75.72	78.52	24.14	77.8	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	81.02	77.54	78.59	21.30	75.3	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Years)	84.59	78.61	68.32	14.78	75.1	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Years)	75.71	73.41	64.43	13.79	70.3	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	81.71	76.20	66.91	14.58	73.5	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Years)	76.37	72.14	66.03	13.33	68.4	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Years)	76.43	70.52	62.42	12.64	70.1	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	76.39	71.39	64.72	13.19	69.0	♦ ♦ ♦

^ Measures not collected or denominator too small to calculate reliable rate.

Access/Availability of Care Domain

Access/Availability of Care Domain Measure Name HEDIS 2015 (MY2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	71.63	78.64	64.36	57.04	67.6	♦
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	79.98	0.00	73.60	68.06	76.3	♦
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	78.57	0.00	0.00	56.76	71.9	♦
Adults' Access to Preventive/Ambulatory Health Services (Total)	74.44	78.64	67.99	60.52	70.6	♦
Annual Dental Visit (2-3 Years)	62.92	55.56	6.82	55.15	54.8	♦♦♦
Annual Dental Visit (4-6 Years)	77.23	74.62	11.06	68.86	67.9	♦♦♦
Annual Dental Visit (7-10 Years)	76.08	79.56	12.08	68.77	65.9	♦♦
Annual Dental Visit (11-14 Years)	71.18	75.00	10.10	62.20	60.5	♦♦
Annual Dental Visit (15-18 Years)	60.60	68.43	10.13	48.35	51.9	♦♦
Annual Dental Visit (19-21 Years)	41.11	58.07	7.15	32.94	35.8	♦♦
Annual Dental Visit (Total)	67.37	69.79	9.94	59.10	58.0	♦♦
Call Answer Timeliness	92.56	96.39	84.41	76.46	91.5	♦♦♦
Children and Adolescents' Access To PCP (12-24 Months)	94.17	93.44	89.96	86.00	91.9	♦
Children and Adolescents' Access To PCP (25 Months-6 Years)	88.37	91.69	82.56	81.43	86.8	♦
Children and Adolescents' Access To PCP (7-11 Years)	0.00	94.95	84.03	0.00	93.4	♦♦
Children and Adolescents' Access To PCP (12-19 Years)	0.00	92.75	79.14	0.00	91.5	♦♦
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	0.00	1.23	2.40	0.00	2.4	♦

Access/Availability of Care Domain Measure Name HEDIS 2015 (MY2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	0.00	11.11	26.14	0.00	25.5	♦
Prenatal and Postpartum Care - Postpartum Care	46.39	48.94	54.74	33.25	47.2	♦
Prenatal and Postpartum Care - Timeliness of Prenatal Care	64.34	77.66	81.75	62.57	69.4	♦

Utilization Domain

Utilization Domain Measure Name HEDIS 2015 (MY 2014)	ACDC MY 2014 %	HSCSN MY 2014 %	MFC MY 2014 %	THP MY 2014 %	District Weighted Average MY 2014 %	Diamond Rating
Adolescent Well-Care Visits	62.0	71.4	55.2	45.8	60.4	♦♦♦
Frequency of Ongoing Prenatal Care (<21%)	12.82	8.51	7.06	15.45	11.4	♦
Frequency of Ongoing Prenatal Care (21-40%)	10.02	15.96	6.08	10.47	9.1	♦♦
Frequency of Ongoing Prenatal Care (41-60%)	18.18	17.02	12.17	18.59	16.5	♦♦♦
Frequency of Ongoing Prenatal Care (61-80%)	28.67	31.91	19.95	27.23	26.1	♦♦♦
Frequency of Ongoing Prenatal Care (≥81%)	30.3	26.6	54.7	28.3	36.8	♦
Well-Child Visits in the first 15 Months of Life (0 visits)	3.01	0.00	5.11	6.27	4.0	♦♦♦
Well-Child Visits in the first 15 Months of Life (1 visit)	1.16	3.90	4.14	6.27	2.6	♦♦
Well-Child Visits in the first 15 Months of Life (2 visits)	3.94	1.30	3.16	8.12	4.2	♦♦
Well-Child Visits in the first 15 Months of Life (3 visits)	4.86	5.19	4.14	9.23	5.2	♦
Well-Child Visits in the first 15 Months of Life (4 visits)	9.72	12.99	6.33	17.34	10.0	♦
Well-Child Visits in the first 15 Months of Life (5 visits)	23.84	11.69	16.55	18.08	21.0	♦♦♦
Well-Child Visits in the first 15 Months of Life (6 or more visits)	53.5	64.9	60.6	34.7	53.2	♦
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	83.1	85.7	76.9	70.8	80.8	♦♦♦

Appendix 2
2015 CAHPS Survey

The tables include adult and child CAHPS survey performance measure results. Individual 2015 MCO results, the District average, and a comparison of the 2015 District average to the 2015 Quality Compass national Medicaid benchmarks are provided. For trending purposes, the 2014 District average is also included. Comparisons to the benchmarks are made via a diamond rating system.

National Medicaid Percentile Ranges	Diamond Rating
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.	♦♦♦

Adult CAHPS Measures

Adult CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2014 %	District Average 2015 %	Diamond Rating
Customer Service Composite	87.9	83.9	82.5	NA	86.3	84.8	♦
Getting Needed Care Composite	80.7	81.5	75.0	73.2	75.5	77.6	♦
Getting Care Quickly Composite	83.5	80.8	77.0	71.9	76.3	78.3	♦
How Well Doctors Communicate Composite	94.0	93.3	92.5	88.7	92.8	92.1	♦♦
Shared Decision Making Composite	76.2	76.7	77.7	NA	52.1	76.9	♦
Health Promotion and Education Composite	76.9	73.8	77.0	64.9	74.0	73.2	♦♦
Coordination of Care Composite	80.1	89.8	58.0	74.3	80.3	75.5	♦
Rating of Health Plan (8+9+10)	78.6	76.0	75.0	70.6	73.5	75.0	♦
Rating of All Health Care (8+9+10)	76.5	79.2	71.0	69.3	70.8	74.0	♦♦
Rating of Personal Doctor (8+9+10)	87.0	78.3	82.0	77.7	81.8	81.2	♦♦

Adult CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2014 %	District Average 2015 %	Diamond Rating
Rating of Specialist Seen Most often (8+9+10)	87.3	79.4	75.0	NA	79.7	80.6	♦ ♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	77.9	69.4	57.0	44.2	65.0	62.1	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	44.0	38.9	39.0	28.1	34.0	37.5	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	44.6	50.0	31.0	22.5	31.3	37.0	♦
Aspirin Use and Discussion - Take daily aspirin/ every other day	22.0	0.0	22.0	15.9	16.7	15.0	^
Aspirin Use and Discussion - Discussed risks and benefits of using aspirin	39.3	0.0	42.0	30.3	31.3	27.9	^
Flu measure - Had flu shot or spray in the nose since July 1, 2014	41.3	44.8	38.0	29.1	36.7	38.3	♦

Benchmark Source: 2015 Quality Compass National Medicaid
NA - Responses <100
^ - National benchmark not available

Child CAHPS Measures

Child CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2014 %	District Average 2015 %	Diamond Rating
Child Survey - General Population: Customer Service Composite	87.8	86.0	86.5	78.2	85.8	84.6	♦
Child Survey - General Population: Getting Needed Care Composite	80.7	83.0	78.5	75.0	78.8	79.3	♦
Child Survey - General Population: Getting Care Quickly Composite	83.8	88.3	57.0	79.4	84.0	77.1	♦
Child Survey - General Population: How Well Doctors Communicate Composite	92.6	93.3	90.5	89.2	91.5	91.4	♦
Child Survey - General Population: Shared Decision Making	82.1	81.4	78.3	NA	59.5	80.6	♦ ♦
Health Promotion and Education Composite	76.7	77.6	79.0	71.0	76.3	76.1	♦ ♦ ♦
Coordination of Care Composite	85.5	86.1	84.0	NA	84.7	85.2	♦ ♦ ♦
Child Survey - General Population: Rating of Health Plan (8+9+10)	85.5	81.8	85.0	82.2	81.8	83.6	♦
Child Survey - General Population: Rating of All Health Care (8+9+10)	83.9	86.0	89.0	83.1	85.8	85.5	♦ ♦
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	89.2	88.9	91.0	90.5	90.5	89.9	♦ ♦ ♦
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	87.3	79.3	78.0	NA	86.3	81.5	♦

Benchmark Source: 2015 Quality Compass National Medicaid
NA - Responses <100

Child CAHPS Measures – Supplemental Dental Questions

Child CAHPS Measures Supplemental Dental Questions	ACDC %	HSCSN %	MFC %	THP %	District Average 2014 %	District Average 2015 %	Diamond Rating
Dental: Child has a regular dentist	87.4	93.9	80.0	NR	79.3	87.1	^
Dental: Child has seen regular dentist for a check-up or routine care in the last 6 months	86.5	85.8	78.0	NR	79.5	83.4	^
Dental: How often child received dental appointments with regular dentist as soon as you wanted	85.6	90.2	81.0	NR	78.8	85.6	^
Dental: If child does not have a regular dentist, child still got a check-up or other routine dental care in the last 6 months	37.7	77.1	22.0	NR	33.8	45.6	^

^ - National benchmark not available
NR - MCO did not report the rate or the rate was biased