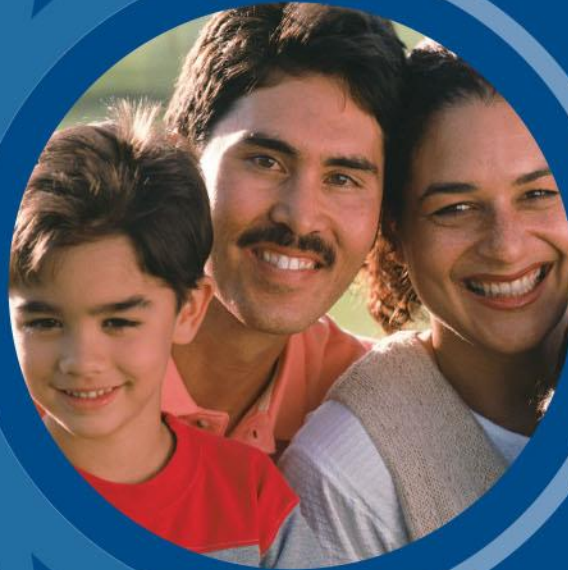


District of Columbia
Department of Health Care Finance



Medicaid Managed Care Organizations

2016 Annual Technical Report



Delmarva Foundation

A subsidiary of Quality Health Strategies

Submitted by:
Delmarva Foundation
April 2017

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District of Columbia - Department of Health Care Finance

2016 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 2016, approximately 182,494 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 Set (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 (NCQA).

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

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

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 assessment of the quality and timeliness of, and access to healthcare services provided to the District's Medicaid MCO members during the period from January 1, 2016, through December 31, 2016.

Methodology

During 2016, federal regulations required that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the Centers for Medicare and Medicaid Services (CMS).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 federal requirements, 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.
- 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 OSR was conducted in 2014. Therefore, DHCF elected to have the 2016 external quality review (EQR) compliance review activities focus on four distinct areas: (1) evaluating the timeliness and appropriateness of the MCO's resolution of grievances; (2) case management procedures and documentation specific to services for pregnant women and children with asthma; (3) provider access and availability; and (4), actions undertaken by the MCOs to address areas of non-compliance and recommendations for improvement from the 2015 findings.

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

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.

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 members 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 members. 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 and link payment to quality.

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. The DC Managed Care Quarterly Performance Report results are now published on a quarterly basis including a year-end report. The most recent 2016 reports analyze performance from April 2016 – June 2016. Beginning in FY2018 the reports will be published on a semi-annual basis. Overall, care coordination is the biggest opportunity for improvement—including managing low acuity ED utilization, potentially preventable hospital admissions, and reducing 30 day hospital readmissions.

To further quality improvement efforts on the part of the MCOs, DHCF developed and implemented a pay-for-performance (P4P) program which began in FY2017. The P4P program incentivizes MCOs to improve performance and reduce inappropriate utilization. The program will continue in the new risk-based MCO contracts that will begin in October 2017.

In FY2016, MCOs began submitting HEDIS® and PIP performance measure data quarterly for the purposes of conducting qualitative and quantitative analysis, identifying opportunities for improvement, interventions and evaluating intervention effectiveness during DHCF MCO Quality and QI Collaborative meetings.

In FY2016, DHCF also began the planning phase of a MCO care coordination/case management initiative to address the care coordination deficiencies identified in the DC Managed Care Performance Report. The implementation phase began in October, FY2017. This initiative puts in place a set of comprehensive standards and guidelines for care coordination/case management to ensure core consistencies management; reporting of enrollment and program outcomes. As part of the perinatal quality improvement collaborative, DHCF DQHO and Health Care Innovation and Reform Administration (HCIRA) secured CMS Medicaid Innovation Accelerator Program (IAP) funding to launch a perinatal “registry”. The goal of IAP is to improve care and improve health for Medicaid beneficiaries, and reduce costs by supporting states in accelerating new payment and service delivery reforms. The IAP focuses on populations with significant needs served by Medicaid programs, such as pregnant women and newborns, children, individuals with mental illness, individuals receiving long-term services and supports, and others. The perinatal “registry” will provide a venue for providers to utilize electronic health record (EHR) data to auto populate components of the Obstetrics Authorization and Initial Assessment Form electronically and allow for better care coordination between DHCF, MCOs, and Medicaid providers to 1) maximizing community partnerships through a quality improvement collaborative 2) enhanced care coordination through the use of technology, and 3) Utilize IAP funding to improve healthcare for pregnant Medicaid beneficiaries.

In addition to the DC Managed Care Quarterly Performance Report, DHCF requires all MCOs to collect and submit annual audited HEDIS® performance measures and CAHPS® surveys. DHCF has set performance goals for these measures at the NCQA Quality Compass Medicaid HMO 75th percentiles. However, Measurement Year (MY) 2015 reported rates show that the District weighted average was below the 75th percentile for most HEDIS® and CAHPS® measures. DHCF is strategizing and working to prioritize performance and survey measures based on opportunities for improvement. MCOs will be required to develop action plans to improve performance and reduce gaps in care.

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 described below, 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 asthma 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 initially by three MCOs and subsequently by the last MCO after revisions. Remeasurement Year 1 (Measurement Year 2015) results were compared to baseline measurements (MY 2014) and to internal goals and/or benchmarks when available.

MCO performance compared favorably to national and District-wide March of Dimes benchmarks for the Improving Perinatal and Birth Outcomes PIP. Additionally, documentation of HIV testing improved considerably compared to the prior year; however, almost half of pregnant members' records still lack documentation of receipt of this test. In regard to the Pediatric Asthma PIP, results indicated that Emergency Department (ED) and inpatient hospital utilization remains highest among children in the 2-4 years of age category. Appropriate medications were prescribed for 72.33% of members; however, only 52.47% were compliant with medication use for at least half of the prescribed period of treatment.

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 and Initial Assessment Form. Lastly, performance measure results should be monitored on a regular basis to ensure the interventions are achieving the desired impact.

Performance Measure Validation

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. All measure indicators and final rates were deemed reportable for both collaborative PIPs.

HEDIS® Performance Measures and CAHPS® Surveys

Three of the seven MCO weighted averages for the Comprehensive Diabetes Care indicators, HbA1c control under 7%, HbA1c control under 8%, and Poor HbA1c Control (greater than 9%), exceeded the NCQA Quality Compass Medicaid HMO averages but were below the 75th percentile. Four of the seven MCO weighted averages were below the national Medicaid average benchmarks. The MCO weighted average for the Controlling High Blood Pressure performance measure similarly fell below the national Medicaid average. Based on the MCO averages, performance for all but two quality related CAHPS® measures was below the national 75th percentile benchmarks. Adult rating of personal doctor and the Health Promotion and Education component of the child survey exceeded the 75th percentile. In general, members were less satisfied with the quality of care and services provided to children than for adults.

Access Findings

HEDIS® Performance Measures and CAHPS® Surveys

The MCOs had mixed results in child and adult access related measures. The District MCO weighted average exceeded the Quality Compass Medicaid HMO average in adolescent access, childhood and adolescent immunizations, lead screening, well-child visits (3 – 6 years of age), and children (25 months – 6 years) and adolescent access measures. It also exceeded the 75th percentile in children's access (7 – 11 years), adolescent well care, and annual dental measures. It did not meet the Medicaid national average in adult and infant (12 – 24 months) access, as well as in well-child visits (first 15 months of life) measures.

In regard to member surveys, the MCO average fell below the Quality Compass Medicaid HMO national average in Getting Needed Care for both adults and children and decreased over the prior year's results.

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.

Provider Directory Listings

Based upon validation of provider contact information listed in each MCO's provider directory opportunities exist for improving the accuracy of provider addresses and phone numbers. Inaccurate contact information can be a contributing factor to member access issues.

Timeliness Findings

HEDIS® Performance Measures and CAHPS® Surveys

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

Appointment Timeliness

Overall contractual compliance with appointment availability standards across all appointment categories was 45% with a range of 38% to 51% among the MCOs. Availability of non-urgent behavioral health appointments represented the lowest compliance rate at 23% closely followed by initial OB appointments at 24%. Wide variation in compliance rates with timely appointment availability standards exists among the MCOs.

Grievance Resolution

Compliance with required timeframes for grievance resolution was not consistently met by any of the MCOs. Additionally, opportunities were identified for ensuring an appropriate resolution to each grievance.

Status of 2015 Recommendations

As a result of the 2015 review activities, several recommendations for improvement were made to the MCOs. The MCOs were expected to act on the recommendations during 2016. The MCOs developed and implemented OFI Action Plans to address all 2015 recommendations. All OFIs were addressed by the MCOs; however, a few opportunities remain open. Two of the MCOs still do not have a majority of their new mothers attending postpartum appointments within the appropriate timeframe or at all. In addition, pediatric asthma case management remains an issue for two MCOs. One MCO is not monitoring medication compliance in their case management system, while the other MCO should ensure that their high utilizer pediatric asthmatics are being followed by a care manager. These OFIs will remain open and continue to be monitored until improvement is demonstrated and performance meets requirements.

2016 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. MCOs should strive to meet or exceed the PIP collaborative goals established by DHCF in January 2017. Goals were developed based on DC MCO averages, desired outcomes, and realistic incremental improvement targets. Additionally, the MCOs need to focus on improving performance in all HEDIS® performance measures and CAHPS® survey measures that are not meeting the Quality Compass Medicaid HMO 75th percentile benchmark. Based on 2016 assessments, Delmarva Foundation developed the following MCO specific OFIs. MCOs will be required to develop OFI Action Plans that will be approved and monitored by Delmarva Foundation. Delmarva Foundation will continue to monitor OFIs until MCOs demonstrate compliance.

AmeriHealth Caritas District of Columbia

- The overall compliance rate for member access to appointments within DHCF required timeframes is 41%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*

Health Services for Children with Special Needs, Inc.

- During the validation of the Provider Directory, it was determined that 15 out of the 30 providers contacted had incorrect information (50%). Thirteen errors were found in the provider's address,

and 2 phone numbers were incorrect. *The MCO should verify its provider directory information and create a procedure for maintaining accurate provider contact information in the provider directory.*

- The overall compliance rate for member access to appointments within DHCF required timeframes is 48%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*
- During the review of HSCSN's current complaint and grievance review process, it was determined that only 50% of written acknowledgements of grievances were issued within two business days of receipt. *The MCO should ensure that for all grievances, the date of receipt, independent of the party initially contacted (HSCSN or one of its vendors) should be the date documented as the start of the resolution process.*
- HSCSN reported that IMPACT DC does not routinely submit clinical assessments performed as part of the IMPACT DC intervention. During the case management review, only 50% of the records reviewed had asthma action plans or any type of medication education or management documentation. *HSCSN should work closely with IMPACT DC to ensure timely receipt of the member's assessment and intervention forms. This will assist in providing timely follow-up for members who have had an IMPACT DC intervention and who may need additional education, medication monitoring, or who are at high risk for another emergency department or inpatient visit.*
- Postpartum care appointment rates remain relatively low at 50% compliance based on the case management file review. *The MCO should conduct a thorough barrier analysis with particular focus on identifying interventions to improve postpartum visit compliance.*

MedStar Family Choice

- The overall compliance rate for member access to appointments within DHCF required timeframes is 45%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*
- The language in resolution letters to members may be too advanced. Words like "centricity" and phrases such as, "to be taken as advisement" or "pharmacy override" may be confusing wording for the member. *All member materials should adhere to DHCF's 5th grade reading level requirement.*
- Results from the case management review revealed that only 36% of the sample had an OB Authorization and Initial Assessment Form in their file. *It is recommended that MFC focus on identifying barriers to receipt of the OB Authorization and Initial Assessment Form. MFC may consider a provider incentive or other intervention to improve the rate of return.*

Trusted Health Plan

- The overall compliance rate for member access to appointments within DHCF required timeframes is 52%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*

- Documentation of and follow-up on the member complaint/grievance was sparse in the sample of files reviewed. Only 5 of 26 records showed evidence of a written acknowledgement of the grievance (19%). In addition, only 38% provided evidence of compliance with a written resolution within 30 days. *Going forward, THP should follow the grievance definition released by DHCF in the fourth quarter of 2016. It is consistent with the definition provided by the Code of Federal Regulations and provides clear instruction on grievance classification. THP should conduct staff trainings which outline resolution and documentation requirements. Staff should also understand the difference between a grievance and an inquiry. In addition, the MCO should develop a quality assurance process to conduct ongoing reviews of the handling of member grievances.*
- Eleven (11) of the 26 grievance files reviewed demonstrated evidence of unreasonable resolution (42%). For example, 5 demonstrated lack of a reasonable resolution such as asking a member to contact the provider regarding a billing issue. *The MCO must ensure reasonable resolution and should develop a quality assurance process to conduct ongoing reviews of the handling of member grievances.*
- THP's inability to provide 30 high risk pregnancy case management files presents an opportunity for improvement. Only 3 files were available for review. *THP clinical staff should work with the MCO's data analysts and programming staff to review existing criteria for identification of high risk pregnant members to ensure validity and reliability of results. It appears that the current procedure is not adequately capturing all members with high risk pregnancies and/or members are not being case managed.*
- Postpartum care was identified as an opportunity for improvement based on the 2015 OSR case management file review. This continues to be an opportunity for THP. Only 33% of the small sample of high risk pregnancies received postpartum care within the HEDIS required timeframe. *THP should continue efforts to identify barriers to care and implement interventions in response.*
- Per THP staff, IMPACT DC does not routinely submit assessments completed as part of the pediatric asthma intervention. During the case management file review, only 20% of the selected files had an asthma action plan, 10% showed evidence of a care plan, and 30% had an asthma assessment and evidence of medication education and monitoring. *THP has a dedicated care coordinator for members with pediatric asthma; this coordinator should ensure the timely receipt of IMPACT DC assessments. These assessments include valuable information including asthma action plans and evidence of member medication education.*

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:

- The MCOs and DHCF are encouraged to collaborate and work to identify additional sources for data for the collaborative measures, particularly for HIV testing. HIV testing may be part of a standardized prenatal laboratory screening panel completed in the first trimester of pregnancy. However, administrative data for HIV testing appears to be lacking for all MCOs. The performance measure specifications allow for medical record reviews. MCOs may want to take advantage of this opportunity to identify HIV testing for the pregnant members.

- Given the relatively low appointment access compliance rates across each of the MCOs, consider replicating the Timely Appointment Availability Study as part of a focused study. Comparisons can be made with the 2016 baseline data to determine if improvements have been made. DHCF and the MCOs have performed similar studies in the past. DHCF is encouraged to continue to focus efforts on monitoring performance and requiring the MCOs to develop action plans when performance is not meeting contractual requirements.
- Based on case management review findings and HEDIS® performance measure results, continue to include Timeliness of Prenatal Care and Postpartum Care measures to the Improving Perinatal and Birth Outcomes Collaborative PIP analysis. The District weighted averages for both measures fail to meet national Medicaid averages. Significant improvement is required by the MCOs to meet the District's goal of the Quality Compass Medicaid HMO 75th percentile.
- As a component of the perinatal collaborative, consider working with the MCOs to address common barriers to OB appointment access which may be a contributing factor to low prenatal and postpartum care rates. Consider devoting one of the Perinatal Collaborative meetings to this topic. MCOs can present barriers to care and discuss interventions.
- Consider having MCOs present successful strategies that improve timely completion and receipt of the OB Authorization and Initial Assessment Form. This form is key to identifying pregnant members early and has the potential to initiate the process for early intervention. This could be an agenda item during a Perinatal Collaborative meeting.

District of Columbia Department of Health Care Finance

2016 Annual Technical Report

Introduction

The District of Columbia (the District) Department of Health Care Finance (DHCF) is the single state agency responsible for managing the District's Medicaid program which provides healthcare coverage to low-income children, adults, elderly, and persons with disabilities. As of December 2016, approximately 182,494 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).⁶ 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 Set (HEDIS®)⁷ and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁸ data; and
- Attain and maintain National Committee for Quality Assurance (NCQA) accreditation.⁹

As noted, DHCF requires NCQA accreditation for the MCOs providing services to managed care members. 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 experience of care (CAHPS®). NCQA accreditation has been widely recognized by federal and state regulators as the gold standard for health plan

⁶ 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.

⁷ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁸ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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operations. Information from the NCQA accreditation activities is often used to augment state strategies for assessing 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. 2016)	Accreditation Status
AmeriHealth Caritas District of Columbia	90,260	NCQA Health Plan Accreditation ¹⁰ - expires 12/8/18
Health Services for Children with Special Needs, Inc.	5,535	NCQA Certification ¹¹ for Utilization Management - expires 4/13/17 (next scheduled review 1/17/17)
MedStar Family Choice	50,216	NCQA Health Plan Accreditation - expires 4/20/18
Trusted Health Plan	30,483	NCQA Health Plan Accreditation - expires 3/1/19

Purpose

Federal regulations (42 CFR §438.350) 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) Protocols¹² that describe procedures for conducting mandatory and optional activities to assess MCO performance. During 2016, DHCF required the EQRO to conduct the following mandatory activities:

- 1) A review conducted within the previous three-year period to determine MCO compliance with standards established by the State to comply with federal requirements, as well as applicable elements of the MCOs' contracts. This activity is known as the Operational Systems Review (OSR) in the District.
§438.358(b)(iii)
- 2) Validation of State-required performance measures, known as the Performance Measure Validation (PMV) audit. §438.358(b)(ii)
- 3) Validation of State-required performance improvement projects that were underway during the previous 12 months, known as the Performance Improvement Project (PIP) review. §438.358(b)(i)

¹⁰ 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.

¹¹ 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.

¹² 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 §438.340(a) also state that each State contracting with a managed care entity must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services provided by the managed care entity. 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 members.

In addition, 42 CFR §438.364(a) 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. This document is Delmarva Foundation's report to DHCF on the assessment of the quality and timeliness of, and access to healthcare services provided to DC Medicaid enrollees by MCOs for the period from January 1, 2016 through December 31, 2016.

Methodology

Operational Systems Review

The purpose of the OSR is to assess MCO performance against federal regulations and DHCF contractual requirements. A comprehensive OSR is required by CMS every three years. In 2014, a comprehensive review of these requirements was conducted, including standards established by DHCF to comply with the requirements of 42 CFR including a review of Enrollee Rights (ER) and Protections, Quality Assessment and Performance Improvement (QAPI), and 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 review.

At the request of DHCF, Delmarva Foundation conducted focused reviews of MCOs' structure and operations in 2015 and 2016. Key areas of focus for 2016 included:

- MCO compliance with contractual requirements for Grievance Resolution. This included a file review to assess compliance with timeframes for written acknowledgement of the grievance and written notification of the resolution and the appropriateness of the resolution.
- MCO Case Management procedures and documentation specific to services for pregnant women and children with asthma.
- Assessment of Provider Access and Availability based upon specific MCO contract requirements. Two activities were conducted to evaluate components within this area: (1) validation of the accuracy of the MCO hard copy provider directory and (2) an assessment of compliance with appointment availability timeframes.
- MCO actions taken to address OFIs from 2015.

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 upcoming focused OSR. This was followed with a document that detailed OSR preparation instructions. In order to provide evidence of compliance with focused OSR requirements, MCOs were asked to submit electronic copies of their 2016 Provider Directory, grievance policies and procedures, a spreadsheet containing complaints and grievances, and lists of high risk pregnant members and members who participated in IMPACT DC's pediatric asthma intervention, within specified timeframes. From the spreadsheet and lists provided, records were selected for review on-site. For the case management files selected for review, Delmarva Foundation submitted a data request for each member included in the sample. The MCOs furnished the requested data which was reviewed prior to the on-site visits. This pre-site review gives the review team an opportunity to discuss MCO procedures and to develop questions necessary to clarify findings. Additionally, it allows the review team to focus on MCO personnel interviews and observation of operational procedures while on-site.

A full day on-site visit was conducted at each MCO during October 2016 to interview MCO representatives and to observe the manner in which the MCOs implemented written policies and procedures. The audit included a grievance file review and focused case management file reviews. The review activities were conducted by a team of healthcare professionals with experience in managed care and quality improvement systems.

An exit conference was held with each MCO upon completion of the on-site review. Preliminary findings and opportunities for improvement were shared with the goal of improving the care provided to Medicaid managed care members. For the case management file reviews, qualitative assessments are provided in this report. When available, quantitative information is used to support findings. Because case management activities and electronic systems vary among the MCOs, a comparative analysis is limited.

During the review cycle a Provider Access and Availability Study was also conducted by Delmarva Foundation at the request of DHCF. The study consisted of two telephone based survey components. The first survey was designed to validate provider contact information contained within each MCO's hard copy provider directory. Inaccurate provider directory information can present a barrier to member access to timely care and, as such, is an important area of study. This was the first year DHCF requested this survey; therefore, there are no comparison data to assess if improvements were made or if operational/system changes were made as a result of the findings.

At the request of Delmarva Foundation, all MCOs submitted their most current provider directory in September 2016. A sample of providers representing PCPs, OB/GYNs, pediatricians, and behavioral health specialists were selected from each of the four MCO's provider directory. If a provider had more than one location only the first location was contacted. The telephone number listed in the hard copy provider directory was used to contact the provider's office. If the surveyor encountered an incorrect or disconnected number, an Internet search was conducted to determine if another number existed. If a provider's current phone number could not be retrieved through either source a notation was made on the tracking log.

All calls were made by an experienced surveyor from Delmarva Foundation who followed a prepared script. Neither the MCOs nor the providers were made aware of the survey in advance. Upon reaching the provider's office, the staff member identified herself, her organization, and the purpose of the call. A callback was offered if office staff were too busy or unavailable to take the call.

As provider offices can be very busy and the respondent easily distracted a decision was made to request specific provider contact information rather than having the office staff simply validate the information included in the directory. While this process takes slightly more time it yields more reliable results.

The following hard copy provider directory information was requested during the call:

- Provider name
- Provider address
- Provider phone number

Calls were conducted between October and November 2016. Aggregate data was collected using an excel spreadsheet.

The second component of the Provider Access and Availability study was a focused review of a select number of provider offices to determine if members have access to needed preventive care according to the time frames established by DHCF. This was the first year DHCF requested this survey; therefore, there are no comparison data to assess if improvements were made or if operational/ system changes were made as a result of the findings.

In order to carry out the assessment of next available appointment times Delmarva Foundation administered a telephone-based availability survey to ensure that the MCOs' provider networks were following the standards for office hour appointments. No provider offices were made aware of the survey in advance. The study focused on a member's ability to schedule an appointment within four separate appointment categories: Adult Regular, Non-Urgent appointments within 30 days; Pediatric Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen within 30 days; Initial OB appointment within 10 days; and Mental/Behavioral Health (BH), Non-Urgent appointment within 30 days. Provider types surveyed included PCPs, pediatricians, OB/GYNs, and BH specialists.

The sample was obtained from the MCO's 2016 provider directory. A total of 30 unique provider names were randomly selected within each of the four different appointment categories. In some instances, the clinic or group name also was included with the name of the individual provider for those practicing within a group setting. If the provider had multiple locations, only one location was contacted despite the individual providers being different.

Surveys were conducted using a "secret shopper" approach during November and December, 2016. An experienced surveyor from Delmarva Foundation acted as a District MCO member seeking an appointment using scenarios for what to say when requesting an appointment for care. A total of three attempts (at different times of the day and in some cases different days of the week) were made to contact a provider office staff member (live voice) versus a recorded office message. Reasons for not reaching a live voice were noted as were reasons for an appointment not being scheduled when a live voice was reached. If a provider office indicated that it did not make appointments but accepted walk-ins, this was considered a compliant appointment time frame.

The total sample size used in the analysis varied for each of the four provider categories due to the following aspects of the survey methodology:

- Size of the provider network based upon MCO membership and the provider directory listing;
- Removal of duplicates when a practice with multiple locations was selected more than once;
- If the surveyor did not reach a live voice, or was unable to make an appointment, replacement providers were not used, reducing the sample size from which compliance could be measured.

Following completion of all OSR activities preliminary results are compiled and submitted to DHCF for review. Upon DHCF's approval, the MCO receives a report which identifies areas of strength and opportunities for improvement. The MCO is asked to develop (within 45 days) an Opportunity for Improvement Action Plan for any item that is not fully in compliance. 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 implementation, 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 2016 included an assessment of Measurement Year (MY) 2015 performance (remeasurement year 1). 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 number of infant deaths (age 0-365 days) due to any cause during the measurement year.
- The number of unduplicated pregnancies during the measurement year with one or more adverse events (a new measure for MY 2015).

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 admission 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, who 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 and reliability 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 and reporting 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 required specifications; and
- Verification that the reported rates are reliable and based on accurate sources of information.

Pre-Site Review

The validation process begins with the auditor confirming the performance measures for review with DHCF. A conference call follows between the audit team and each MCO to confirm the measures, measure specifications, the date of the site visit, and the agenda items for the audit. Additionally, the auditor discusses the Information Systems Capabilities Assessment (ISCA) tool and supporting documentation.

Each MCO then completes and submits the ISCA along with program source code and other supporting documents to Delmarva. The auditor evaluates the information in the ISCA for consistency to findings reported in previous assessments, when available. Program source code is reviewed for the performance measures. A summary of ISCA and source code issues are compiled and provide direction and points of discussion for the on-site visit.

On-Site Review

The validation team conducts the 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 performance measure data.

The on-site visit begins with an entrance meeting between the auditor and relevant quality and technical MCO staff. The auditor explains the validation purpose, identifies staff for interviews, and requests additional documentation where needed. Interviews are conducted and additional documentation is requested that provides insight into the accuracy and reliability of the reporting processes. The MCO is allowed to clarify any concerns and demonstrate processes. Source code is reviewed during the process. Throughout the visit, the auditor reviews the information systems structure, protocols, procedures, and data collection methodology for each specific performance measure.

The on-site visit concludes with a closing conference between the auditor and MCO staff. The purpose of the closing session is to review preliminary findings, identify follow-up items, 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 which follow with their abbreviations: M = Met, NM = Not Met, or N/A = Not Applicable. A final measure designation is assigned in one of the four categories below:

- R – A reportable rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- NA – Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
- NB – Benefit Not Offered. The organization did not offer the health benefits required by the measure (e.g., Mental Health / Chemical Dependency).
- NR – Not Reportable. The calculated rate was materially biased. The organization chose not to report or was not required to report the measure.

DHCF contracts with Delmarva Foundation to validate the accuracy and reliability of the MCOs' performance measures reported in conjunction with its mandated PIPs: (1) Improving Perinatal and Birth Outcomes and (2) Pediatric Asthma.

HEDIS® Performance Measures and CAHPS® Surveys

HEDIS® and CAHPS® rates have become an invaluable evaluation tool used by over 90% of health plans nationally. Because the District requires MCOs to report HEDIS® and CAHPS® rates 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 preventive health care such as well child visits and immunizations,

management of chronic diseases, and access to care. CAHPS® measures specifically address members' experience of care 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 an MCO... “increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement.” (CFR §438.320).
- **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 averages,¹³ and to national Medicaid benchmarks where available.

Quality Findings

This assessment of quality encompasses key areas of MCO operations likely to impact member health outcomes, care delivery, and the experience of receiving care. Therefore, the quality domain focuses on MCO 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 regulations (42 CFR §438.340(a)) require that each state contracting with a managed care entity must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services provided by the managed care entity. The DHCF Division of Quality and Health Outcomes (DQHO) 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 members. The DHCF Quality Strategy guides the activities within the agency toward health delivery transformation utilizing quality improvement, performance measurement and linking health outcomes to payment. It builds upon the foundation of the DHCF strategy, specifically aligning with and integrating established aims from the following key initiatives:

- The National Strategy for Quality Improvement in Health Care and CMS Quality Strategy in pursuit of "Triple Aim;"
- Healthy People 2020;
- DC Healthy People 2020;
- The DC Mayoral priority of *A Healthy Community*, and
- DC State Health Innovation Plan (SHIP)

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

- 1) Ensure 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.

¹³ Weighted averages allow the MCOs with more enrollees to have more relevance on an aggregate rate. Weighted averages are used in HEDIS® and HEDIS®-like performance measures. Simple or straight averages are preferred in survey data and are used in the CAHPS® survey analyses.

- 3) Establish greater control and predictability over the District's spending on health care and link payment to quality.

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:

- Member utilization financial condition
- Administrative performance
- Case management outcomes
- Network adequacy 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. The DC Managed Care Quarterly Performance Report results are now published on a quarterly basis. The most recent 2016 reports analyze performance from January 2016 – June 2016. Reports 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, potentially preventable hospital admissions, and reducing 30 day hospital readmissions.

To further quality improvement efforts on the part of the MCOs, DHCF will incentivize MCOs beginning in FY 2017 by implementing a pay-for-performance program with the three (3) risk-based MCOs. Performance measures will be based on existing measures currently collected for the DC Managed Care quarterly Performance Report: low acuity non-emergent (LANE); potentially preventable admission (PPA) and 30 day hospital readmission.

DHCF requires all MCOs to collect and submit annual audited HEDIS® performance measures and CAHPS® survey results. DHCF has set performance goals for these measures at the National Medicaid 75th percentiles. However, MY 2015 reported rates show that the District weighted average was below the 75th percentile for nearly all HEDIS® and CAHPS® measures. DHCF requires MCOs to implement OFIs) plans for all measures not meeting the 75th percentile. In FY2016, MCOs began submitting HEDIS® and PIP performance measure data quarterly for the purposes of conducting qualitative and quantitative analysis, identifying opportunities for improvement, interventions and evaluating intervention effectiveness during DHCF MCO Quality and QI Collaborative meetings.

In FY2016, DHCF also began the planning phase of a MCO care coordination/case management initiative to address the care coordination deficiencies identified in the DC Managed Care Performance Report. The implementation phase began in October, FY2017. This initiative puts in place a set of comprehensive standards and guidelines for care coordination/case management to ensure core consistencies management; reporting of enrollment and program outcomes. As part of the perinatal quality improvement collaborative,

DHCF DQHO and Health Care Innovation and Reform Administration (HCIRA) secured CMS Medicaid Innovation Accelerator Program (IAP) funding to launch a perinatal registry. The goal of IAP is to improve care and improve health for Medicaid beneficiaries, and reduce costs by supporting states in accelerating new payment and service delivery reforms. The IAP focuses on populations with significant needs served by Medicaid programs, such as pregnant women and newborns, children, individuals with mental illness, individuals receiving long-term services and supports, and others. The perinatal registry will provide a venue for providers to complete the Obstetrics Authorization and Initial Assessment Form electronically and allow for better coordination between DHCF, MCOs, and Medicaid providers to 1) maximizing community partnerships through a quality improvement collaborative 2) enhanced care coordination through the use of technology, and 3) Utilize IAP funding to improve healthcare for pregnant Medicaid beneficiaries.

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 member, 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 described below. A total of 60 files were requested and reviewed, if available, 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 and Initial Assessment Form from providers, which is the collaborative intervention in which all MCOs are using as they aim to improve performance. These forms provide notification of pregnant members and an initial prenatal assessment completed by the provider, which allows MCOs to gain valuable insight into possible risks for the identified 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				
File Reviews	ACDC #	HSCSN #	MFC #	THP #
Number of files meeting criteria for review	28	30	28	3
Element	ACDC %	HSCSN %	MFC %	THP %
Obstetrical Assessment Forms received from providers (collaborative intervention)	93	27	36	100
Evidence of a care plan	96	100	100	100
Birth outcome: low birth weight (<2,500 grams)	0	17	23	0
Birth outcome: <37 weeks gestational age	7	17	35	0
Birth outcome: No evidence of an HIV test	61	7	7	33
Birth outcome: Pregnancies ending in miscarriage or fetal loss	0	0	4	0
Birth outcome: Infant deaths (0-365 days)	0	0	3	0
Member participation in prenatal care	93	97	93	100
Member participation in postpartum care (between 21-56 days post-delivery)	75	47	50	33

Each of the MCOs have well-structured case management programs for high risk pregnant members that demonstrate ongoing attempts to effectively engage members through creative approaches. Opportunities for improvement exist, however, in several key measures. Specifically, all MCOs have an opportunity to improve the postpartum care rate through more tailored interventions based upon an improved understanding of the differences in health care attitudes, beliefs, and behaviors among population subgroups. ACDC should continue to explore options for identifying HIV testing and implement small tests of change to assess the effectiveness of interventions. HSCSN and MFC have an opportunity to improve receipt of the OB Authorization and Initial Assessment Form. Timely member assessments and accompanying interventions may contribute to improved birth outcomes for both of these MCOs. Lastly, THP had difficulty accurately identifying high risk pregnant members for the requested sample and as such, no conclusions can be drawn from their results due to the extremely low numbers, except it does not appear that improvements have been made in increasing postpartum visits. This will continue to be an opportunity for improvement for THP.

Pediatric Asthma Case Management File Review

This is the second year that Delmarva Foundation conducted a pediatric asthma case management file review for each of the four MCOs in conjunction with the DHCF Pediatric Asthma PIP Collaborative. The purpose of the review was to assess asthma care for members participating in the collaborative intervention, IMPACT DC, during the period of January through June 2016. The IMPACT DC Asthma Clinic based out of Children's National Medical Center focuses on the care of children with recent or frequent asthma-related emergency department visits, hospitalizations, or other indications of poorly controlled asthma. The program's goal is to steer children away from inpatient hospitalizations and episodic use of the emergency department for their asthma management, and towards more effective primary long-term asthma care and management.

During the course of the record review, it was determined that not all members identified in the case management file sample were actively participating in case management activities. For the most part, MCOs were able to produce documentation of repeated attempts to engage the members; however, the MCO was not always successful in reaching members or in obtaining their agreement to participate in case management.

In addition to engagement in case management, a member's asthma care was evaluated based upon evidence of an asthma assessment, an asthma action plan, an initial and, if relevant, an updated care plan, and an appropriately prescribed asthma medication regimen with monitoring of medication compliance. 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 an asthma assessment	100%	70%	90%	30%
Evidence of an asthma action plan	100%	50%	90%	20%
Evidence of a care plan	100%	70%	100%	10%
Evidence of monitoring of medication compliance	100%	50%	90%	30%

* A total of 30 files of members enrolled in IMPACT DC Jan-June 2016 were reviewed with 10 receiving a focused review.

All MCOs provided evidence of dedicated care management staff and diligent data mining to identify pediatric members with asthma. ACDC and MFC have sound care management programs and clearly document member interactions. THP and HSCSN have opportunities to work more closely with IMPACT DC to ensure timely receipt of the member's assessment and intervention forms. This will help to ensure timely follow-up for members who have had an IMPACT DC visit and who may need additional teaching, medication monitoring, or who are at high risk for another emergency department or inpatient visit.

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 meet on a quarterly basis. Both collaborative work groups have sought community participation to solicit input from providers and relevant stakeholders 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 2015 were used to calculate MCO remeasurement year 1 rates and Delmarva Foundation calculated a District weighted average for each indicator. Results for the 2014 baseline measurement and the first remeasurement year 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	Met	Met	Partially Met
9) Assess Whether Improvement is Real Improvement	Met	Partially Met	Met	Partially Met
10) Assess Sustained Improvement	NA	NA	NA	NA

NA denotes that the element could not be assessed. Explanations are provided below.

The MCOs generally met all requirements with individual exceptions for Steps 8 and 9. THP received a partially met finding for Step 8, Review Data Analysis and Interpretation of Study Results, as there were errors in the MCO's performance assessment. Both HSCSN and THP received a partially met finding for Step 9, Assess Whether Improvement is Real Improvement. THP's improvement in the HIV testing indicator was likely the result of better data collection methodologies, rather than a true intervention that changes behavior.

Two steps were not applicable. Step 5, Review Sampling Methods, was not applicable as the entire population was studied; sampling was not completed. 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 ongoing 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

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/ata glance.html>

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 (2016) indicate that there were 10 perinatal HIV cases diagnosed in the District between 2011 and 2015.¹⁵

In addition to the validation activity, Delmarva Foundation conducted analysis and aggregation of indicator results which often varied widely among the MCOs. Baseline and remeasurement year 1 rates for adverse perinatal outcomes can be found in Table 6. (The measures are inverse and lower rates are better than higher rates.)

Table 6. Perinatal Collaborative Indicator Rates

Measurement Year	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
Indicator 1: Neonates with weight <2500 grams					
Baseline Yr. 1/1/2014 – 12/31/2014	10.15	12.69	7.08	1.03	5.96
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	13.76	15.05	2.89	2.54	8.41
Indicator 2: Neonates <37 weeks gestational age					
Baseline Yr. 1/1/2014 – 12/31/2014	9.91	14.93	8.40	1.86	4.10
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	12.08	7.53	3.23	3.93	7.79
Indicator 3: No maternal HIV testing					
Baseline Yr. 1/1/2014 – 12/31/2014	65.87	5.97	59.85	77.56	60.10

¹⁵ Annual Epidemiology & Surveillance Report, District of Columbia Department of Health. Retrieved January 10, 2017 from, http://doh.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/2016%20HAHSTA%20Annual%20Report%20-%20final.pdf

Measurement Year	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	52.96	4.30	28.94	35.03	41.29
Indicator 4: Miscarriage or fetal loss					
Baseline Yr. 1/1/2014 – 12/31/2014	13.02	15.67	12.57	5.07	11.42
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	9.73	17.20	12.94	7.74	10.45
Indicator 5: Birth outcome unknown					
Baseline Yr. 1/1/2014 – 12/31/2014	0.00	0.00	0.00	0.00	0.00
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	0.00	0.00	0.00	0.00	0.00
Indicator 6: Infant death rate*					
Baseline Yr. 1/1/2014 – 12/31/2014	0.12	0.98	0.09	0.13	0.26
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	0.05	0.33	0.03	0.21	0.08
Indicator 7: Unduplicated pregnancies with one or more adverse event					
Baseline Yr. 1/1/2015 - 12/31/2015	27.57	38.71	36.68	45.05	33.92

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

*The Infant Death Rate is calculated using the number of infant deaths in the first year of life divided by the number of live births. Therefore a rate of less than 1.0% is reasonable.

- The MCO Weighted Average for all Perinatal Collaborative rates for remeasurement year 1 improved over the baseline rates for all but two measures:
 - The MCO weighted average for the rate of neonates with weight less than 2500 grams increased 2.45 percentage points over the baseline rate.

- The MCO weighted average for neonates less than 37 weeks gestational age increased 3.69 percentage points over the baseline rate.
- The greatest improvement was seen in no maternal HIV testing where every MCO improved over the baseline rate and the MCO Weighted Average improved 18.81 percentage points over baseline.
- MCO indicator rates compare favorably to national and District-wide March of Dimes benchmarks:¹⁶
 - The District's MY 2015 MCO weighted average of 8.41% for low birth weight (<2500 grams) infants compares favorably to the MY 2014 national rate of 8.0% and the District-wide rate of 9.8%.
 - Preterm births among MCO members for MY 2015 averaged 7.79%. This compares favorably to the MY 2014 national rate of 9.6% and the District-wide rate of 9.6%.
 - The infant death rate (age 0-365 days) for the District's MCOs for MY 2015 was 0.08 per 1,000 live births. The March of Dimes national rate for the latest 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 specific member, provider, and MCO barriers. All of the MCOs identified lack of provider compliance with completion and submission of the OB Authorization and Initial Assessment Form as an ongoing problem that severely limits the MCOs' ability to identify 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.

¹⁶ National Center for Health Statistics, final natality data. Retrieved January 3, 2017, from www.marchofdimes.org/peristats.

- 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 files 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 and Initial Assessment Forms, the MCOs have continued to work collaboratively to improve provider completion and submission of the forms. In 2015 the MCOs included a letter to accompany the OB Authorization and Initial Assessment Form that described the value of completing the risk assessment and submitting it to the MCO in a timely manner. In 2016, the MCOs worked with DHCF to revise the form to make it more meaningful and user friendly, including the ability to complete the form electronically; however, the form will still need to be submitted manually. The revised form will be rolled out in 2017.

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 baby showers on a routine basis 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.
- Adding a support person to the OB Team to assist in collection of OB Authorization and Initial 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.
- Developing a claims and OB lab panel report to capture "possible" pregnancies.
- Developing and implementing an early pregnancy training program, What to Do When You are Having a Baby, to reduce risks associated with adverse perinatal outcomes through awareness and promotion of positive behaviors.
- 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.

- Contracting with a specialty case management agency that monitors high-risk pregnancies, provides 48 hour assessments for newborn intensive care unit (NICU) discharges, and assists in preparing the member's home in preparation to meet the newborn's needs.
- Continuing 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 breastfeeding 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 member 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

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

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 members 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

Element	Pediatric Asthma PIP			
	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	Met	Met	Met
9) Assess Whether Improvement is Real Improvement	Met	Met	Met	Met
10) Assess Sustained Improvement	NA	NA	NA	NA

NA denotes that the element could not be assessed. Explanations are provided below.

All MCOs met requirements and were assessed as fully met. Similar to the Perinatal PIP Collaborative validation, two steps were not applicable as the MCOs used population rather than sample data and there were insufficient remeasurement periods to determine if improvement was sustained.

In addition to the PIP validation activities, Delmarva Foundation conducted an analysis of reported rates for baseline and remeasurement year 1. As in CY 2014, the utilization and medication compliance indicator rates for members with asthma fluctuated widely among MCOs. Table 8 provides baseline and remeasurement year 1 rates for the Pediatric Asthma PIP.

Table 8. Baseline Pediatric Asthma PIP Rates

Measurement Year	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %
Indicator 1: ED Asthma Visits (Total Ages 2-20 Years)					
Baseline Yr. 1/1/2014 – 12/31/2014	46.09	28.98	35.04	89.35	32.44
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	44.19	24.87	31.67	65.14	41.59
Indicator 2: Inpatient Admissions for Asthma (Total Ages 2-20 Years)					
Baseline Yr. 1/1/2014 – 12/31/2014	10.11	3.00	5.02	10.97	5.69
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	8.63	4.11	3.18	2.50	5.07
Indicator 3: Use of Appropriate Medications for People with Asthma (Total Ages 2-20 Years)					
Baseline Yr. 1/1/2014 – 12/31/2014	93.61	76.86	59.14	45.48	78.00
Remeasurement Yr. 1 1/1/2015 - 12/31/2015	94.25	97.49	57.44	25.35	72.33
Indicator 4: Medication Management for People with Asthma 50% Compliance (Total Ages 2-20 Years)					
Baseline Yr. 1/1/2014 – 12/31/2014	49.92	76.86	45.98	6.45	59.29
Remeasurement Yr.1 1/1/2015 - 12/31/2015	53.21	96.57	41.83	12.76	52.47
Indicator 5: Medication Management for People with Asthma 75% Compliance (Total Ages 2-20 Years)					
Baseline Yr. 1/1/2014 – 12/31/2014	29.98	75.44	33.13	6.45	41.74
Remeasurement Yr.1 1/1/2015 - 12/31/2015	32.41	94.98	29.31	9.34	41.85

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 41.59%, an increase of 9.15 percentage points over baseline. Utilization was highest in the 2-4 years of age category with a rate of 57.79%.
- Acute hospital admissions were also highest in the 2-4 years of age category at 7.11%, compared to the 5.07% District weighted average for total members 2-20.
- Appropriate medications were prescribed for 72.33% of MCO members with asthma, a decrease of 5.67 percentage points over baseline. Only 52.47% were compliant with medication use for at least half of the prescribed period of treatment.
- The 12-18 years of age group was most compliant with medication treatment – 60.17% compliant for at least half of the prescribed treatment period and 50.60% 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/caregiver 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 ED 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, 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.

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 members with asthma to a primary care medical home for ongoing care, and connecting members to community resources. The goal is to reduce ED visits and acute hospital admissions and improve self-management.

Individual MCO interventions include:

- 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.
- Partnering with Breathe DC Camp 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.
- Breathe DC, Breathe Easy, and District Department of the Environment Healthy Homes Programs. Case Managers refer members to the home visit programs when the need is identified. Programs aim to assess home triggers, conduct in-home education, and provide materials to mitigate identified triggers.
- Continuing 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.
- Developing 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 three ED visits or two inpatient hospitalizations.
- Conducting weekly asthma rounds for team discussion and review of individual cases. Issues addressed include community resources such as food banks, shelters, utility assistance, and applicable referrals to specialists.
- Providing training for two care managers to become asthma specialists by the Asthma Educator Institute who, in turn, trained MCO members and staff.
- 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.
- Maintaining an Asthma Disease Management Program which utilizes 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.
- Identifying and implementing alternate contact methods for hard to reach members through a collaborative effort initiated by the Asthma Case Manager with the Customer Service, Utilization Review, and Outreach teams.

Performance Measure Validation

Given that the MCOs are required to submit audited HEDIS®/CAHPS® rates, the District chose to direct EQRO activities to 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 PMV activities for all four MCOs.

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

Three key validation activities are conducted:

- Review of data systems and processes used by the MCO to construct the measures;
- Assessment of the calculated rates for algorithmic compliance to required specifications; and
- Verification that the reported rates are reliable and 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);
- HEDIS® Final Audit Report, if available;
- Other documentation (i.e., specifications, data dictionaries, program source code, data queries, policies and procedures) for review prior to or during the site visit;
- Observations made during the site visit;
- Interviews with MCO staff; and
- Information submitted as part of the follow-up items requested after the site visit.

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 and time parameters were accurate. Additionally, the review determined that numerators included appropriate parameters and members following precise specification requirements.

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 Designation	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 produced a reportable rate (R), the denominator was too small to report a valid rate (NA), the MCO did not offer the health benefits required by the measure (NB), or the calculated rate was materially biased and not reportable (NR).	R	R	R	R

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. 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.

The MCOs and DHCF are encouraged to collaborate and work to identify additional sources for data for the collaborative measures, particularly for HIV testing. HIV testing may be part of a standardized prenatal laboratory screening panel completed in the first trimester of pregnancy. However, administrative data for HIV testing appears to be lacking for all MCOs.

HEDIS® Performance Measures and CAHPS® Surveys

As previously noted, all District Medicaid MCOs are required to calculate and submit audited HEDIS® performance measures and CAHPS® experience of care survey results to DHCF. Delmarva Foundation selected and analyzed results from HEDIS® effectiveness of care measures and CAHPS® survey 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 disease 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 Quality Compass Medicaid HMO Averages for all but three indicators. Comprehensive Diabetes Care - HbA1c Control <7%, HbA1c Control <8%, and Poor HbA1c Control >9% exceeded the National Medicaid Average but were below the 75th percentile for Medicaid.

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® 2016 (MY 2015)	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	53.99	31.58	61.31	41.63	54.0	♦
Comprehensive Diabetes Care - Eye Exams - % of members who had a retinal eye exam	52.43	34.21	39.05	33.50	45.6	♦
Comprehensive Diabetes Care - HbA1c Testing - % members 18–75 years of age with Hemoglobin A1c (HbA1c) testing	87.85	89.47	84.12	76.12	85.0	♦
Comprehensive Diabetes Care - HbA1c Control <7%	36.29	NQ	31.94	28.93	33.8	♦ ♦
Comprehensive Diabetes Care - HbA1c Control <8%	53.99	23.68	48.72	41.13	50.3	♦ ♦
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	36.81	76.32	41.24	48.92	40.2	♦ ♦
Comprehensive Diabetes Care - Medical Attention for Nephropathy (Kidney Disease)	88.19	94.74	89.60	82.09	87.7	♦

NQ – Not required

♦ – 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® 2016 (MY 2015)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Controlling High Blood Pressure	47.33	45.95	57.80	40.22	49.1	♦

♦ – 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.

Medication Management for People with Asthma

According to the CDC, nationally 7.4% of adults age 18 and over and 8.6% of children under the age of 18 had asthma in 2014.²⁰ It is one of the most common chronic diseases in childhood and accounts for about \$50 billion in associated medical costs annually.²¹ The overall prevalence of asthma in the District is estimated to be 11.5% in 2014.²²

¹⁹ "High Blood Pressure Facts". Centers for Disease Control and Prevention. Available at: www.cdc.gov/bloodpressure/facts.htm

²⁰ "Asthma FastStats", Centers for Disease Control and Prevention. Available at: www.cdc.gov/nchs/fastats/asthma.html.

²¹ "Asthma in the U.S". Centers for Disease Control and Prevention. Available at www.cdc.gov/VitalSigns/Asthma/index.html

²² "State or Territory Data". Centers for Disease Control and Prevention. Available at www.cdc.gov/asthma/most_recent_data_states.htm

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® measures 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 2015 are found in Table 12.

Table 12. HEDIS® Medication Management for People with Asthma

Measure HEDIS® 2016 (MY 2015)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Medication Management for People with Asthma – Medication Compliance 50% (Total)	55.10	41.33	47.57	77.70	55.7	^
Medication Management for People with Asthma – Medication Compliance 75% (Total)	31.21	18.08	24.07	58.14	32.5	♦

^ – 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 Medication Management for People with Asthma – Medication Compliance 50% has decreased compared to MY 2014; however, only two MCOs reported at that time due to insufficient denominator size.
- The District's weighted average for Medication Management for People with Asthma – Medication Compliance 75% is slightly below the national Medicaid average.

CAHPS® Survey

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

Tables 13, 14, and 15 provide results from the adult and child CAHPS® surveys for 2016 on measures representative of quality. For comparison purposes, 2015 averages are also included.

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

CAHPS® Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	THP 2016 %	MCO Average 2015 %	MCO Average 2016 %	2016 MCO Average Compared to 2016 Benchmarks
Customer Service Composite	91.2	81.7	88.9	71.0	84.8	83.2	♦
How Well Doctors Communicate Composite	91.7	91.6	93.3	91.0	92.1	91.9	♦ ♦
Shared Decision Making Composite (A lot/Yes)	74.6	72.8	72.4	71.0	76.9	72.7	♦
Health Promotion and Education Composite	77.7	74.7	77.3	69.4	73.2	74.8	♦ ♦
Coordination of Care Composite	80.0	85.5	83.6	69.5	75.5	79.6	♦
Rating of Health Plan (8+9+10)	78.5	78.4	80.1	68.6	75.0	76.4	♦ ♦
Rating of All Health Care (8+9+10)	79.7	73.6	74.5	68.2	74.0	74.0	♦ ♦
Rating of Personal Doctor (8+9+10)	83.4	84.1	85.4	81.2	81.2	83.5	♦ ♦ ♦
Rating of Specialist Seen Most often (8+9+10)	81.3	79.0	76.0	66.3	80.6	75.6	♦

♦ - 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.

Four measures, Health Promotion and Education, Coordination of Care, Rating of Health Plan, and Rating of Personal Doctor, exceeded the 2015 rate. MCOs, however, fell below the 75th percentile for experience of care ratings by adults for all but one measure. Additional assessments include:

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

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

CAHPS® Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	THP 2016 %	MCO Average 2015 %	MCO Average 2016 %	2016 MCO Average Compared to 2016 Benchmarks
Customer Service Composite	84.8	92.4	85.9	83.1	84.6	86.6	♦
How Well Doctors Communicate Composite	92.8	93.0	91.7	91.1	91.4	92.2	♦
Shared Decision Making	76.4	86.8	73.9	70.4	80.6	76.9	♦
Health Promotion and Education Composite	78.8	80.4	74.1	74.7	76.1	77.0	♦♦♦
Coordination of Care Composite	78.7	92.2	73.3	71.8	85.2	79.0	♦
Rating of Health Plan (8+9+10)	85.5	84.2	83.7	77.6	83.6	82.8	♦
Rating of All Health Care (8+9+10)	85.2	87.4	83.0	86.3	85.5	85.5	♦
Rating of Personal Doctor (8+9+10)	91.3	90.8	89.2	90.0	89.9	90.3	♦♦
Rating of Specialist Seen Most often (8+9+10)	86.7	85.6	85.4	82.1	81.5	85.0	♦

♦ - 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.

Five measures, Customer Service, How Well Doctors Communicate, Health Promotion and Education, Rating of Personal Doctor, and Rating of Specialist, exceeded the 2015 rate. In general, however, members were less satisfied with the care and services provided to children than for adults.

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

Table 15. Child CAHPS® (Experience with Care) Representative of Quality

CAHPS® Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	THP 2016 %	MCO Average 2015 %	MCO Average 2016 %	2016 MCO Average Compared to 2016 Benchmarks
Child has a regular dentist	86.1	96.4	83.7	62.0	87.1	82.1	^
Child has seen regular dentist for a check-up or routine care in the last 6 months	87.5	89.8	85.9	81.3	83.4	86.1	^
How often child received dental appointments with regular dentist as soon as you wanted	73.6	89.4	86.7	73.8	85.6	80.9	^
If child does not have a regular dentist, child still got a check-up or other routine dental care in the last 6 months	34.2	55.6	29.8	21.5	45.6	35.3	^

^ - National benchmark is not available.

National benchmarks were not available for dental measures; however, comparisons can be made with the prior year's rates and between the general and children with chronic conditions populations. Specifically,

- The MCO average for 2016 was above the 2015 average rate for "Child has seen regular dentist for a check-up or routine care in the last 6 months."
- The MCO average was below the 2015 average rate for the remaining three dental measures.

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 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 members routinely through analysis of HEDIS® measures of access (such as preventive care and well visits), and analysis of CAHPS® survey results regarding member experience of care with access. Additionally, at the request of DHCF Delmarva Foundation designed and conducted a telephonic survey in 2016 to validate information listed in each MCO's hard copy provider directory. Inaccurate provider directory information can present an access barrier to care and, as such, is an important area of study. This was the first year DHCF requested this survey; therefore, there are no comparison data to assess if improvements were made or if operational/ system changes were made as a result of the findings.

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 16 provides information on the MCOs' performance on measures of access.

Table 16. Access to Preventive Care

Measure HEDIS® 2016 (MY 2015)	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)	70.59	84.97	61.99	54.89	65.5	♦
Adults' Access to Preventive/ Ambulatory Health Services (45-64 Years)	79.15	NA	70.87	66.19	74.2	♦
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	80.09	77.12	75.91	55.79	75.2	♦ ♦
Childhood Immunization Status - Combo 3 - % of children with Combo 2 and 4 PCV vaccines by 2nd birthday	78.24	75.42	73.48	52.08	72.9	♦ ♦

Measure HEDIS® 2016 (MY 2015)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Lead Screening in Children - % of members with a lead screening by age 2	82.57	86.44	83.68	55.32	78.6	♦ ♦
Children and Adolescents' Access To PCP (12-24 Months)	94.59	97.53	93.14	88.87	93.5	♦
Children and Adolescents' Access To PCP (25 Months-6 Years)	89.09	91.17	84.83	84.89	87.9	♦ ♦
Children and Adolescents' Access To PCP (7-11 Years)	94.24	97.89	89.55	89.91	93.3	♦ ♦ ♦
Children and Adolescents' Access To PCP (12-19 Years)	91.76	95.94	84.27	84.85	90.4	♦ ♦
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	61.48	58.06	57.97	47.76	58.6	♦
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	77.38	83.09	76.72	76.62	77.4	♦ ♦

Measure HEDIS® 2016 (MY 2015)	ACDC %	HSCSN %	MFC %	THP %	MCO Weighted Average %	Comparison of MCO Weighted Average to National Benchmarks
Adolescent Well-Care Visits - % of members 12-21 who had at least 1 well-care visit with a PCP or an OB/GYN	64.81	69.59	52.58	53.24	62.0	◆◆◆
Immunizations for Adolescents - Combination 1	73.38	85.00	80.69	62.09	74.6	◆◆
Annual Dental Visit (Total-Age 2-21 Years)	73.57	76.32	36.20	66.33	66.6	◆◆◆

*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
 - Children and Adolescents' Access to PCP – 12-24 months
 - 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:
 - Childhood Immunization Status – Combo 2 and Combo 3
 - Lead Screening
 - Children and Adolescents' Access to PCP – 25 months-6 years
 - Children and Adolescents' Access to PCP (12-19 years)
 - Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - Immunizations for Adolescents (Combo 1)
- The District weighted average exceeded the Medicaid 75th percentile in the following measures:
 - Children and Adolescents' Access to PCP (7-11 years)
 - Adolescent Well-Care Visits (ages 12-21)
 - Annual Dental Visit (ages 2-21)

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 17 provides a comparison of 2015 and 2016 performance on the CAHPS® measure related to getting needed care. This measure gauges the member's or parent/guardian's perceptions and experience of care with access to care and services.

Table 17. Adult and Child CAHPS® Experience of Care with Access to Care

CAHPS® Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	THP 2016 %	MCO Average 2015 %	MCO Average 2016 %	2016 MCO Average Compared to 2016 Benchmarks
Getting Needed Care Composite (Adult)	74.8	79.7	79.8	68.0	77.6	75.6	♦
Getting Needed Care Composite (Child)	80.4	81.6	70.9	74.2	79.3	76.8	♦

♦ - 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:

- Experience of care with access to Needed Care for adults decreased from 2015 to 2016, from 77.6% to 75.6%.
- Experience of care with access to Needed Care for children also decreased from 2015 to 2016, from 79.3% to 76.8%.
- Adult and Child rates for Getting Needed Care were below the national Medicaid average indicating an opportunity for continued improvement.

Validation of Provider Directory Contact Information

Table 18 provides the results of the following provider contact information listed in each MCO's hard copy provider directory: provider name, provider address, and provider phone number.

Table 18. Validation Results of Hard Copy Provider Directory Survey

Provider Directory Element	ACDC %	HSCSN %	MFC %	THP %
Listed provider name is accurate	100	100	100	100
Listed provider address is accurate	100	57	89	69
Listed provider phone number is accurate	97	93	90	80

The listed provider name was accurate for all directory entries validated. Opportunities exist, however, for improving the accuracy of provider address and phone listings in the hard copy provider directory.

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 a member 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 member complaints and dissatisfaction. Presumably, the earlier a member 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 19 provides MCOs' performance on timeliness of prenatal care for pregnant women and the frequency at which women receive prenatal care visits.

Table 19. Timeliness and Frequency of Prenatal Care

Measure HEDIS® 2016 (MY 2015)	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	68.84	73.08	75.06	69.37	70.8	♦
Frequency of Ongoing Prenatal Care (≥ 81%)	32.79	39.74	45.72	30.63	36.3	♦

♦ - 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 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® Survey

CAHPS® surveys query adults and parents/guardians of children regarding experience with how quickly they can get needed care. Table 20 provides information regarding members' experience with getting care quickly.

Table 20. Adult and Child CAHPS® Experience of Care with Timeliness of Care

CAHPS® Measure	ACDC 2016 %	HSCSN 2016 %	MFC 2016 %	THP 2016 %	MCO Average 2015 %	MCO Average 2016 %	2015 MCO Average Compared to 2015 Benchmarks
Getting Care Quickly Composite (Adult)	77.3	80.3	76.5	71.0	78.3	76.3	♦
Getting Care Quickly Composite (Child)	85.1	88.1	86.0	76.7	77.1	84.0	♦

♦ - 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.

Member experience of care with how quickly care could be obtained fell below the National Medicaid average for both adults and children.

- Adult experience of care decreased from 78.3% in 2015 to 76.3% in 2016.
- Child experience of care increased by almost seven percentage points from 77.1% in 2015 to 84.0% in 2016.

Timely Appointment Availability

The Appointment Availability Study was conducted to determine if MCO members have access to needed preventive care according to the appointment access timeframes established by DHCF. Four appointment categories were the focus of this telephonic survey. Appointment standards for each of these categories are identified below.

- Adult regular, non-urgent – within 30 days
- Pediatric EPSDT – within 30 days
- Initial OB – within 10 days
- Behavioral Health non-urgent – within 30 days

Table 21 indicates that of the 344 calls made, surveyors were able to connect with 207 (60%) offices to schedule an appointment with MFC having the highest “reach rate” at 66% and ACDC the lowest at 51%.

Table 21. Successful Appointment Contact Rate for Providers Surveyed

Element	MCO				TOTAL
	ACDC	HSCSN	MFC	THP	Total
# Providers Called	81	86	98	79	344
Failed Attempts to schedule an appointment	40	30	33	34	137
Successful Appointment Contact*	41	56	65	45	207
Provider Contact Rate	51%	65%	66%	57%	60%

* Indicates that a provider office scheduled an appointment, independent of whether it did or did not meet the required appointment timeframes.

During this study, Delmarva Foundation surveyors identified and documented reasons for not being able to make an appointment as illustrated in Table 22.

Table 22. Reasons No Appointment Scheduled Across Appointment Categories

Reason	Frequency by Appointment Category				
	Adult	Pediatric	BH	OB	TOTAL
No answer-recorded message	13	3	11	4	31
Incorrect telephone number	8	6	7	1	22
Excessive hold time (range 9-20 minutes)	4	4	2	1	11
Not accepting/wait list for new patients	3	5	4	2	14
Need intake assessment before an appointment is made			13	1	14
Provider not seeing pediatric or adult psychiatry		10	1		11
Need to sign up with clinic before being seen				1	1
Person who does scheduling is not available			5		5
Need insurance/demographics verification first		1	1	2	4
Office closed when calling	1	2			3
Wrong provider	2	1		1	4
Contracted to see students at Georgetown only	2	1			3
Wrong insurance	3	1			4
Provider no longer has a DC office	2				2
Need confirmation of pregnancy first				1	1
Need reassignment to another PCP	1	1			2
Benefit coverage issue		1			1
Provider only takes GYN				1	1
Provider refers to hospitals after 12 weeks gestation				1	1
Provider doesn't accept Medicaid				2	2
Total	39	36	44	18	137

No answer – recorded message was cited as the top reason for not being able to make an appointment. Surveyors were put on hold anywhere from 9-20 minutes, especially when contacting one high volume provider. Surveyors also obtained incorrect information from the provider directory, such as an incorrect telephone number, wrong age group, or the provider is not accepting new patients.

Surveyors had challenges scheduling appointments for specific appointment categories as well. For example, when attempting to schedule appointments for a behavioral/mental health visit, surveyors were asked to contact the Department of Behavioral Health access hotline in order to schedule an intake appointment with social worker before being seen. When trying to access prenatal care, a federally qualified health center (FQHC) informed the caller that they needed to sign up with the clinic before being seen. For those needing a well child visit or a mental health visit, some offices informed the caller that the provider was not seeing that particular member population.

Tables 23 through 26 show the appointment access results within each of the four appointment categories for each MCO and the MCO Aggregate.

Table 23. Timely Appointment Availability Findings for Adult Non-Urgent Appointments by MCO

Adult Regular-Non Urgent Appointment Required within 30 Days					
Element	ACDC	HSCSN	MFC	THP	MCO Aggregate
# Providers Surveyed	30	26	30	30	116
Unable to make appointment	8	6	18	7	39
Unable to schedule within 30 Days	3	5	0	3	11
Appointments scheduled within 30 Days	19	15	12	20	66
Compliance Rate	63%	58%	40%	67%	57%

Table 24. Timely Appointment Availability Findings for Pediatric/EPSTD Appointments by MCO

Pediatric EPSTD Screen Required within 30 Days					
Element	ACDC	HSCSN	MFC	THP	MCO Aggregate
# Providers Surveyed	30	30	30	27	117
Unable to make appointment	15	8	5	8	36
Unable to schedule within 30 Days	2	3	10	3	12
Appointments scheduled within 30 Days	13	19	15	16	63
Compliance Rate	43%	63%	50%	59%	53%

Table 25. Timely Appointment Availability Findings for BH- Non-Urgent Appointments by MCO

Behavioral Health- Non-Urgent Required within 30 Days					
Element	ACDC	HSCSN	MFC	THP	MCO Aggregate
# Providers Surveyed	12	17	20	16	65
Unable to make appointment	12	10	6	16	37
Unable to schedule within 30 Days	0	3	3	0	13
Appointments scheduled within 30 Days	0	4	11	0	15
Compliance Rate	0%	24%	55%	0%	23%

Table 26. Timely Appointment Availability Findings for Initial OB Appointments by MCO

Initial OB Visit Required within 10 Days					
Element	ACDC	HSCSN	MFC	THP	MCO Aggregate
# Providers Surveyed	9	13	18	6	46
Unable to make appointment	5	6	4	3	18
Unable to schedule within 10 Days	3	4	8	0	15
Appointments scheduled within 10 Days	1	3	6	3	13
Compliance Rate	11%	23%	33%	50%	28%

Table 27 illustrates the aggregate compliance rate by MCO for scheduling an appointment across all appointment categories. Comparison show the relationship between the numbers of survey calls made to each MCO to the number of provider offices that were able to schedule an appointment (provider “reach” rate). The compliance rate was calculated by comparing the number of appointments scheduled within the required DHCF timeframes to the total number of survey calls made (compliance rate).

Table 27. Aggregate Provider Reach Rate and Timely Appointment Availability Compliance Rate by MCO

Aggregate Compliance Rate by MCO Across All Appointment Categories Based Upon Total Providers Called and Total Providers Reached					
Element	ACDC	HSCSN	MFC	THP	TOTAL
Total # Providers Reached	41	56	65	45	207
# Appointments Scheduled within Required Time Frame	33	41	44	40	158
Appointment Compliance for Providers Reached	80%	73%	68%	88%	76%
Total # Providers Called	81	86	98	79	344
# Appointments Scheduled within Required Time Frame	33	41	44	40	158
Overall Appointment Compliance for All Calls	41%	48%	45%	52%	46%

Total providers reached includes contact where an appointment was scheduled. A compliance rate was calculated based upon the number of appointments scheduled within the required timeframe standards. Total providers called includes successful *contact* with the provider offices. In many cases, appointments were not scheduled due to no return phone call after leaving a message, being on hold too long, provider not accepting new patients, etc. The overall compliance rate takes into account all providers called and the number of appointments scheduled within the required timeframe. The overall compliance rate is negatively impacted by failed attempts to schedule an appointment as well as appointments scheduled outside of the timeframe requirements. Failed attempts to schedule an appointment adversely impacts access to care, and the results in the table emphasize the missed opportunities for getting members in to care.

For example, for ACDC, contact was made with 81 providers. Of the 81 providers, appointments were scheduled with 41. Of the 41 appointments, 33 were within the timeframe requirements. ACDC's overall compliance was 41%.

The aggregate compliance rate for all appointment categories across the MCOs was 46%. Key study findings include:

- Aggregate compliance with the behavioral health – non-urgent appointment standard was the lowest of all appointment categories at 23%.
- The second lowest aggregate compliance rate was for an initial OB appointment at 28%.
- Wide variation in compliance rates with appointment availability standards exists among the MCOs.

Grievance Resolution

The following DHCF standards were used to assess MCO's compliance with requirements for grievance resolution with the exception of HSCSN. (HSCSN requirements are described below). The MCO must:

- Send a written acknowledgement of the complaint/grievance within two business days of receipt.
- Give oral notification to the member of the complaint/grievance resolution when possible.
- Notify the member or designee in writing of the resolution results within 30 days from receipt.
- Offer an appropriate resolution to the grievance, (e.g., documenting how the issue was addressed and by whom, and how the member can ask for further investigation through the appeal/fair hearing process).

HSCSN's contractual requirements with DHCF are unique to this MCO. According to HSCSN, prior to their new contract with DHCF effective October 1, 2016, the MCO was not required to provide a written acknowledgment or written resolution of complaints to the member. Only an oral notice of the resolution was required.

HSCSN makes an exception for complaints relating to the transportation vendor. For these complaints, a written acknowledgment and an oral and written notice of the resolution is sent to the member. Therefore, for this review time frame, HSCSN's transportation-related complaints were assessed for: (1) a written acknowledgement within 2 business days; (2) an oral notification of the resolution when possible; and (3) a written notification of the resolution within 30 days.

For grievances, HSCSN's policy is to provide the member with a written acknowledgement, and both an oral resolution and a written resolution.

Table 28. Grievance Timeliness

Grievance Timeliness	ACDC 2016 %	HSCSN 2016* %	MFC 2016 %	THP 2016 %
Issue a written acknowledgement of the grievance within 2 business days of receipt	90	50	76	19
Provide oral notification of the resolution when possible	86	50	97	62
Provide written resolution within 30 days from receipt	100	94	86	38
Provide an appropriate resolution to the grievance	79	100	72	58

*Includes grievances and transportation complaints, as they are treated as grievances.

Analysis of grievance data found the following:

- Wide variation in compliance was observed among the MCOs.
- A common opportunity for improvement exists related to consistent documentation of the date of receipt of the complaint/grievance as the date received by any internal department or an external vendor.
- Confusion often exists among the terms complaint, grievance, and inquiry.

Summary of Findings

Quality

DHCF Quality Strategy

The DHCF Quality Strategy guides the activities within the agency toward health delivery transformation utilizing quality improvement, performance measurement and linking health outcomes to payment. It builds upon the foundation of the DHCF strategy, specifically aligning with and integrating established aims from the following key initiatives:

- The National Strategy for Quality Improvement in Health Care and CMS Quality Strategy in pursuit of “Triple Aim;”
- Healthy People 2020;
- DC Healthy People 2020;
- The DC Mayoral priority of *A Healthy Community*, and
- DC State Health Innovation Plan (SHIP)

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

- 1) Ensure 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 and link payment to quality.

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:

- Member utilization financial condition
- Administrative performance
- Case management outcomes
- Network adequacy 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. The DC Managed Care Quarterly Performance Report results are now published on a quarterly basis including a year-end report. The most recent 2016 report analyzes performance from April 2016 – June 2016. Beginning in FY 2018 the reports will be published on a semi-annual basis. Overall, care coordination is the biggest opportunity for improvement—including managing low acuity ED utilization, potentially preventable hospital admissions, and reducing 30 day hospital readmissions.

To further quality improvement efforts on the part of the MCOs, DHCF will incentivize MCOs beginning in FY 2017 by implementing a pay-for-performance program with the three (3) risk-based MCOs. Performance measures will be based on existing measures currently collected for the DC Managed Care quarterly Performance Report: low acuity non-emergent (LANE); potentially preventable admission (PPA) and 30 day hospital readmission.

DHCF requires all MCOs to collect and submit annual audited HEDIS® performance measures and CAHPS® survey results. DHCF has set performance goals for these measures at the National Medicaid 75th percentiles. However, MY 2015 reported rates show that the District weighted average was below the 75th percentile for nearly all HEDIS® and CAHPS® measures. DHCF requires MCOs to implement opportunities for improvement plans for all measures not meeting the 75th percentile. In FY2016, MCOs began submitting HEDIS® and PIP performance measure data quarterly for the purposes of conducting qualitative and quantitative analysis, identifying opportunities for improvement, interventions and evaluating intervention effectiveness during DHCF MCO Quality and QI Collaborative meetings.

In FY2016, DHCF also began the planning phase of a MCO care coordination/case management initiative to address the care coordination deficiencies identified in the DC Managed Care Performance Report. The implementation phase began in October, FY2017. This initiative puts in place a set of comprehensive standards and guidelines for care coordination/case management to ensure core consistencies management; reporting of enrollment and program outcomes. As part of the perinatal quality improvement collaborative, DHCF DQHO and Health Care Innovation and Reform Administration (HCIRA) secured CMS Medicaid Innovation Accelerator Program (IAP) funding to launch a perinatal “registry.” The goal of IAP is to improve care and improve health for Medicaid beneficiaries, and reduce costs by supporting states in accelerating new payment and service delivery reforms. The IAP focuses on populations with significant needs served by Medicaid programs, such as pregnant women and newborns, children, individuals with mental illness, individuals receiving long-term services and supports, and others. The perinatal “registry” will provide a venue for providers to utilize electronic health record (EHR) data to auto populate components of the Obstetrics Authorization and Initial Assessment Form electronically and allow for better care coordination between DHCF, MCOs, and Medicaid providers to 1) maximizing community partnerships through a quality improvement collaborative 2) enhanced care coordination through the use of technology, and 3) Utilize IAP funding to improve healthcare for pregnant Medicaid beneficiaries.

In addition to the established performance measures reported in the DC Managed Care Quarterly Performance Reports, DHCF requires all MCOs to collect and submit annual audited HEDIS® performance measure and CAHPS® experience of care results. DHCF has set performance goals for these measures at the Quality Compass Medicaid HMO 75th percentiles. However, for measurement year (MY) 2015 MCOs failed to meet the desired threshold for many HEDIS® performance measure and CAHPS® experience of care results. DHCF is prioritizing opportunities for improvement and will be asking MCOs to develop opportunities for improvement action plans to address gaps in care.

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 asthma members are also engaged in case management to improve medication compliance and reduce ED utilization and inpatient admissions.

DHCF is collaboratively working with the MCOs to develop and standardize guidelines for Case Management services. The goal is to ensure consistency, compare programs across MCOs, and improve health outcomes for all persons enrolled in Case Management throughout the District. Based on a comprehensive assessment of each new enrollee, Case Management needs will be assessed and intensity levels will be determined by level of need. Case Management services will be standardized to allow for comparable outcome measurement.

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 initially by three MCOs and subsequently by the last MCO after revisions. Remeasurement 1 (MY 2015) results were compared to baseline measurements (MY 2014) and to internal goals and/or benchmarks when available.

MCO performance compared favorably to national and District-wide March of Dimes benchmarks for the Improving Perinatal and Birth Outcomes PIP. Additionally, documentation of HIV testing improved considerably over the prior year; however, almost half of pregnant member's records still lack documentation of receipt of this test. In regard to the Pediatric Asthma PIP, results indicated that ED and inpatient hospital utilization remains highest among children in the 2-4 years of age category. Appropriate medications were prescribed for 72.33% of members; however, only 52.47% were compliant with medication use for at least half of the prescribed period of treatment.

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 and Initial Assessment Form.

Performance Measure Validation

MCOs met all documentation requirements for data capture and integration for calculating the indicator rates for both collaborative PIPs. All measure indicators and final rates were deemed reportable for both collaborative PIPs.

HEDIS® and CAHPS® Performance Measures

Two of the seven MCO weighted averages for the Comprehensive Diabetes Care indicators, HbA1c control under 7% and HbA1c control under 8%, exceeded the national Medicaid averages but were below the 75th percentile. Five of the seven MCO weighted averages were below the national Medicaid averages. The MCO weighted average for the Controlling High Blood Pressure performance measure similarly fell below the national Medicaid average. Based on the MCO averages, performance for all but two quality related CAHPS® measures was below the national 75th percentile benchmarks. Adult rating of personal doctor and the Health Promotion and Education component of the child survey exceeded the 75th percentile. In general, members were less satisfied with the quality of care and services provided to children than for adults.

Access**HEDIS® Performance Measures and CAHPS® Surveys**

The MCOs had mixed results in child and adult access related measures. The District MCO weighted average exceeded the Medicaid average in adolescent access, childhood and adolescent immunizations, lead screening, well-child visits (3 – 6 years of age), and children (25 months – 6 years) and adolescent access measures. It also exceeded the 75th percentile in children's access (7 – 11 years), adolescent well care, and annual dental measures. It did not meet the Medicaid national average in adult and infant (12 – 24 months) access, as well as in well-child visits (first 15 months of life) 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 and decreased over the prior year's results.

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.

Provider Directory Listings

Based upon validation of provider contact information listed in each MCO's provider directory opportunities exist for improving the accuracy of provider addresses and phone numbers. Inaccurate contact information can be a contributing factor to member access issues.

Timeliness**HEDIS® Performance Measures and CAHPS® Surveys**

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

Appointment Availability

Overall compliance with appointment availability standards across all appointment categories was 46% with a range of 41% to 52% among the MCOs. Availability of non-urgent behavioral health appointments represented the lowest compliance rate at 23% closely followed by initial OB appointments at 28%. Wide variation in compliance rates with appointment availability standards exists among the MCOs.

Grievance Resolution

Compliance with required timeframes for grievance resolution was not consistently met by any of the MCOs. Additionally, opportunities were identified for ensuring an appropriate resolution to each grievance.

Status of 2015 Recommendations

As a result of the 2015 review activities several recommendations for improvement were made to the MCOs. The MCOs were expected to act on the recommendations during 2016. The status of each recommendation is described below.

AmeriHealth Caritas District of Columbia**2015 Opportunity for Improvement:**

- 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. During the 2015 case management review, 97% of cases assessed had no evidence of the member receiving an HIV test prior to delivery. 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.

Follow Up Activity and 2016 Finding:

- The 2016 case management file review revealed that of the 28 files selected, 17 members did not show evidence of an HIV test (61%). While this is an improvement over the 2015 case management file review (97% did not show evidence of an HIV test), there is still room for improvement. In late 2016, the MCOs worked with DHCF to revise the OB Authorization and Initial Assessment Form to capture an HIV test prior to delivery. ACDC, along with other MCOs, are expecting to improve performance as they capture the HIV testing status of their pregnant members.
- Of the 10 records reviewed during the 2016 pediatric asthma case management file review, all showed evidence that medication education was provided as a part of the IMPACT DC intervention; however, ongoing documentation of medication management in the case files was limited. However, ACDC does have several documented programs in place to ensure members are compliant with their medication. Per staff interview, Case Managers send out refill reminder reports on a bi-weekly basis to PCPs whose

patients need a refill or whose medication refill will expire within one week. Also, Breathe Easy Start Today (BEST) offers prescription refills at PCP offices. Finally, ACDC Care Connectors and community health workers make outreach calls to members who have been to the ER or been hospitalized for asthma, to ensure they are taking their maintenance medications properly and to remind them of the importance of adherence to their asthma action plan. It is recommended that these important efforts to ensure compliance with medication are documented within the member's case management file.

Health Services for Children with Special Needs, Inc.

2015 Opportunities for Improvement:

- Based on the results of the 2015 case management file review, an opportunity to improve monitoring and compliance with postpartum visits exists.
- During the case management file review, it was determined that medication compliance is not routinely monitored by Care Managers for pediatric members with asthma, despite a requirement to include medication compliance as a goal in the member care plan.

Follow Up Activity and 2016 Finding:

- During the 2015 perinatal case management file review, it was revealed that of the 30 files selected, only 16 members had completed their postpartum visit (53% compliance). While onsite for the 2016 case management file review, it was identified that only 15 of the 30 members selected had completed their postpartum visit (50% compliance)—a three percentage point reduction in compliance. While there was evidence of documentation in the HSCSN IT system that the OB Case Manager followed up with members to ensure postpartum visits were scheduled and/or completed, the rate of completion remains very low.
- HSCSN has a unique population in which members already have multiple scheduled appointments. Postpartum appointments may seem unnecessary to this population with competing medical priorities. It is recommended that HSCSN perform another comprehensive barrier analysis identifying reasons why members are not attending their scheduled postpartum appointments and discover alternative opportunities to get these members to their appointments.
- Regarding the monitoring of medication compliance, of the 10 records reviewed during the 2016 pediatric asthma case management file review, only 5 revealed documentation regarding medication management (50%). While this is an improvement over the previous year's file review (33%), it is still a low rate of compliance considering all of HSCSN members are case managed. The care managers should make notes within the member files that prescription medication reports from their pharmacy benefits manager are reviewed for each member. Notes should also include the discussion with the member and caregivers of the importance of medication adherence for all members with asthma. Greater documentation of communication with members regarding medication management will ensure that members are not falling thru the cracks and will greatly improve HSCSN's medication management rate.

MedStar Family Choice

2015 Opportunity for Improvement:

- 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 and Initial Assessment Forms (PIP collaborative intervention), MFC should scan and save the documents rather than destroying the forms after extracting necessary information.

Follow Up Activity and 2016 Finding:

- MFC's 2016 CQI Plan was revised to meet contract requirements. The plan now includes explicit language that addresses confidentiality and privacy policy and procedure requirements.
- The OB Case Manager stopped shredding the OB Authorization and Initial Assessment Form and now saves them electronically. During the 2016 follow-up onsite review, MFC provided evidence of the scanned OB Authorization and Initial Assessment forms.

Trusted Health Plan

2015 Opportunities for Improvement:

- 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."

Follow Up Activity and 2015 Finding:

- THP developed and implemented an Ethnic and Racial Healthcare Disparities program. The program was implemented in the 4th quarter of 2016. The purpose of this program is to identify differences in health status and service use and to develop, implement, and monitor intervention programs aimed at reducing or eliminating gaps in care for specific member demographics.

The program has the following three-pronged approach:

- Collection and analysis of data to identify issues including utilizing HEDIS null results which are cross-referenced with the member's race, ethnicity, location and primary care physician to determine presence of ethnic/racial disparities in THP members.
- Tailor programs based on results of data analysis process.
- Remeasure quarterly (post implementation).

The topic of Ethnic and Racial Disparities was added as a standing agenda item for the Quality Executive Committee (QEC). Evidence of the standing agenda item was documented in the 9/21/16 meeting minutes. Results were not available in 2016.

- THP revised its CQI Program Description to include explicit language that the Chief Quality Officer is accountable for the CQI activities for THP's own providers as well as the subcontracted providers.
- THP revised its CQI Program Description to include explicit language that the Chief Quality Officer participates in monthly CQI meetings with DHCF and the EQRO.
- THP's Clinical Quality Manager and Director of Utilization Management implemented a monthly auditing process in which perinatal as well as other case management files are reviewed against the collaborative and NCQA standards. The purpose of the audits and subsequent follow-up discussions is to ensure that the following issues are closely monitored for compliance and improvements in health outcomes:
 - Timely identification of pregnant members;
 - Ensuring comprehensive completion of the District's obstetrical needs assessment form and the NCQA related health risk assessment(s);
 - Early engagement in required/recommended health regimens to include prenatal and postpartum visits;
 - Timely referrals to THP's high risk Case Management program as needed; and
 - Updated plans of care as goals and interventions are met.
- Based on the 2016 perinatal case management file review, it does not appear that improvements have been made in increasing postpartum visits for THP members and this remains an opportunity for improvement. THP did not have 30 high risk case managed pregnant members and therefore submitted a file of 15 members. Only three of the 15 files provided met criteria. Six files were Alliance members, three were outside of the sample timeframe (all delivered in 2015), and three did not meet high risk criteria. Of the three files reviewed that met criteria as high risk, there was evidence that two of the members received postpartum care. One of the members, however, received her postpartum visit one day after delivery which is not only outside the HEDIS timeframe window, but it is also too early to determine any post-delivery complications. Three files were reviewed that did not meet the high risk category and of these three, one member had a postpartum visit, but it was only two days after delivery.
- After training, THP's case management staff are now aware of the location of the birth outcomes data within THP's utilization review application vs locating it in the case management documentation system. Of the six charts that were reviewed during the perinatal file review, all had documentation of birth

outcomes such as birthweight and gestational age. While this is a small sample and it is difficult to determine whether global changes have been made, preliminary evidence indicates that THP case managers are aware of how to obtain birth outcomes data so they may monitor and follow up accordingly.

- THP reviewed its process to address gaps in care in regard to managing pediatric members with asthma. Policies and procedures for the Low Acuity Non-Emergency (L.A.N.E.) report, high and low utilizers were re-enforced through staff retraining. On a monthly basis, THP produces a list of members who qualify for the Adverse Chronic Conditions PIP. The list is provided to the Asthma Case Manager to facilitate the assessment process for the eligible population. A standard operating procedure (SOP) was developed and reviewed. The SOP demonstrates the process by which the Asthma case manager provides care coordination services and oversight of cases that are referred externally to THP's asthma vendors (IMPACT DC and Breathe DC). THP also implemented a monthly auditing process in which asthma as well as other case management files are reviewed against the collaborative and NCQA standards. The purpose of the audits and subsequent follow-up discussions is to ensure that the following issues are closely monitored for compliance and improvements in health outcomes.
- A recommendation was made from the 2015 OSR to ensure that all pediatric asthmatics with high utilization are contacted by care management. While it is difficult to make a definite conclusion based on the limited file review, there was evidence that pediatric asthmatics were either in care management or were seen through the IMPACT DC intervention. Some members refused care management; however, there was limited documentation as to why. Also, unfortunately, there is little documentation of the asthmatic children enrolled in care management overall. Most did not have an asthma action plan, an asthma assessment, or evidence of a care plan. There continues to be a concern that children needing intervention may continue to slip through the cracks.

DHCF

2015 Opportunities for Improvement and Follow Up Activities:

- Develop performance improvement goals for PIP collaborative performance measures. This will improve MCO accountability and engagement in collaborative efforts. *DHCF, in collaboration with Delmarva Foundation, developed PIP goals for each PIP indicator.*
- 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. *DHCF is strategizing and working to prioritize select performance and survey measures. Measures that require action plans will be based on opportunities for improvement and identified gaps in care or member experience.*
- 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. DHCF required the MCOs to report the *Timeliness of Prenatal Care and Postpartum Care measures in their 2016 PIPs. The measures will continue to be included in the PIPs.*

- 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. *As part of the 2016 PIP submissions, DHCF required MCOs to report at least one intervention that related to improving member awareness and understanding of HIV status and steps to be taken to treat HIV or reduce transmission. The goal was to expand MCO efforts beyond improving data collection for HIV testing.*
- 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. *Due to the anticipated release of the CMS Medicaid and CHIP Managed Care Final Rule and the pending new MCO contracts, this was not addressed in 2016. However, it was included in the MCO RFP that was released in 2016. The new contracts will be effective in October 2017.*
- To provide clarity and consistency, DHCF should provide MCOs with separate and distinct definitions for member complaints and grievances. *DHCF revised its definition of a member grievance to be consistent with federal regulations and eliminated the definition for member complaint.*

2016 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. MCOs should strive to meet or exceed the PIP collaborative goals established by DHCF in January 2017. Additionally, the MCOs need to focus on improving performance in all HEDIS® performance measures and CAHPS® survey measures that are not meeting the Quality Compass Medicaid HMO 75th percentile benchmark. Based on 2016 assessments, Delmarva Foundation developed the following MCO specific OFIs. MCOs will be required to develop OFI Action Plans that will be approved and monitored by Delmarva Foundation. Delmarva Foundation will continue to monitor OFIs until MCOs demonstrate compliance.

AmeriHealth Caritas District of Columbia

- The overall compliance rate for member access to appointments within DHCF required timeframes is 41%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the*

Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.

Health Services for Children with Special Needs, Inc.

- During the validation of the Provider Directory, it was determined that 15 out of the 30 providers contacted had incorrect information (50%). Thirteen errors were found in the provider's address, and 2 phone numbers were incorrect. *The MCO should verify its provider directory information and create a procedure for maintaining accurate provider contact information in the provider directory.*
- The overall compliance rate for member access to appointments within DHCF required timeframes is 48%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*
- During the review of HSCSN's current complaint and grievance review process, it was determined that only 50% of written acknowledgements of grievances were issued within two business days of receipt. *The MCO should ensure that for all grievances, the date of receipt, independent of the party initially contacted (HSCSN or one of its vendors) should be the date documented as the start of the resolution process.*
- HSCSN reported that IMPACT DC does not routinely submit clinical assessments performed as part of the IMPACT DC intervention. During the case management review, only 50% of the records reviewed had asthma action plans or any type of medication education or management documentation. *HSCSN should work closely with IMPACT DC to ensure timely receipt of the member's assessment and intervention forms. This will assist in providing timely follow-up for members who have had an IMPACT DC intervention and who may need additional education, medication monitoring, or who are at high risk for another emergency department or inpatient visit.*
- Postpartum care appointment rates remain relatively low at 50% compliance based on the case management file review. *The MCO should conduct a thorough barrier analysis with particular focus on identifying interventions to improve postpartum visit compliance.*

MedStar Family Choice

- The overall compliance rate for member access to appointments within DHCF required timeframes is 45%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*
- The language in resolution letters to members may be too advanced. Words like "centricity" and phrases such as, "to be taken as advisement" or "pharmacy override" may be confusing wording for the member. *All member materials should adhere to DHCF's 5th grade reading level requirement.*
- Results from the case management review revealed that only 36% of the sample had an OB Authorization and Initial Assessment Form in their file. *It is recommended that MFC focus on identifying barriers to receipt of the OB Authorization and Initial Assessment Form. MFC may consider a provider incentive or other intervention to improve the rate of return.*

Trusted Health Plan

- The overall compliance rate for member access to appointments within DHCF required timeframes is 52%, thus offering an opportunity for improvement. *The MCO should review the detailed findings of the Operational Systems Review report which captures all factors that contributed to noncompliance, and develop a plan of action to improve timely access to provider appointments.*
- Documentation of and follow-up on the member complaint/grievance was sparse in the sample of files reviewed. Only 5 of 26 records showed evidence of a written acknowledgement of the grievance (19%). In addition, only 38% provided evidence of compliance with a written resolution within 30 days. *Going forward, THP should follow the grievance definition released by DHCF in the fourth quarter of 2016. It is consistent with the definition provided by the Code of Federal Regulations and provides clear instruction on grievance classification. THP should conduct staff trainings which outline resolution and documentation requirements. Staff should also understand the difference between a grievance and an inquiry. In addition, the MCO should develop a quality assurance process to conduct ongoing reviews of the handling of member grievances.*
- Eleven (11) of the 26 grievance files reviewed demonstrated evidence of unreasonable resolution (42%). For example, 5 demonstrated lack of a reasonable resolution such as asking a member to contact the provider regarding a billing issue. *The MCO must ensure reasonable resolution and should develop a quality assurance process to conduct ongoing reviews of the handling of member grievances.*
- THP's inability to provide 30 high risk pregnancy case management files presents an opportunity for improvement. Only 3 files were available for review. *THP clinical staff should work with the MCO's data analysts and programming staff to review existing criteria for identification of high risk pregnant members to ensure validity and reliability of results. It appears that the current procedure is not adequately capturing all members with high risk pregnancies and/or members are not being case managed.*
- Postpartum care was identified as an opportunity for improvement based on the 2015 OSR case management file review. This continues to be an opportunity for THP. Only 33% of the small sample of high risk pregnancies received postpartum care within the HEDIS required timeframe. *THP should continue efforts to identify barriers to care and implement interventions in response.*
- Per THP staff, IMPACT DC does not routinely submit assessments completed as part of the pediatric asthma intervention. During the case management file review, only 20% of the selected files had an asthma action plan, 10% showed evidence of a care plan, and 30% had an asthma assessment and evidence of medication education and monitoring. *THP has a dedicated care coordinator for members with pediatric asthma; this coordinator should ensure the timely receipt of IMPACT DC assessments. These assessments include valuable information including asthma action plans and evidence of member medication education.*

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:

- The MCOs and DHCF are encouraged to collaborate and work to identify additional sources for data for the collaborative measures, particularly for HIV testing. HIV testing may be part of a standardized prenatal laboratory screening panel completed in the first trimester of pregnancy. However, administrative data for HIV testing appears to be lacking for all MCOs. The performance measure specifications allow for medical record reviews. MCOs may want to take advantage of this opportunity to identify HIV testing for the pregnant members.
- Given the relatively low appointment access compliance rates across each of the MCOs, consider replicating the Timely Appointment Availability Study as part of a focused study. Comparisons can be made with the 2016 baseline data to determine if improvements have been made. DHCF and the MCOs have performed similar studies in the past. DHCF is encouraged to continue to focus efforts on monitoring performance and requiring the MCOs to develop action plans when performance is not meeting contractual requirements.
- Based on case management review findings and HEDIS® performance measure results, continue to include Timeliness of Prenatal Care and Postpartum Care measures to the Improving Perinatal and Birth Outcomes Collaborative PIP analysis. The District weighted averages for both measures fail to meet national Medicaid averages. Significant improvement is required by the MCOs to meet the District's goal of the Quality Compass Medicaid HMO 75th percentile.
- As a component of the perinatal collaborative, consider working with the MCOs to address common barriers to OB appointment access which may be a contributing factor to low prenatal and postpartum care rates. Consider devoting one of the Perinatal Collaborative meetings to this topic. MCOs can present barriers to care and discuss interventions.
- Consider having MCOs present successful strategies that improve timely completion and receipt of the OB Authorization and Initial Assessment Form. This form is key to identifying pregnant members early and has the potential to initiate the process for early intervention. This could be an agenda item during a Perinatal Collaborative meeting.

Appendix 1

HEDIS 2016 - Measurement Year (MY) 2015

The HEDIS performance measure result tables include MY 2015 results. Individual MCO performance rates, the District weighted average, and a comparison of the District weighted average to the HEDIS 2016 (MY 2015) NCQA Quality Compass Medicaid HMO benchmarks 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 HMO Average.	♦
The District Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦♦
The District Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦♦♦

Effectiveness of Care Domain

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	33.33	44.44	28.57	28.92	32.3	♦
Adult BMI Assessment	86.11	70.74	93.08	78.24	86.1	♦♦
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	86.49	80.00	87.19	79.03	85.2	♦
Annual Monitoring for Patients on Persistent Medications – Digoxin	62.50	NA	54.55	NA	50.0	♦
Annual Monitoring for Patients on Persistent Medications – Diuretics	84.34	88.24	85.00	74.82	82.7	♦

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Annual Monitoring for Patients on Persistent Medications - Total	85.42	85.19	86.05	76.90	84.0	♦
Antidepressant Medication Management - Effective Acute Phase Treatment	44.38	32.43	41.46	74.32	48.0	♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	31.34	18.92	24.87	60.31	33.9	♦
Appropriate Testing for Children With Pharyngitis	83.91	84.48	88.13	50.88	80.9	♦ ♦
Appropriate Treatment for Children With Upper Respiratory Infection	97.26	96.04	97.78	97.77	97.3	♦ ♦ ♦
Asthma Medication Ratio (5-11)	54.63	63.43	63.86	48.89	55.8	♦
Asthma Medication Ratio (12-18)	47.15	58.18	59.55	35.85	49.9	♦
Asthma Medication Ratio (19-50)	50.87	51.85	43.70	55.70	50.3	♦ ♦
Asthma Medication Ratio (51-64)	58.00	NA	50.82	64.2	57.3	♦ ♦
Asthma Medication Ratio (Total)	52.72	59.40	52.40	52.81	53.2	♦
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	31.55	42.86	46.61	37.43	36.7	♦ ♦ ♦
Breast Cancer Screening	65.54	NQ	54.24	50.97	60.6	♦ ♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	66.67	NA	NA	NA	-	-
Cervical Cancer Screening	68.05	70.67	59.79	48.14	62.6	♦ ♦
Childhood Immunization Status - Combo 2	80.09	77.12	75.91	55.79	75.2	♦ ♦
Childhood Immunization Status - Combo 3	78.24	75.42	73.48	52.08	72.9	♦ ♦
Childhood Immunization Status - Combo 4	77.78	75.42	73.48	51.85	72.6	♦ ♦ ♦
Childhood Immunization Status - Combo 5	64.81	48.31	61.56	40.97	59.7	♦ ♦
Childhood Immunization Status - Combo 6	44.68	47.46	50.12	35.19	44.5	♦ ♦
Childhood Immunization Status - Combo 7	64.58	48.31	61.56	40.74	59.6	♦ ♦
Childhood Immunization Status - Combo 8	44.68	47.46	50.12	35.19	44.5	♦ ♦

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Childhood Immunization Status - Combo 9	39.12	32.20	43.07	30.09	38.4	♦♦
Childhood Immunization Status - Combo 10	39.12	32.20	43.07	30.09	38.4	♦♦
Childhood Immunization Status - DTaP	83.56	78.81	79.81	61.57	79.0	♦♦
Childhood Immunization Status - Hepatitis A	92.13	96.61	90.02	78.70	89.6	♦♦♦
Childhood Immunization Status - Hepatitis B	89.12	89.83	86.37	72.92	85.9	♦
Childhood Immunization Status - HiB	91.44	91.53	88.32	75.93	88.3	♦♦
Childhood Immunization Status - Influenza	49.54	54.24	57.66	43.52	50.6	♦♦
Childhood Immunization Status - IPV	91.20	93.22	86.62	74.07	87.5	♦
Childhood Immunization Status - MMR	92.59	96.61	91.24	79.86	90.4	♦♦
Childhood Immunization Status - Pneumococcal Conjugate	84.72	80.51	80.54	62.04	80.0	♦♦
Childhood Immunization Status - Rotavirus	70.60	54.24	68.61	52.31	66.7	♦
Childhood Immunization Status - VZV	92.36	97.46	89.54	78.47	89.7	♦♦
Chlamydia Screening in Women (Lower Age Stratification)	79.32	81.93	75.10	66.67	77.8	♦♦♦
Chlamydia Screening in Women (Upper Age Stratification)	77.27	79.52	74.30	73.31	76.2	♦♦♦
Chlamydia Screening in Women - Total	78.27	80.78	74.63	71.37	76.9	♦♦♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	53.99	31.58	61.31	41.63	54.0	♦
Comprehensive Diabetes Care - Eye Exams	52.43	34.21	39.05	33.50	45.6	♦
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	36.29	NQ	31.94	28.93	33.8	♦♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	53.99	23.68	48.72	41.13	50.3	♦♦
Comprehensive Diabetes Care - HbA1c Testing	87.85	89.47	84.12	76.12	85.0	♦
Comprehensive Diabetes Care - Medical Attention for Nephropathy	88.19	94.74	89.60	82.09	87.7	♦

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) (Lower score is better)	36.81	76.32	41.24	48.92	40.2	♦♦
Controlling High Blood Pressure	47.33	45.95	57.80	40.22	49.1	♦
Diabetes Monitoring for People With Diabetes and Schizophrenia	56.25	50.00	42.86	50.00	51.0	♦
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	71.17	68.97	78.40	54.97	69.30	♦
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	76.00	NA	82.14	68.42	76.2	♦♦
FU Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	66.67	44.44	37.5	25.00	55.2	♦♦
FU Care for Children Prescribed ADHD Medication - Initiation	46.23	47.62	22.86	31.25	43.3	♦♦
FU After Hospitalization For Mental Illness - 7 days	42.27	27.32	5.02	35.21	32.1	♦
FU After Hospitalization For Mental Illness - 30 days	54.67	47.54	10.46	41.31	43.2	♦
Human Papillomavirus Vaccine for Female Adolescents	48.61	48.00	36.52	28.43	45.0	♦♦♦
Immunizations for Adolescents - Meningococcal	85.55	89.50	84.11	67.30	84.2	♦♦
Immunizations for Adolescents - Tdap/Td	76.43	89.00	84.11	64.45	77.8	♦
Immunizations for Adolescents - Combination 1	73.38	85.00	80.69	62.09	74.6	♦♦
Lead Screening in Children	82.57	86.44	83.68	55.32	78.6	♦♦
Medication Management for People With Asthma: Medication Compliance 50% (5-11 Years)	52.7	43.20	32.89	73.00	51.8	^
Medication Management for People With Asthma: Medication Compliance 50% (12-18 Years)	45.5	33.98	32.5	57.9	42.2	^
Medication Management for People With Asthma: Medication Compliance 50% (19-50 Years)	57.20	53.49	47.12	81.00	59.3	^
Medication Management for People With Asthma: Medication Compliance 50% (51-64 Years)	69.90	NA	82.83	91.70	76.2	^

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Medication Management for People With Asthma: Medication Compliance 50% (Total)	55.10	41.33	47.57	77.70	55.7	^
Medication Management for People With Asthma: Medication Compliance 75% (5-11 Years)	27.03	20.80	13.42	50.68	27.6	♦
Medication Management for People With Asthma: Medication Compliance 75% (12-18 Years)	24.03	12.62	12.50	44.74	21.6	♦
Medication Management for People With Asthma: Medication Compliance 75% (19-50 Years)	32.46	23.26	21.63	59.24	34.7	♦
Medication Management for People With Asthma: Medication Compliance 75% (51-64 Years)	50.60	NA	54.55	81.67	56.1	♦♦♦
Medication Management for People With Asthma: Medication Compliance 75% (Total)	31.21	18.08	24.07	58.14	32.5	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5 Years) 1st Year	NA	NA	NA	NA	-	-
Metabolic Monitoring for Children and Adolescents on Antipsychotics (6-11 Years)	34.78	28.85	33.33	37.50	32.2	♦♦♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics (12-17 Years)	40.21	36.36	39.13	11.11	37.1	♦♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	37.93	34.13	37.14	23.53	35.3	♦♦♦
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) (Lower score is better)	5.66	0.47	0.65	1.38	3.9	♦
Persistence of Beta-Blocker Treatment after a Heart Attack	67.57	NA	56.25	61.54	63.6	♦
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.41	NQ	87.88	87.50	87.6	♦♦♦
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	66.43	NQ	62.63	60.42	64.1	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-5 Years)	NA	NA	NA	NA	-	-

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6-11 Years)	43.18	53.85	NA	25.00	35.9	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Years)	31.18	28.57	8.00	80.00	28.5	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	34.29	32.05	5.26	46.15	30.1	♦
Use of Imaging Studies for Low Back Pain	82.71	96.00	82.45	82.27	82.7	♦♦♦
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1-5 Years)	NA	NA	NA	NA	-	-
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6-11 Years)	NA	2.78	NA	NA	-	-
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12-17 Years)	1.89	0.90	NA	NA	1.1	♦
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	1.25	1.36	NA	NA	1.2	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 Years)	81.17	BR	85.16	62.39	78.2	♦♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 Years)	78.57	BR	81.06	64.20	77.3	♦♦♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	80.37	BR	83.76	62.73	77.9	♦♦♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Years)	75.34	BR	77.34	59.26	72.50	♦♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Years)	72.45	BR	72.73	56.79	70.4	♦♦♦

Effectiveness of Care Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	74.45	BR	75.77	58.80	71.9	◆◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Years)	69.06	BR	73.44	52.71	66.7	◆◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Years)	71.43	BR	71.21	48.15	68.3	◆◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	69.78	BR	72.68	51.85	67.2	◆◆◆
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available BR – Biased rate NA – Small denominator (<30) NB – No benefit NQ – Not required NR – Not reported						

Access/Availability of Care Domain

Access/Availability of Care Domain Measure Name HEDIS 2016 (MY2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	70.59	84.97	61.99	54.89	65.5	♦
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	79.15	NA	70.87	66.19	74.2	♦
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	73.97	NA	86.11	71.43	77.2	♦
Adults' Access to Preventive/Ambulatory Health Services (Total)	73.55	84.97	65.43	58.54	68.5	♦
Annual Dental Visit (2-3 Years)	66.44	69.23	31.33	57.50	58.7	♦♦♦
Annual Dental Visit (4-6 Years)	82.12	77.41	42.87	74.49	75.1	♦♦♦
Annual Dental Visit (7-10 Years)	80.61	81.78	42.09	73.63	73.8	♦♦♦
Annual Dental Visit (11-14 Years)	76.75	81.76	38.04	68.81	69.8	♦♦♦
Annual Dental Visit (15-18 Years)	66.39	72.95	32.22	55.32	59.8	♦♦♦
Annual Dental Visit (19-21 Years)	46.51	67.10	20.41	44.55	43.5	♦♦♦
Annual Dental Visit (Total)	73.57	76.32	36.20	66.33	66.6	♦♦♦
Children and Adolescents' Access To PCP (12-24 Months)	94.59	97.53	93.14	88.87	93.5	♦
Children and Adolescents' Access To PCP (25 Months-6 Years)	89.09	91.17	84.83	84.89	87.9	♦♦
Children and Adolescents' Access To PCP (7-11 Years)	94.24	97.89	89.55	89.91	93.3	♦♦♦
Children and Adolescents' Access To PCP (12-19 Years)	91.76	95.94	84.27	84.85	90.5	♦♦
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	NB	0.00	1.29	NB	-	-

Access/Availability of Care Domain Measure Name HEDIS 2016 (MY2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	NB	28.00	23.06	NB	-	-
Prenatal and Postpartum Care - Postpartum Care	49.30	47.44	57.21	41.07	50.2	♦
Prenatal and Postpartum Care - Timeliness of Prenatal Care	68.84	73.08	75.06	69.37	70.8	♦
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available BR - Biased rate NA - Small denominator (<30) NB - No benefit NQ - Not required NR - Not reported						

Utilization Domain

Utilization Domain Measure Name HEDIS 2016 (MY 2015)	ACDC MY 2015 %	HSCSN MY 2015 %	MFC MY 2015 %	THP MY 2015 %	District Weighted Average MY 2015 %	Diamond Rating
Adolescent Well-Care Visits	64.81	69.59	52.58	53.24	62.0	◆◆◆
Frequency of Ongoing Prenatal Care (<21%)	9.77	3.85	7.58	11.60	9.3	◆
Frequency of Ongoing Prenatal Care (21-40%)	12.33	3.85	8.56	10.44	10.7	◆◆◆
Frequency of Ongoing Prenatal Care (41-60%)	20.70	20.51	13.20	17.63	18.1	◆◆◆
Frequency of Ongoing Prenatal Care (61-80%)	24.42	32.05	24.94	29.70	25.6	◆◆◆
Frequency of Ongoing Prenatal Care (≥81%)	32.79	39.74	45.72	30.63	36.3	◆
Well-Child Visits in the first 15 Months of Life (0 visits)	1.86	0.00	3.54	7.46	3.0	◆◆
Well-Child Visits in the first 15 Months of Life (1 visit)	1.62	1.61	1.27	2.49	1.6	◆
Well-Child Visits in the first 15 Months of Life (2 visits)	3.48	4.84	3.8	5.72	3.9	◆◆
Well-Child Visits in the first 15 Months of Life (3 visits)	6.03	3.23	4.56	10.95	6.2	◆◆
Well-Child Visits in the first 15 Months of Life (4 visits)	9.51	16.13	10.13	12.19	10.2	◆◆
Well-Child Visits in the first 15 Months of Life (5 visits)	16.01	16.13	18.73	13.43	16.5	◆
Well-Child Visits in the first 15 Months of Life (6 or more visits)	61.48	58.06	57.97	47.76	58.6	◆
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	77.38	83.09	76.72	76.62	77.4	◆◆
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available BR – Biased rate NA – Small denominator (<30) NB – No benefit NQ – Not required NR – Not reported						

Appendix 2

2016 CAHPS Survey

The tables include adult and child CAHPS survey performance measure results. Individual 2016 MCO results, the District average, and a comparison of the 2016 District average to the 2016 Quality Compass national Medicaid HMO benchmarks are provided. For trending purposes, the 2015 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 HMO Average.	♦
The District Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦♦
The District Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦♦♦

Adult CAHPS Measures

Adult CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2015 %	District Average 2016 %	Diamond Rating
Customer Service Composite	91.2	81.7	88.9	71.0	84.8	83.2	♦
Getting Needed Care Composite	74.8	79.7	79.8	68.0	77.6	75.6	♦
Getting Care Quickly Composite	77.3	80.3	76.5	71.0	78.3	76.3	♦
How Well Doctors Communicate Composite	91.7	91.6	93.3	91.0	92.1	91.9	♦♦
Shared Decision Making Composite	74.6	72.8	72.4	71.0	76.9	72.7	♦
Health Promotion and Education Composite	77.7	74.7	77.3	69.4	73.2	74.8	♦♦
Coordination of Care Composite	80.0	85.5	83.6	69.5	75.5	79.6	♦
Rating of Health Plan (8+9+10)	78.5	78.4	80.1	68.6	75.0	76.4	♦♦
Rating of All Health Care (8+9+10)	79.7	73.6	74.5	68.2	74.0	74.0	♦♦

Adult CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2015 %	District Average 2016 %	Diamond Rating
Rating of Personal Doctor (8+9+10)	83.4	84.1	85.4	81.2	81.2	83.5	◆◆◆
Rating of Specialist Seen Most often (8+9+10)	81.3	79.0	76.0	66.3	80.6	75.6	◆
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	80.4	75.0	80.2	49.5	62.1	71.3	◆
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	49.6	48.1	55.7	31.8	37.5	46.3	◆
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	53.7	46.8	47.9	26.1	37.0	43.6	◆◆
Aspirin Use and Discussion - Take daily aspirin/ every other day	28.3	0.0	21.1	16.8	15.0	16.6	^
Aspirin Use and Discussion - Discussed risks and benefits of using aspirin	45.0	0.0	37.7	34.6	27.9	29.3	^
Flu measure - Had flu shot or spray in the nose since July 1, 2014	35.9	38.5	34.3	35.7	38.3	36.1	◆
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available							

Child CAHPS Measures

Child CAHPS Measures	ACDC %	HSCSN %	MFC %	THP %	District Average 2015 %	District Average 2016 %	Diamond Rating
Child Survey - General Population: Customer Service Composite	84.8	92.4	85.9	83.1	84.6	86.6	♦
Child Survey - General Population: Getting Needed Care Composite	80.4	81.6	70.9	74.2	79.3	76.8	♦
Child Survey - General Population: Getting Care Quickly Composite	85.1	88.1	86.0	76.7	77.1	84.0	♦
Child Survey - General Population: How Well Doctors Communicate Composite	92.8	93.0	91.7	91.1	91.4	92.2	♦
Child Survey - General Population: Shared Decision Making	76.4	86.8	73.9	70.4	80.6	76.9	♦
Health Promotion and Education Composite	78.8	80.4	74.1	74.7	76.1	77.0	♦♦♦
Coordination of Care Composite	78.7	92.2	73.3	71.8	85.2	79.0	♦
Child Survey - General Population: Rating of Health Plan (8+9+10)	85.5	84.2	83.7	77.6	83.6	82.8	♦
Child Survey - General Population: Rating of All Health Care (8+9+10)	85.2	87.4	83.0	86.3	85.5	85.5	♦
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	91.3	90.8	89.2	90.0	89.9	90.3	♦♦
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	86.7	85.6	85.4	82.1	81.5	85.0	♦
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available							

Child CAHPS Measures – Supplemental Dental Questions

Child CAHPS Measures Supplemental Dental Questions	ACDC %	HSCSN %	MFC %	THP %	District Average 2015 %	District Average 2016 %	Diamond Rating
Dental: Child has a regular dentist	86.1	96.4	83.7	62.0	87.1	82.1	^
Dental: Child has seen regular dentist for a check-up or routine care in the last 6 months	87.5	89.8	85.9	81.3	83.4	86.1	^
Dental: How often child received dental appointments with regular dentist as soon as you wanted	73.6	89.4	86.7	73.8	85.6	80.9	^
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	34.2	55.6	29.8	21.5	45.6	35.3	^
Benchmark source: NCQA Quality Compass National Medicaid HMO ^ Benchmark not available							

Appendix 3

FY 2016 EPSDT Performance Measure Validation

Background and Purpose

Under the Salazar Consent Decree, the District's Medicaid managed care organizations (MCOs) are required to report utilization of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit to the Department of Health Care Finance (DHCF). DHCF reports data District-wide to the Centers for Medicare and Medicaid Services (CMS). The data is reported on the Form CMS-416. The EPSDT benefit is the pediatric component of the Medicaid program and focuses on the prevention, diagnosis and treatment of health problems of children at an early stage to promote optimal growth and development for Medicaid-enrolled children. The hallmark of the EPSDT benefit is comprehensive screenings, which are intended to identify and treat potential physical, mental, or developmental problems before they become more complex and costly. The screenings occur at regular intervals, or whenever issues arise, and include laboratory tests (including lead toxicity screening), physical examination (including hearing and vision screenings), oral health services, health education, etc.²³ In all states, children under the age of 21 who are enrolled in Medicaid are entitled to the EPSDT benefit.

To ensure that MCO reported performance measure rates are accurate and reliable, DHCF contracts with Delmarva Foundation to review the performance measures. Performance measure validation (PMV) is an External Quality Review (EQR) activity per the Code of Federal Regulations (42 CFR §438.358) and is conducted in a manner consistent with that described in the CMS EQR Protocol, *Validation of Performance Measures Reported by the MCO, Protocol 2, Version 2.0*.

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

This report includes EPSDT/Form CMS-416 PMV-related findings for the District's four MCOs:

- AmeriHealth Caritas District of Columbia (ACDC)
- Health Services for Children with Special Needs (HSCSN)

²³<http://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/early-periodic-screening-diagnosis-and-treatment>

- MedStar Family Choice (MFC)
- Trusted Health Plan (THP)

Assessments are for the reporting period of October 1, 2015 through September 30, 2016 for Fiscal Year 2016 (FY 2016).

Methodology

Delmarva Foundation's PMV audit team utilizes methods consistent with the EQR Protocol, *Validation of Performance Measures Reported by the MCO, Protocol 2, Version 2.0*, to assess each MCO's performance measure data collection and reporting processes. The validation process is interactive and concurrent to the MCO calculating the EPSDT performance measures. The validation activities occur before, during, and after a site visit to the MCO and include two principle components:

- An overall assessment of the MCO's information systems capability to capture and process data required for reporting; and
- An evaluation of the processes (e.g. source code programs) that the MCO used to prepare each measure.

Essential PMV activities include:

- Review of the MCO's data systems and processes used to construct the measures;
- Assessment of the calculated rates for algorithmic compliance to required specifications; and
- Verification that the reported rates are reliable and based on accurate sources of information.

Information from several sources is used to satisfy the validation requirements. These sources include, but are not limited to, the following documents provided by the MCO:

- Information Systems Capabilities Assessment (ISCA);
- EPSDT Policies;
- EPSDT Training Material;
- EPSDT Source Code;
- HEDIS^{®24} Final Audit Report, if available;
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies and procedures) for review prior to or during the site visit;
- Observations made during the site visit;
- Interviews with MCO staff; and
- Information submitted as part of the follow-up items requested after the site visit.

²⁴ HEDIS[®] – Health Care Effectiveness Data and Information Set. HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Throughout the review process, the audit team works closely with the MCO quality staff to obtain appropriate documentation, prepare for the site visit, and follow-up on issues not resolved during the site visit.

The EPSDT performance measures under review are based on administrative data (claims, HEDIS® supplemental files, and DHCF bump reports including lead and EPSDT visit reports) and supplemental medical record collection and are specifically for the children enrolled in a Medicaid managed care plan for at least 90 continuous days in the reporting period. The performance measures reflect the number of children who are provided preventive health services and other EPSDT screenings according to the DC Medicaid HealthCheck Periodicity Schedule.

Results: Information Systems Capabilities Assessment

Each MCO is required to demonstrate it has the automated systems, information management practices, and data control procedures necessary to ensure that all required information for performance measure reporting is captured, translated, stored, analyzed, and reported.

Data Integration and Control Findings

The MCO's processes for data integration and control are reviewed for the following standards:

- Accuracy of data transfers to assigned performance measure repository.
- Accuracy of file consolidations, extracts, and derivations.
- Accuracy of performance measure repository structure and format.
- Assurance of effective management of report production and of the reporting software.

All four MCOs met requirements for Integration and Control of Data.

Data and Processes Used to Produce Performance Measure Findings

The auditor assesses the MCO documentation of data and processes used to calculate and report the measures. The documentation reveals how the MCO interprets the measure specifications and how well the MCO applies them to constructing each measure.

All four MCOs met requirements for Data and Processes Used to Produce Performance Measures.

Measure Validation Findings

The auditor assesses the MCO to determine if all the relevant populations are identified according to measure specifications, if the MCO uses appropriate and complete data to identify the entire population, and assure that no area is undercounted.

All four MCOs met requirements for Measure Validation Findings.

Validation Findings

EPSDT/Form CMS-416 Validation Results and Reporting Designations

Table 1 provides the EPSDT/Form CMS-416 performance measures,²⁵ assessments, and reporting designations.

Table 1. FY 2016 ACDC Validation Results for EPSDT/Form CMS-416 Performance Measures

Performance Measures	MCO Reporting Designation			
	ACDC	HSCSN	MFC	THP
Total Individuals Eligible for EPSDT for 90 Continuous Days	Report	Report	Report	Report
Average Period of Eligibility	Report	Report	Report	Report
Expected Number of Screenings	Report	Report	Report	Report
Total Screens Received	Report	Report	Report	Report
Screening Ratio	Report	Report	Report	Report
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	Report	Report	Report	Report
Total Eligibles Receiving at Least One Initial or Periodic Screen	Report	Report	Report	Report
Participant Ratio	Report	Report	Report	Report
Total Eligibles Referred for Corrective Treatment	Report	Report	Report	Report

²⁵ Form CMS-416: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

Performance Measures	MCO Reporting Designation			
	ACDC	HSCSN	MFC	THP
Total Eligibles Receiving Any Dental Service From a Dentist	Report	Report	Report	Report
Total Eligibles Receiving Preventive Dental Service From a Dentist	Report	Report	Report	Report
Total Eligibles Who Received Dental Treatment Services From a Dentist	Report	Report	Report	Report
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	Report	Report	Report	Report
Total Eligibles Receiving Diagnostic Dental Services	Report	Report	Report	Report
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	Report	Report	Report	Report
Total Eligibles Receiving Any Dental or Oral Health Service	Report	Report	Report	Report
Total Number of Screening Blood Lead Tests	Report	Report	Report	Report

The PMV audit team determined that all MCOs were found to be compliant and received a finding of “met” for each performance measure’s documentation, denominator, and numerator. Based on these findings, all performance measures were assessed as being reportable.

Initial or Periodic Screen Medical Record Over-Read Analysis

For each MCO, Delmarva Foundation nurses conducted a medical record audit, or over-read, of 30 (numerator positive) randomly selected medical records to confirm evidence of preventative health visits (Initial or Periodic Screen) occurring October 1, 2015 through September 30, 2016. The over-read was performed in accordance with the DC Health Check Periodicity Schedule.²⁶ A medical record was considered compliant if *all* five of the following elements and associated components were verified within the record:

- Health history
- Physical exam

²⁶ https://www.dchealthcheck.net/documents/DC_Medicaid_HealthCheck_Periodicity.pdf

- Developmental history
- Mental health/developmental history
- Health education/anticipatory guidance

Table 2 identifies the medical record audit/over-read elements and corresponding components, if applicable. The physical and mental health development elements include age-specific corresponding components. It is important to note that the age of the child, based on the date of service, dictates screening requirements.

Table 2. Initial or Periodic Screen/DC Health Check Periodicity Schedule

Initial or Periodic Screen/DC Health Check Periodicity Schedule		
Element	Component	Age
Health History	N/A	Newborn – 21 Years
Physical Exam	N/A	Newborn – 21 Years
Physical Development/ Measurements	Length/Height and Weight	Newborn – 21 Years
	Head Circumference	Newborn – 24 Months
	Weight for Length	Newborn – 18 Months
	Body Mass Index	24 Months – 21 Years
	Blood Pressure	3 Years – 21 Years
Health Education/Anticipatory Guidance	N/A	Newborn – 21 Years
Mental Health Development/Behavioral Health Screening	Developmental Surveillance	Newborn – 6 Months, 12-15 Months, 24 Months, 3-21 Years
	Developmental Screening	9 Months, 18 Months, 30 Months
	Autism Screening	18 Months, 24 Months
	Psychosocial/ Behavioral Surveillance	Newborn – 21 Years
	Psychosocial/ Behavioral Screening	Newborn – 21 Years
	Alcohol and Drug Use Assessment	Subject to Conditions

In order to have confidence in the MCO reported results, the Delmarva Foundation nurse reviewers must agree with the MCO's numerator positive assessment and achieve a 90% agreement rate. There must be agreement in at least 27 of the 30 records. When the nurse reviewers do not agree with the MCO findings, the record fails. A record may fail for one or more missing elements. Table 3 displays Delmarva Foundation's medical record over-read agreement rate for the Initial or Periodic Screen measure for each MCO. Delmarva Foundation's nurse reviewers scored a 98% inter-rater reliability assessment prior to conducting MCO medical record over-reads.

Table 3. Initial or Periodic Screen Medical Record Over-Read Agreement

Initial or Periodic Screen Medical Record Over-Read Agreement				
MCO	Record Sample Size	Compliant Records	Agreement Percent	MCO Average Agreement Percent
ACDC	30	28	93%	95%
HSCSN	30	29	97%	
MFC	30	28	93%	
THP	30	29	97%	

Delmarva Foundation nurse reviewers completed medical record over-read assessments of 30 numerator positive records for each MCO. An agreement rate was achieved for each MCO that exceeded the 90% threshold. There was a 97% agreement rate for both HSCSN and THP. For ACDC and MFC, there was a 93% agreement rate. The MCO average agreement rate was 95%. Because all MCOs passed, DHCF can have confidence in their reported numerator positives for the Initial or Periodic Screen measure.

EPSDT/CMS 416 Results

Table 4 includes the EPSDT/Form CMS-416 results for FY 2016 for all four MCOs.

Table 4. FY 2016 EPSDT/Form CMS-416 Performance Measure Results

Performance Measures	ACDC	HSCSN	MFC	THP
Total Individuals Eligible for EPSDT for 90 Continuous Days	51,257	4,762	18,410	11,441
Average Period of Eligibility	0.88	0.94	0.80	0.78
Expected Number of Screenings	58,334	5116	22,497	12,552
Total Screens Received	47,577	5,748	19,601	13,343
Screening Ratio	0.82	1.00	0.87	1.00
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	46,421	4519	15,761	9,660
Total Eligibles Receiving at Least One Initial or Periodic Screen	34,804	3,624	11,999	7,861
Participant Ratio	0.75	0.80	0.76	0.81
Total Eligibles Referred for Corrective Treatment	15,195	3,467	3,120	1,458
Total Eligibles Receiving Any Dental Service From a Dentist	32,374	3,205	9,208	5,753

Performance Measures	ACDC	HSCSN	MFC	THP
Total Eligibles Receiving Preventive Dental Service From a Dentist	30,301	3,033	8,246	5,294
Total Eligibles Who Received Dental Treatment Services From a Dentist	12,099	1,218	2,972	1,865
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	6,704	330	1,562	865
Total Eligibles Receiving Diagnostic Dental Services	31,440	3,165	8,959	5,605
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	1,406	16	345	428
Total Eligibles Receiving Any Dental or Oral Health Service	32,815	3,231	9,248	5,753
Total Number of Screening Blood Lead Tests	2,444	300	3,218	1,240

Table 5 provides an MCO comparative analysis for three key ratios: screening, participant, and preventive dental services.

Table 5. FY 2016 MCO EPSDT/Form CMS-416 Performance Measure Ratios

Performance Measures	ACDC	HSCSN	MFC	THP
Screening Ratio	0.82	1.00	0.87	1.00
Participant Ratio	0.75	0.80	0.76	0.81
Preventive Dental Services Ratio	0.65	0.67	0.52	0.55

- The Screening Ratio is calculated using the Total screenings received compared to Expected Number of Screenings. MCO ratios ranged from a low of 0.82 (ACDC) to a high of 1.00 (HSCSN and THP).
- The Participant Ratio is measured as Total Eligibles Receiving at Least One Initial or Periodic Screen compared to Total Eligibles Who Should Receive at Least One Initial or Periodic Screen. ACDC had the lowest performance (0.75) while THP had the highest (0.81).
- The Preventive Dental Services Ratio is calculated using the Total Eligibles Receiving Preventive Dental Service From a Dentist and Total Eligibles Who Should Receive at Least One Initial or Periodic Screen measures. MFC scored the lowest at 0.52 compared to HSCSN's highest at 0.67.

Table 6 includes the FY 2016 EPSDT/Form CMS-416 DC MCO averages compared to the FY 2015 DC MCO averages.

Table 6. FY 2016 and FY 2015 DC MCO Average EPSDT/Form CMS-416 Performance Measure Results

Performance Measures	FY 2016 DC MCO Average	FY 2015 DC MCO Average
Screening Ratio	0.88	0.84
Participant Ratio	0.76	0.72
Preventive Dental Services Ratio	0.61	0.60

The FY 2016 DC MCO average ratios compare favorably to the FY 2015 average ratios. The Screening and Participant Ratios increased by 0.04 each while there was marginal improvement in the Preventive Dental Services Ratio (0.01).

Conclusion

At the direction of DHCF, Delmarva Foundation conducted a performance measure validation audit of each DC MCO's EPSDT/Form CMS-416 performance measures for FY 2016. Each MCO's information systems capabilities assessment was evaluated including the MCO's data integration and control and data and processes used to produce performance measures. All elements were found to be satisfactory and met requirements. Based upon documentation, numerators, and denominators, all performance measures received a "Report" designation. Delmarva Foundation nurse reviewers conducted a medical record over-read for the Initial or Periodic Screen measure. Study results indicated that each MCO passed the 90% threshold agreement rate and provided an average agreement rate of 95%; therefore, DHCF can have confidence in the reported results. The FY 2016 DC MCO average ratios compare favorably to the FY 2015 average ratios.

MCO Strengths

All MCOs exhibited the following strengths:

- The MCOs successfully used CPT and ICD 10 codes for reporting EPSDT measures.
- The MCOs effectively collaborates with DHCF to capture all data possible for EPSDT including lead and EPSDT visit reports.
- The MCOs passed the medical record over-read with an agreement rate of over 90% for the Initial or Periodic Screen performance measure.

ACDC exhibited strengths in the following areas:

- ACDC has a dedicated EPSDT analyst that works with the EPSDT manager to collect and review EPSDT data.
- ACDC's workflows for obtaining EPSDT data from all sources are easy to follow and well-designed.
- ACDC provided an overview for processes in place for collecting data from medical record reviews, third party liability (TPL) calls, the DC Scores partnership program with DC Public Schools, and newborn identification.
- The MCO has a standard medical record collection worksheet by age to collect EPSDT elements.

HSCSN exhibited strengths in the following areas:

- EPSDT source code is programmed in-house which allows HSCSN more flexibility to revise code as needed and to report EPSDT rates in a timely manner.
- HSCSN's FY 2016 EPSDT performance compared favorably to the FY 2016 DC MCO averages, as well as the FY 2015 DC MCO averages.

MFC exhibited strengths in the following areas:

- MFC uses medical record data collected from HEDIS® well-child measures to supplement EPSDT measures.
- MFC's FY 2016 Participant Ratio exceeded the FY 2015 DC MCO average and was equal to the FY 2016 DC MCO average.

THP exhibited strengths in the following areas:

- THP records measure information and scans part of the medical record into their CareConnect system.
- THP has robust quality checks in place for claims.
- THP has implemented a new provider portal to enhance information exchange with their network providers.
- THP compared favorably to all DC MCO average for FYs 2015 and 2016 for the Screening and Participant Ratios.

MCO Recommendations

ACDC is encouraged to consider the following recommendations:

- Provide evidence of service when collecting medical records for the DHCF supplemental list. The MCO is expected to maintain evidence of services, screenings, or assessments completed in the medical record. The MCO is required to retain proof of service documentation for future EPSDT PMV medical record over-read activities.
- Collect medical records on a monthly or quarterly basis. The increase in frequency will assist in improving data completeness and quarterly EPSDT results.

- Include HEDIS® medical record data and supplemental data in EPSDT reporting when appropriate.
- Continue efforts with DHCF to incorporate all appropriate data sources for reporting.
- Review failed elements/components of the medical record over-read analysis to determine if there are opportunities for improvement.
- Review the Screening Ratio results and examine opportunities for improvement. ACDC's Screening Ratio was notably lower than the DC MCO average.

HSCSN is encouraged to consider the following recommendations:

- Collect medical records on a monthly or quarterly basis. The increase in frequency will assist in improving data completeness and quarterly EPSDT results.
- Consider implementing wellness days at high-volume providers to increase screenings for noncompliant members.
- Include HEDIS® medical record data in EPSDT reporting when appropriate.
- Continue efforts with DCHF to incorporate all appropriate data sources for reporting.
- Continue efforts to exceed the DC MCO averages.

MFC is encouraged to consider the following recommendations:

- Continue to collect medical records throughout the year as the frequent collection and review assists in improving data completeness and quarterly EPSDT results.
- Consider implementing wellness days with high-volume providers for non-compliant members.
- Continue efforts with DHCF to incorporate all appropriate data sources for reporting.
- Review failed elements/components of the medical record over-read analysis to determine if there are opportunities for improvement.
- Consider implementing interventions to improve dental visits. The Preventive Dental Services Ratio illustrates opportunity for improvement as results compare unfavorably to the DC MCO averages.

THP is encouraged to consider the following recommendations:

- Collect medical records on a monthly or quarterly basis. The increase in frequency will assist in improving data completeness and quarterly EPSDT results.
- Continue efforts with DHCF to incorporate all appropriate data sources for reporting.
- Consider implementing interventions to improve the Preventive Dental Services Ratio.
- Strengthen the MCO's internal EPSDT policy to require sign-offs for reported rates.

DHCF Recommendations

DHCF is encouraged to consider the following recommendations:

- Continue to encourage efforts to improve performance in EPSDT and well-child/preventive care measures.
- Continue to share data with MCOs including lead and well-child visit (WCV) claim reports.

- Develop a standardized data collection worksheet, with formulas, for the collection of EPSDT measures and calculation of rates.
- Consider an encounter data validation (EDV) study to provide insight into data completeness and accuracy used by the MCOs to report EPSDT rates.