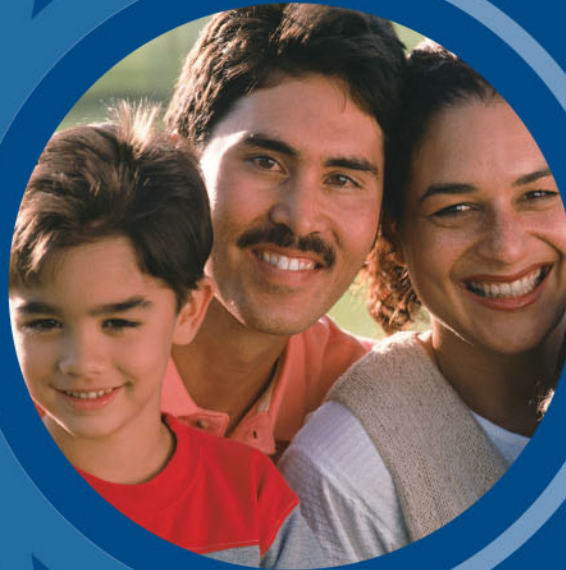


District of Columbia  
Department of Health Care Finance



## Medicaid Managed Care

## 2013 Annual Technical Report



Delmarva Foundation

*A subsidiary of Quality Health Strategies*

Submitted by:  
Delmarva Foundation  
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# CY 2013 District of Columbia Annual Technical Report

## Executive Summary

### Introduction

The District of Columbia (the District) Department of Health Care Finance (DHCF) is the single state agency responsible for managing the District's Medicaid program which provides healthcare coverage to low-income children, adults, elderly, and persons with disabilities. As of December 2013, nearly 160,000 Medicaid enrollees were receiving healthcare services through one of three (3) managed care organizations (MCOs) or one (1) pre-paid inpatient health plan (PIHP)<sup>1</sup> that contracts with DHCF to manage the healthcare of Medicaid beneficiaries.

In May 2012, DHCF issued a request for proposals for re-procurement of managed care services for the District's Medicaid members. As a result of the procurement activities, effective July 1, 2013, three (3) MCOs were selected to provide managed care services to the District's Medicaid residents. The lone PIHP's contract was extended. The PIHP has been providing services to the Supplemental Security Income (SSI) population in the District since 1994. For purposes of this report the MCOs and PIHP are referred to collectively as the MCOs and include:

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

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

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

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<sup>1</sup> The PIHP serves SSI eligible Medicaid members age 0-26 years.

<sup>2</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

## Purpose

To ensure managed care plans provide care and service that meets acceptable standards for quality, access, and timeliness, federal regulations require States contracting with managed care plans to perform an independent annual external review of each health plan for quality, timeliness, and access. In fulfillment of this requirement, DHCF contracts with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This document is Delmarva's report to DHCF on the quality and timeliness of, and access to healthcare services that managed care plans provided to DC Medicaid enrollees during the period from July 1, 2013 through December 31, 2013.

## Methodology

Federal regulations require that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the Centers for Medicare and Medicaid Services (CMS) for conducting the activities.<sup>4</sup> These protocols specify that the EQRO must conduct the following activities to assess managed care performance:

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

Information from the mandatory activities must be used by the EQRO to develop an Annual Technical Report (ATR) that addresses the quality of, access to, and timeliness of services provided to Medicaid managed care enrollees. During the period under review, the District's MCOs did not have data available to accurately and reliably calculate performance measures due to the limitations presented by continuous enrollment requirements for measure indicators. Therefore, this evaluation of quality, access, and timeliness of services for the period July through December 2013 is based on the limited data available from the MCOs' Operational Systems Reviews (OSRs) to assess contractual and federal regulatory compliance and the MCOs' initial PIP submissions.

For 2013, Delmarva conducted a desktop review of MCOs' policies, procedures, committee minutes, work plans, reports, and other written documentation submitted by the MCOs to demonstrate regulatory compliance in the areas of member rights, grievance systems, and quality assessment and performance

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<sup>4</sup> The protocols can be downloaded at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

improvement. In addition, Delmarva validated the MCOs' initial PIP submissions to ensure that PIPs are developed in a methodologically sound manner. Measurement data is not yet available to determine baseline status or effectiveness of PIPs.

In aggregating and analyzing the data, Delmarva allocates findings from key operational systems to domains indicative of quality, access, or timeliness to care and services. The PIP validation activities are allocated to the quality domain.

## Findings

### Quality

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

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

The MCOs have developed QAPI work plans that describe a range of quality improvement (QI) and monitoring activities, timeframes for completion of activities, and identify roles and responsibilities. However, all plans must set specific goals for measures such as HEDIS and CAHPS once baseline data is available.

## Access

Access, 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 healthcare, and member services.” In assessing MCO performance for the access domain, Delmarva considered key areas of MCO operations likely to have the largest impact on access to services for individuals. Therefore, the access domain focuses on member communications and access and availability of providers.

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

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

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

## Timeliness

Timeliness, as defined by NCQA, is whether “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.” The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of healthcare (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*). In assessing MCO performance for the timeliness domain, Delmarva considered key areas of MCO operations where timeliness is likely to have the largest

impact on access to services and health outcomes for individuals. Therefore, the timeliness domain focuses on timeliness of MCO decision making and notification to members.

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

## Status of Prior Year Recommendations

### Recommendations for MCOs

Although each health plan is committed to delivering high quality care and services to its managed care members, opportunities exist for continued performance improvement. The following recommendations from the CY 2012 ATR are applicable only to HSCSN, the only MCO from CY 2012 still participating in the managed care program:

- Renew efforts to obtain stakeholder involvement in the collaborative PIPs. HSCSN increased participation from internal MCO stakeholders such as Medical Director and analytic staff and have engaged in communication with several local asthma programs such as Impact DC and Breathe DC.
- Identify and leverage current quality improvement efforts underway in the District that support the collaborative aims. HSCSN is working with several stakeholders in the District with a focus on improving outcomes for children with asthma, among these, Impact DC, Breathe DC, and the District Department of Environment. For perinatal collaborative efforts, HSCSN works with the National Strong Start, Text 4 Baby, and Healthy Start programs.
- Tie proposed interventions to data points to enable analysis of the effectiveness of the interventions. Implementation of this recommendation cannot be assessed until HSCSN completes development of its PIP submissions for CY 2014.

### Recommendations for DHCF

Understanding that new health plans would begin providing healthcare services to District residents beginning in July 2013, Delmarva offered several recommendations for DHCF to consider in revising its quality strategy:



- Set performance improvement goals for each MCO for key PIP indicators. This will improve MCO accountability and engagement in collaborative efforts. DHCF, in concert with the collaborative work groups, will set MCO specific goals for PIPs in 2015 after collection and analysis of baseline data.
- Require that each collaborative identify at least one intervention that will be conducted jointly by the MCOs. DHCF has implemented this recommendation and, in conjunction with the MCOs, is working to identify joint interventions through the collaborative work groups.
- Consider expanding the perinatal collaborative indicators to include a new measure of deliveries prior to 39 weeks gestation. DHCF is considering adding an indicator for deliveries prior to 37 weeks and is currently evaluating data sources and potential benchmarks for goal setting.
- Set minimum performance goals for health plans on select HEDIS and CAHPS measures. These should include an array of measures pertinent to the District's enrolled managed care population. In particular, we would recommend that measure goals be set for diabetes and prenatal care. DHCF is evaluating the potential for setting specific goals for a select set of measures, possibly for CY 2015 data. The MCOs do not currently have baseline data available for evaluation in setting reasonable goals.

## Opportunities for Improvement

### Recommendations for MCOs

#### *AmeriHealth District of Columbia*

- AHDC should revise its QAPI program description to include DHCF reporting requirements.
- AHDC must establish goals for performance measures noted in its work plan once baseline data is available.
- AHDC must revise its policy on member rights to include notification to the member at least 30 days prior to the effective date of any change to policies related to member rights.

#### *Health Services for Children with Special Needs*

- HSCSN must continue to monitor timeliness of authorization decisions.

#### *MedStar Family Choice*

- When data becomes available, MSFC must assess current performance and set specific goals for performance as a component of the annual work plan.
- In areas related to communication of benefit changes to members, MSFC must revise policies to clearly address notification requirements at least 30 days prior to the effective date of a policy change.



*Trusted Health Plan*

- THP must revise its work plan when data become available to include specific goals for performance measures.
- THP must strengthen its policies and procedures regarding member rights and responsibilities to ensure appropriate notification to members of changes to policies at least 30 days prior to the effective date of a change.
- THP must review and revise policies and procedures regarding timeframes for notice of action to members at least 10 days prior to the effective date of a denial.
- THP must examine contract language and revise policies and procedures to meet contractual requirements regarding resolution of appeals and permissible timeframes for extensions.

**Recommendations for DHCF**

- Although DHCF has processes in place to monitor the quality of services provided to District residents, DHCF must update its managed care quality strategy to reflect current and planned initiatives to assure that District residents receive high quality care that is accessible and timely. The managed care quality strategy must include performance indicators and measureable goals.

## CY 2013 District of Columbia Annual Technical Report

### Introduction

The District of Columbia (the District) Department of Healthcare 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 2013, nearly 160,000 Medicaid enrollees were receiving healthcare services through one of three (3) managed care organizations (MCOs) or one (1) pre-paid inpatient health plan (PIHP) that contracts with DHCF to manage the healthcare of Medicaid beneficiaries.

In May 2012, DHCF issued a request for proposals for re-procurement of managed care services for the District's Medicaid members. As a result of the procurement activities, effective July 1, 2013, three (3) MCOs were selected to provide managed care services to the District's Medicaid residents. The lone PIHP's contract was extended. The PIHP has been providing services to the SSI population in the District since 1994. For purposes of this report the MCOs and PIHP are referred to collectively as the MCOs. Table 1 provides brief profiles of the health plans.

**Table 1. Health Plan Profiles**

Health Plan	Medicaid Enrollment (as of Nov. 2013)	Accreditation Status
AmeriHealth District of Columbia (AHDC)	95,134	Pending – NCQA accreditation survey scheduled for May 2014
Health Services for Children with Special Needs (HSCSN)	5,689	NCQA Organization Certification for Utilization Management and Credentialing obtained March 2013
MedStar Family Choice (MSFC)	34,811	NCQA Interim Health Plan Accreditation obtained January 2014
Trusted Health Plan (THP)	24,271	Pending – NCQA accreditation survey requested for July 2014

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

DHCF's Strategic Plan for fiscal years 2012-2014 described its goals in support of its mission "to improve health outcomes for residents of the District of Columbia by providing access to a comprehensive and cost-effective array of quality health care services."<sup>5</sup> To ensure this, DHCF mandates that MCOs:

- Achieve 100% compliance with federal and contractual operational requirements;
- Conduct ongoing quality improvement initiatives and submit performance results;
- Calculate and submit valid and reliable Healthcare Effectiveness Data and Information Systems (HEDIS®)<sup>6</sup> and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>7</sup> data; and
- Attain National Committee for Quality Assurance (NCQA) accreditation.

## Purpose

To ensure managed care plans provide care and service that meets acceptable standards for quality, access, and timeliness, federal regulations require States contracting with managed care plans to perform an independent annual external review of each health plan for quality, timeliness, and access. In fulfillment of this requirement, DHCF contracts with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). With implementation of new MCO contracts, data does not yet exist to assess MCO performance against the District's strategic plan. However, this report will address: MCO performance on structural and operational standards representative of quality, access and timeliness; MCO ongoing quality improvement initiatives; and the status of NCQA accreditation for the new MCOs.

This document is Delmarva's report to DHCF on the quality and timeliness of, and access to healthcare services that managed care plans provided to DC Medicaid enrollees during the period from July 1, 2013 through December 31, 2013. The performance of MCOs participating in the District from January through June 2013 is discussed in the calendar year (CY) 2012 Annual Technical Report (ATR).

## Methodology

Federal regulations require that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the Centers for Medicare and Medicaid Services (CMS) for

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<sup>5</sup> Department of Health Care Finance FY2012-2014 Strategic Plan Available at:  
<http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStrategicPlanFY12-14.pdf>

<sup>6</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>7</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

conducting the activities.<sup>8</sup> These protocols specify that the EQRO must conduct the following activities to assess managed care performance:

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

CMS requires that information obtained through these activities be aggregated and analyzed to assess MCO performance in the areas of quality, access, and timeliness of services provided to Medicaid enrollees. During the period under review, the District's MCOs did not have data available to accurately and reliably calculate performance measures due to the limitations presented by continuous enrollment requirements for measure indicators. Therefore, this evaluation of quality, access, and timeliness of services for the period July through December 2013 is based on the limited data available from the MCOs' Operational Systems Reviews (OSRs) and the MCOs' initial PIP submissions.

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

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is “the degree to which a Managed Care Organization (MCO)... increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge” (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is “the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services” (*NCQA 2013 Health Plan Standards and Guidelines*).

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<sup>8</sup> The protocols can be downloaded at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care” (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*).

## Operational Systems

The 2013 OSR was conducted as a desktop review of MCO policies, procedures, committee minutes, work plans, reports, and other written documentation submitted by the MCO to demonstrate contractual and federal regulatory compliance. The review is performed by a team of healthcare professionals with experience in managed care and quality improvement systems. Findings for this review are based solely on the review of documentation submitted by the MCO. It does not include interviews with beneficiaries, providers, or families of beneficiaries, nor does it include reviews of case files, visits to service provision locations, or on-site observation of actual service provision.

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

- **Enrollee Rights and Protections (ER)** - 42 CFR § 438 Subpart C, Enrollee Rights and Protections, details requirements to ensure that managed care enrollees have the right to receive information about available healthcare services, how to access services, policies and procedures relative to obtaining services, and the right to make healthcare decisions.
- **Grievance Systems (GS)** - 42 CFR § 438 Subpart F, Grievance Systems, mandates that each MCO has in effect a grievance system that meets specific requirements to ensure notification of enrollees in a timely manner for all types of grievances and appeals. Access to a grievance system affords enrollees with the right to express dissatisfaction with care or services provided by the MCO or its providers and the ability for MCOs to potentially identify issues that need to be addressed (e.g. requesting payment from enrollees, inappropriate denial of payment or services).
- **Quality Assessment and Performance Improvement (QA)** - 42 CFR § 438 Subpart D, Quality Assessment and Performance Improvement, sets forth MCO specifications for quality strategies to ensure the delivery of high quality healthcare and customer service. MCOs must measure performance (e.g. immunization rates, preventive screening rate) and use their data to improve the quality of services provided to enrollees through quality of care studies and other activities. Standards for quality, access,

and timeliness of care are defined and MCOs must monitor these to ensure enrollees receive the benefits and services to which they are entitled.

In October 2013, Delmarva conducted an on-site orientation for each MCO, providing a description of the standards, elements, and components of each standard for review and a list of potential supporting documents. The MCO submitted written policies and procedures to show evidence of compliance with the Federal regulations and the District's contractual requirements. A review of these documents took place in December 2013.

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

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

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

The content of all action plans is evaluated and a determination is made as to its adequacy in collaboration with DHCF. An action plan is determined to be adequate only if it addresses all required elements and components (timelines, action steps, etc.). Delmarva reviews any additional materials submitted by the MCO and monitors implementation of the action plan. MCOs are required to submit action plans based on identified opportunities for improvement as a result of the CY 2013 OSR by March, 31, 2014. The MCOs' progress in implementing these action plans will be discussed in the CY 2014 Annual Technical Report.

The 2013 OSRs were conducted as a preliminary review of MCO structure and operations to identify and provide feedback to the MCOs on opportunities for improvement. A comprehensive on-site review of all MCOs will take place in CY 2014, at which time it is an expectation that any deficiencies noted at the time of

the preliminary review will have been corrected and MCOs will be fully compliant with all contractual and federal requirements.

## Validation of Performance Improvement Projects

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

Each MCO is required to provide the study framework and project description for each PIP at the onset of the projects. This information is reviewed to ensure that each MCO is using relevant and valid study techniques. Initial PIP submissions are assessed on study topics, questions, and indicators.

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

The submissions include results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the MCO's data analysis plan as described in its 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.

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

**Table 2. 10-Step PIP Review Process**

Step	Description
1	Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.
2	Review the Study Question(s) - The study question should reference the study population, activity, and expected outcome. The study question guides the PIP and must be clear and answerable.
3	Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.
4	Review the Identified Study Population - The study population must reflect all individuals to whom the study questions and indicators are relevant.
5	Review Sampling Methods - The sampling method must be valid and protect against bias.
6	Review Data Collection Procedures - The data collection procedures must use a systematic method of collecting valid and reliable data.



Step	Description
7	Assess Improvement Strategies - The improvement strategies, or interventions, must be reasonable and address barriers on a system-level.
8	Review Data Analysis & Interpretation of Study Results - The study findings, or results, must be accurately and clearly stated.
9	Assess Whether Improvement is Real Improvement - Project results must demonstrate real improvement.
10	Assess Sustained Improvement - Sustained improvement must be demonstrated through repeated measurements.

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

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

Delmarva validated the MCOs' collaborative PIPs, *Improving Perinatal and Birth Outcomes* and *Adverse Outcomes of Chronic Diseases*. As these are new PIPs for the MCOs, only steps 1-3 have been assessed at the time of this report. MCOs are required to submit information for steps 4-6 in July 2014. The MCO reporting requirements and validation steps are limited for 2014 since the projects are new and 2014 is serving as the baseline year. As the PIPs progress, annual assessments will validate steps 7-10. A description of the collaborative PIPs can be found in Appendix 1 and 2.

## Findings

### Quality

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

### ***Quality Assessment and Performance Improvement Programs***

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

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

#### *AmeriHealth District of Columbia*

AHDC has a comprehensive QAPI program that describes its mission, goals, objectives, and scope of the program. The QAPI identifies the structure, roles, responsibilities, and qualifications of the governing body and related QAPI committee members. An annual work plan is also developed to capture specific QAPI priorities for the year and includes purpose/scope, frequency, responsible parties, committee reporting, and outcomes evaluation.

AHDC's QAPI program includes:

- Use of data about quality, clinical care and services, and health outcomes to identify improvement initiatives.
- Procedures to ensure adequate practitioner accessibility and availability to serve the membership.
- Credentialing/re-credentialing processes to assure that the health plan's networks are comprised of qualified practitioners.
- Oversight of services provided by delegated entities.
- Coordination of services between various levels of care, network practitioners, and community resources to assure continuity of care and promote optimal physical, psychosocial and functional wellness, including for those with chronic illness or complex health needs.

- Utilization management procedures to ensure care rendered is based on established clinical criteria and clinical practice guidelines.
- Methods to ensure that assessment and appropriate interventions are taken to identify inappropriate, overutilization or underutilization.
- Use of results of member and practitioner/provider satisfaction measures when identifying and prioritizing quality activities.
- Communication of results of clinical and service measures and quality initiatives to practitioners, providers, and members.
- Documenting and reporting monitoring activities to appropriate committees.
- Facilitating the delivery of culturally competent healthcare to reduce healthcare disparities.

AHDC has developed a comprehensive QAPI work plan. Although the work plan identifies specific performance measures and reporting cycles, it does not include goals for each indicator. It is expected that when data becomes available AHDC will add specific indicator goals and timeframes for achieving these goals to the work plan.

#### *Health Services for Children with Special Needs*

Unlike the new Medicaid MCOs within the District, HSCSN received a partial (focused) review in 2013; HSCSN underwent a comprehensive review in 2012. Coordination of care was the focus of HSCSN's partial review, as case management is an essential component of HSCSN's services given the special needs population it serves. HSCSN demonstrated implementation of a strong QAPI program with on-going monitoring and evaluation of program goals and objectives at the time of the 2012 OSR. A review of HSCSN's 2013 QAPI program was not conducted.

#### *MedStar Family Choice*

MSFC has a comprehensive QAPI program that describes its mission, goals, objectives, and scope of the program. The QAPI identifies the structure, roles, responsibilities, and qualifications of the governing body and related QAPI committee members. An annual work plan describes specific QAPI priorities for the year and includes purpose/scope, frequency, responsible parties, committee reporting, and outcomes evaluation.

The MSFC program specifically describes activities to:

- Ensure and support efforts to remove any barriers to healthcare services and resources, including but not limited to language barriers.
- Create a review process that is consistent throughout the MSFC provider community and to provide a systematic approach for monitoring the quality, safety and appropriateness and effectiveness of patient care and services.

- Ensure the integration of information into the Quality Improvement (QI) Plan.
- Include all participating practitioners in the MSFC network as appropriate in the QI Plan and QI process.
- Provide integration, coordination and continuity of medical and behavioral health.
- Identify meaningful and relevant issues for assessment based on patient populations, demographics, care settings, types of services and case mix.
- Define quality indicators, measurements, and goals.
- Compare the quality of care and service against available benchmarks for standards of practice.
- Monitor the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings rates and ensure the completion of all components of the EPSDT screenings according to DHCF and the Salazar court order.
- Identify significant disparities in health services and health outcomes between racial and ethnic groups and develop a plan of action for measuring and evaluating efforts to remediate them.
- Develop, implement, and monitor corrective action plans (CAPs), where appropriate.
- Implement integrated improvement strategies and ensure follow up as appropriate by using collected data to identify, analyze, and trend problems.
- Comply with specific quality of care, access to care, documentation and performance standards adopted by DHCF and other regulatory agencies for the treatment of enrollees, especially those with special healthcare needs.
- Provide oversight of continuous and ongoing activities of delegated entities.

MSFC's QAPI work plan is developed annually. The 2013 QAPI focuses on cultural needs of members, meeting standards for network access and availability, effectiveness of complex and disease case management, provider and consumer satisfaction, health education and outreach to members, and health outcomes measurement. Goals have been set for most activities with the exception of HEDIS measures. These will be added to the work plan when CY 2014 HEDIS data is available.

#### *Trusted Health Plan*

THP's QAPI program description provides a broad overview of its mission, goals, objectives, and program scope. Committee structure, roles and responsibilities, and governing body accountability are described in the QAPI program document.

THP QAPI activities include:

- Measurement of performance against key monitors for quality such as HEDIS.
- Review of the quality and utilization of services.
- System interventions, including the establishment or alteration of practice guidelines.
- Analyze, identify and address continuity and coordination of care within treatment plans.

- Analyze, identify and address areas of under and over-utilization, if applicable.
- Monitor, identify and investigate potential quality of care/quality of service issues.
- Analyze, identify and address member and practitioner satisfaction information.
- Analyze, identify and address access to and availability of care.
- Solicit member and provider input on performance and QI activities.
- Collect HEDIS data and maintain a minimum acceptable performance level at the 25<sup>th</sup> percentile.
- Quarterly monitoring of access and availability of services through monitoring of practitioner surveys, on-site visits, complaints, and member satisfaction surveys.

THP submitted an annual QAPI work plan for review. The work plan is based on key areas of performance for ongoing monitoring. It is understood that THP does not have baseline data available for many performance indicators. However, the work plan should include specific measures and monitoring activities, goals and objectives for each measure, responsible party/committee, and timeframes for completion of each activity. Once baseline data is available, THP should select specific HEDIS measures for improvement and set specific goals rather than an overall minimum performance goal at the 25<sup>th</sup> percentile.

### **Performance Improvement Projects**

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

In 2009, recognizing the impact of chronic illnesses and poor birth outcomes on both cost and quality of life for District residents, DHCF and the then participating MCOs launched two collaborative quality improvement projects. These multiyear projects are aimed at reducing adverse perinatal and birth outcomes and adverse outcomes of chronic diseases. In 2013 the original participating MCOs exited the District's managed care program and were replaced by three MCOs, new to the District. Therefore, during the first half of CY 2013 the new MCOs, DHCF, and other stakeholders focused on reevaluating and redefining collaborative goals and objectives.

### ***Adverse Perinatal and Birth Outcomes***

Approximately 6,430 babies were born to women enrolled in the District of Columbia's Medicaid managed care program in 2012. Of these, 228 (3.5%) infants were born at less than 32 weeks gestation and 331 (5.1%) weighed less than 2,500 grams at birth. Only 20 percent of HIV infected mothers whose children were perinatally infected had been tested before or during the birth of the child in 2006; by 2012, the District's perinatal collaborative results showed significant improvement in the rate of women being tested for HIV.

Nearly 71% of pregnant women delivering babies in 2012 received at least one test for HIV during the pregnancy. In addition, the majority of the District's Medicaid managed care membership is African American. Nationally, the rate of infant mortality among African Americans is more than twice that of Caucasians. Much of the discrepancy between infant mortality rates among African Americans and Caucasians can be explained by discrepancies in prematurity and low birth weight rates.<sup>9</sup>

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

- Miscarriage or fetal loss.
- Neonates weighing <2500 grams.
- Neonates with a gestational age <32 weeks.
- Pregnancies for which the outcome is unknown.
- Lack of maternal HIV testing.
- Death of an infant age 0-365 days.

The collaborative work group confirmed the study topic, question, and continued evaluation of the previously chosen indicators. MCOs were instructed to develop individual written PIPs with a focus on assessing the current population and rationale for the PIP. MCOs submitted the written PIPs to Delmarva for validation activities. This validation assessed only steps 1-3 of the CMS protocol. Performance on steps 1-3 can be found in Table 3.

**Table 3. Adverse Perinatal and Birth Outcomes PIP Validation Findings**

Adverse Perinatal and Birth Outcomes PIP				
	AHDC	HSCSN	MSFC	THP
Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.	Met	Met	Met	Met
Review the Study Question(s) - The study question should reference the study population, activity, and expected	Met	Met	Met	Met

<sup>9</sup> El-Mohandes, A A E, Katz K S, El-Khorazaty N, et al. The effect of a parenting education program on the use of preventive pediatric health care services among low-income, minority mothers: a randomized, controlled study. *Pediatrics*, 2003;111:1324-1332.

Adverse Perinatal and Birth Outcomes PIP				
	AHDC	HSCSN	MSFC	THP
outcome. The study question guides the PIP and must be clear and answerable.				
Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.	Met	Met	Met	Met

All of the MCOs conducted data analysis of the eligible population to support the rationale for the study topic.

#### *AmeriHealth District of Columbia*

AHDC analyzed and submitted data to support the project rationale. However, the data submitted included members and services provided prior to implementation of AHDC's contract with DHCF. Therefore, the MCO was required to resubmit data specific to the timeframe when AHDC began participation in the District's managed care program to support the project rationale.

Upon resubmission, AHDC reported that women comprise approximately 57% of its membership—of which 40-50% are of child bearing age. More than 48% of the MCO's membership is African American and many enrollees reside in Wards 6 and 7, where there are many social determinants that contribute to a preponderance of health disparities. Access and availability to prenatal care coupled with socioeconomic disadvantages, challenges with health literacy, and under-education increase the risk of poor birth outcomes.

The MCO reviewed its data from the second half of 2013 and determined that approximately 70% of pregnant members received an HIV test. During that same time period, there were 553 deliveries. Twelve of those babies (2.2%) were born less than 32 weeks gestation. Of more concern, there were 56 (10.1%) babies that weighed less than 2,500 grams.

#### *Health Services for Children with Special Needs*

HSCSN's PIP adequately provides an analysis of its current population and rationale for the PIP based on plan demographics. HSCSN's PIP describes its membership as comprised of enrollees who are considered an at risk population due to qualifying criteria for plan participation. More than 64% of the health plan's enrollees have a behavioral health related diagnosis, which may impact the health and functioning of the enrollees. While HSCSN experiences few births (149 during 2013, approximately 2% of the enrollee population), this collaborative is important and relevant. Approximately 30% of the babies born to HSCSN's members were at  $\leq 32$  weeks of gestation and had a low birth weight of  $< 2,500$  grams. HSCSN also indicates



that 95% of its members are African American and, as reported, are disproportionately affected by the incidence of infant mortality, premature births, low birth weight, and insufficient prenatal care. Additionally, the majority of the population served resides in the poorest wards within the District of Columbia.

#### *MedStar Family Choice*

MSFC supported the project rationale with their plan-specific data. Based on a review of the MCO's 2013 reports of pregnancies, deliveries, and high risk newborns for the last two quarters of 2013, MSFC reported the following:

- 59 babies born with a low birth weight (<2,500 grams).
- 6 babies were born with a gestational age of  $\leq 32$  weeks.
- 83 babies were admitted to the neonatal intensive care unit.
- 21 mothers were enrolled in case management with MSFC's high-risk pregnancy case manager.

To assess HIV testing compliance, MSFC conducted a random chart review of 20 mothers who gave birth in the last two quarters of 2013. Results were positive; HIV testing was completed in 100% of the cases reviewed. MSFC reports that going forward in 2014; the MCO will be collecting and reviewing high-risk pregnancy case management files. Data will be analyzed to identify opportunities for improvement in the case management activities of these members.

#### *Trusted Health Plan*

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

Goals for reduction in adverse health outcomes will be set after analysis of the MCOs' baseline data for measurement year (MY) 2014, which will be reported in June 2015. MCOs are required to submit updates to their PIPs in July 2014, at which time analytic plans and proposed interventions will be evaluated.

#### ***Adverse Outcomes of Chronic Diseases***

The District's MCOs recently completed a multi-year chronic condition collaborative that focused on asthma, diabetes, congestive heart failure, and hypertension. Results indicate high emergency department (ED) utilization for members with asthma (42% based on FY 2011 data). This high rate of ED utilization did not have a corresponding high rate of hospitalizations, indicating that there is potential to decrease ED visits by focusing on medication compliance, coordination of care, and better access to primary care physicians for members with asthma. With this information in mind, DHCF's Division of Quality and Health Outcomes proposed that the new collaborative focus on asthma.

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

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

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

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

MCOs were instructed to develop individual written PIPs with a focus on assessing the current population and rationale for the PIP. MCOs submitted the written PIPs to Delmarva for review and evaluation of the validity of the study topic, question, and selected indicators. This validation assessed only steps 1-3 of the CMS protocol. Performance on steps 1-3 can be found in Table 4.

Table 4. Adverse Outcomes of Chronic Diseases PIP Validation Findings

Adverse Outcomes of Chronic Diseases PIP (Asthma)				
	AHDC	HSCSN	MSFC	THP
Assess the Study Topic - The study topic/project rationale must include demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.	Met	Met	Met	Met
Review the Study Question(s) - The study question should reference the study population, activity, and expected outcome. The study question guides the PIP and must be clear and answerable.	Met	Met	Met	Met
Review the Selected Study Indicator(s) - The study indicator(s) must be meaningful, clearly defined, and measurable.	Met	Met	Met	Met

All of the MCOs conducted data analysis of the eligible population to support the rationale for the study topic.

#### *AmeriHealth District of Columbia*

AHDC reported that the District has the highest rate of asthma in the nation according to the American Lung Association. Further, based on a review of the MCO's own population (since inception in May 2013 through the end of the calendar year); approximately 2,500 individuals with asthma were identified (ages 2 to 50). AHDC did not provide statistics specific to the 2-20 years age range. During that same timeframe there were 607 ED visits for asthma and 54 asthma-related inpatient admissions—indicating a 25% ED utilization rate and a 2% inpatient admission rate for members with asthma. AHDC did not analyze data specific to the 2-20 years age range, however, the ED utilization rate presents an opportunity for improvement in asthma management.

#### *Health Services for Children with Special Needs*

HSCSN conducted a population analysis in relation to the incidence of asthma. Of the 5,690 enrollees, 1,303 have an ICD-9 asthma diagnosis; 538 have this diagnosis in the primary position and 535 have it in the secondary position. HSCSN also reported that 95% of its members are African American and noted that according to the Centers for Disease Control and Prevention, black children are 2-3 times more likely to be hospitalized and 5 times more likely to die from asthma. Although access to care may be a contributing factor, environmental exposures for children who live in substandard housing plays an important role.

HSCSN described the housing in the disadvantaged communities—houses are often old and poorly maintained, leading to increased exposures to many asthma triggers and toxins associated with asthma symptoms. HSCSN also noted that 64% of its enrollees reside within the three poorest wards within the District (Wards 6, 7, and 8). In conclusion, HSCSN stated that its membership is disproportionately affected by numerous social determinants such as poverty, substandard housing, poor education, single parent households, etc. This is in addition to the members existing complex conditions. All of these factors, HSCSN reported, adversely impact emergency room and inpatient utilization related to asthma.

#### *MedStar Family Choice*

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

#### *Trusted Health Plan*

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

Goals for reduction in adverse health outcomes will be set after analysis of the MCOs' baseline data for measurement year (MY) 2014, which will be reported in June 2015. MCOs are required to submit updates to their PIPs in July 2014, at which time analytic plans and proposed interventions will be evaluated.

## **Access**

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

### ***Member Communications***

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

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

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

### ***AmeriHealth District of Columbia***

AHDC publishes member handbooks and provider directories which are sent to members upon enrollment and annually. The handbook is easy to read and meets the District's reading level requirements. In fact AHDC policies state that all written brochures and materials provided to members are written at the fourth (4<sup>th</sup>) grade reading level. AHDC policies also state that AHDC will provide printed copies of all vital documents and written materials in all prevalent non-English languages. The availability of language interpretation and TTD/TTY services, and how to access these services, is also described in the handbook.

The member handbook includes a listing of covered and non-covered services, authorization requirements, and how to file a complaint, grievance, or appeal. Policies regarding access to specialists, women's health

providers, family planning services, and second opinions are also described. The handbook informs members that they may use any hospital or other setting for emergency care and defines routine, urgent and emergency care, along with explanations regarding the extent to which after-hours and emergency care are provided.

#### *Health Services for Children with Special Needs*

A review of member materials and communication was not conducted for HSCSN for CY 2013. However, in CY 2012, HSCSN met all requirements for member materials and communication.

#### *MedStar Family Choice*

MSFC policies regarding member materials requires that all written brochures and materials provided to members are written at the fifth grade reading level as determined by one of the readability indices identified as being accepted by DHCF such as the Flesch-Kincaid or Frey Readability Index. In addition, all materials are developed by the MSFC corporate marketing department to ensure that materials are culturally sensitive. The handbook informs members of the availability of translation and TTY/TTD services free of charge to the enrollee and availability of member materials in alternative formats and languages.

Procedural steps to obtain specialty services, such as referrals and authorization requirements by the Primary Care Physician (PCP) before a member may see a specialist are included in the handbook as are processes for filing complaints, grievances, or appeals. Information about the member's right to obtain access to a second opinion, direct access to women's health practitioners, and direct access to family planning services are also provided in the member handbook. Routine, urgent, and emergency care are defined and it is stated that in the event of an emergency, the member should call 911 or go to the nearest emergency room.

#### *Trusted Health Plan*

THP provides members with an enrollment packet containing a welcome letter; provider directory; primary care provider information; and member enrollment card within 10 days of enrollment into the health plan. THP's member materials policy states that materials are written at a fifth grade reading level. However, THP's language access and cultural competency policy states materials are written at a fourth grade reading level. Although both of these reading levels fall within the DHCF requirements, THP must reconcile its policies for consistency.

In addition to reading level, THP employs readability strategies that include limiting the number of concepts per page, spacing blocks of text, and by using typefaces of at least 12 point font as well as illustrations and diagrams. Enrollee materials are available in English and Spanish, and made available in other languages. A language card informs members of their right to receive written translated materials in any prevalent language

and oral interpretation services, as well as how to access those services free of charge. The language card accompanies all written notices of denial, termination, reduction of services, denial of payment, or any other action upon which an enrollee may file a grievance, or any other vital document.

The member handbook informs the enrollee about rights and responsibilities, procedures for authorization of services and how to file a complaint, grievance, or appeal. Additional information is provided on covered and non-covered services as well as direct access to women's health practitioners and family planning services.

### **Care Coordination/Case Management**

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

#### *AmeriHealth District of Columbia*

The AHDC care coordination team uses various mechanisms to identify and coordinate care for members with complex health needs. To assess needs, AHDC uses health risk assessment data; claims analysis; provider referral; and member calls or face-to-face contact. Health risk assessments are used to stratify members based on risk – low-risk and high-risk. Those deemed high-risk individuals require an individual care plan and comprehensive assessment. Five (5) distinct mechanisms for identifying members in need of chronic care management are employed, including data mining, new member assessment, provider referrals, member requests, and health plan activity. Care managers use the information collected during the assessment, input from the member/caregiver, and information and priorities identified by the PCP and treatment team to develop a comprehensive care plan. The case manager contacts the member's PCP to seek input in development of the care plan and to review questions and any suggested referrals regarding the plan. The case manager also seeks input and agreement from the member and other healthcare team members in the selection of the problems, issues, and cultural, physical, or psychological barriers or concerns that will be addressed.

#### *Health Services for Children with Special Needs*

As previously noted, coordination of care was the focus of HSCSN's partial review for 2013 as case management is an essential component of HSCSN's services given the special needs of the population it serves. A significant distinction of HSCSN is that every enrollee is assigned to a care manager for their entire



period of enrollment according to age or disease category (medical or behavioral health diagnosis). Care management interventions are extensive and include an initial assessment; development of a treatment plan in collaboration with the member, family, PCP, and treating specialists; identification of educational, outreach, and resources needed by the individual; facilitation of transportation; transition services from early intervention programs and from pediatric to adult services; community referrals for food and housing needs; coordination of mental health services; and coordination of language interpretation/translation services. Care coordination is initiated by HSCSN and further developed by the enrollee's PCP, specialists caring for the enrollee, the enrollee, and the enrollee's caretaker or guardian as appropriate.

#### *MedStar Family Choice*

MSFC performs health risk assessments of members to identify those with special healthcare needs or with severe disabilities, including members with HIV/AIDS or other disabling conditions with a cognitive, biological, or psychological basis. The assessment is comprehensive and identifies the need for medical care or special services at home, place of employment or school; dependency on daily medical care, special diet, medical technology, assistive devices, or personal assistance in order to function; complex conditions requiring coordinated services from multiple treatment providers on a frequent basis; enrollees with high-risk pregnancies including, but not limited to, those with: young maternal age; short inter-conception period; late onset of prenatal care; alcohol and drug abuse; domestic violence in the home; documented barriers to accessing healthcare; or maternal illness that may affect the birth of the fetus; enrollees with complex disease management issues or complex psychosocial needs which could adversely affect their health status; enrollees with or at risk of serious life threatening conditions; enrollees with mental healthcare needs; and enrollees receiving services under the Individuals with Disabilities Education Act (IDEA).

Care management staff work with the member, family, PCP, and other members of the healthcare team to develop a plan of care which addresses healthcare and psychosocial needs identified through the risk assessment. The member's care is coordinated with other treatment services provided by District agencies such as the Department of Mental Health, Addiction Prevention and Recovery Administration, and District of Columbia Public Schools.

#### *Trusted Health Plan*

THP engages new enrollees in a telephonic assessment and/or a face to face visit by an outreach worker within 60 days of enrollment. A basic health status questionnaire, and a required health risk questionnaire, are used to identify any enrollee with special healthcare needs. The assessment includes chronic conditions; height, weight, and nutritional status; current prescription and over-the-counter medications; and most recent visits to their PCP, dentist, hospital and/or ED. Additional information is documented along with any particular concerns or desire to participate in a care coordination or disease management program. The

questionnaire responses are calculated and risk stratified based on proprietary analytics and are used to determine if the member should be referred for disease management (Level 1), care coordination for those with moderate needs (Level 2), or complex case management (Level 3). Once a referral to any of these programs is received, a thorough telephonic assessment by the licensed clinician is conducted within five business days of receipt to assess enrollee needs and obtain permission/consent to participate (from the enrollee or parent/guardian). Additionally, the enrollee's PCP and/or specialty providers if actively managing the case are contacted to discuss coordination needs and understand any barriers. If the PCP is not actively managing the case, an appointment is made with the PCP for the enrollee by the care coordinator.

#### *Selection and Retention of Providers*

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

All of the MCOs have appropriate credentialing systems in place to ensure members receive care and services only from qualified healthcare professionals and that credentialing decisions are non-discriminatory. Credentialing programs describe the structure of the credentialing committee and accountability for decision making. Policies include appropriate verification of credentials and screening of applicants for sanctions and/or exclusions from federal or state programs. Site visits are conducted at the time of initial credentialing and upon re-credentialing every three years to ensure the accessibility and safety of provider locations.

#### *AmeriHealth District of Columbia*

AHDC has a comprehensive credentialing and re-credentialing policy for both physicians and allied health practitioners with ultimate accountability for credentialing activities at the QAPI committee level. The criteria, verification methodology and processes used by AHDC are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed. Further, AHDC has policies in place that no provider shall be excluded or terminated from participation with AHDC due to the fact that the provider has a practice that includes a substantial number of patients with expensive medical conditions.

Practitioners must not have any current sanctions from Medicare or Medicaid as indicated by the Office of Inspector General (OIG) excluded provider report, National Practitioner Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB) reports, or other information sources provided on

behalf of other regulatory agencies. In reviewing information, the credentialing committee determines whether the information available signifies that the practitioner has the ability to provide safe and appropriate care to members or if he/she may pose a potential risk of harm to members if the practitioner is approved to be a participant in the MCO network. A practitioner site visit is conducted at the time of initial credentialing and periodically thereafter to assess provider site access and safety.

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

#### *Health Services for Children with Special Needs*

HSCSN was not required to undergo a full review in 2013. However, information gathered at the time of the CY 2012 review found that HSCSN was compliant with practitioner credentialing and re-credentialing requirements.

#### *MedStar Family Choice*

MSFC has comprehensive policies in place for credentialing and re-credentialing of practitioners. MSFC conducts primary source verification of all licensed practitioners by using NCQA approved and/or industry recognized sources. Review of credentials includes verification of professional credentials and verification that the practitioner is professionally in good standing. MSFC queries the OIG excluded practitioners list and the NPDB at the time of initial credentialing, for re-credentialing, and monthly to monitor practitioner standing. Procedures are also in place to notify the appropriate federal and state agencies of any practitioner sanctions.

MSFC's credentialing committee reviews all files that contain information on sanctions, restrictions on licensure or practice, and malpractice claims settlement(s). The committee then makes recommendations to the Medical Director to approve, pend for further investigation, or reduce or terminate the provider's participation. The Medical Director reviews and approves "clean" files (those files which are complete and have no history of sanctions or exclusions) weekly. Policy provisions include non-discrimination of providers based solely on an applicant's race, ethnicity/nationality identity, gender age, sexual orientation, types and/or cost of procedures or types of patients that the provider specializes in. Re-credentialing is performed at least every three years. At the time of re-credentialing, the practitioner's file is reviewed for any quality events or member complaints to determine if there are any performance trends. All practitioner files

include any complaints, grievances, utilization issues, and adverse events that may have occurred. Site visits are conducted at the time of initial credentialing and prior to re-credentialing a provider.

#### *Trusted Health Plan*

THP's credentialing committee in conjunction with the Chief Medical Officer has responsibility for granting credentialing to practitioners who apply for participation in the health plan's network. THP's non-discrimination policy states that no applicant will be deemed ineligible for participation in the network or discriminated against by THP in any unlawful manner on the basis of gender, race, color, religion, age marital status, national origin, sexual orientation, or disability. The policy also states that the health plan will not discriminate against practitioner(s) that serve high-risk populations or specialize in conditions that require costly treatment.

Primary source verification of credentials is completed and queries of the NPDB and the OIG's excluded provider lists are conducted. The status of the practitioner's license is verified directly with the state-licensing agency. A license is considered unencumbered if it is not subject to any adverse actions, including, but not limited to, probation, suspension, revocation, imposition of any condition such as supervision or periodic reporting, limitation, restriction on nature or scope of practice, public, or private censure. An applicant whose license is encumbered or surrendered, put under probation, or otherwise limited or restricted will not be considered eligible for initial credentialing. The practitioner must have an active DEA and/or CDS certificate for the state where the practice will be located.

Practitioner site visits are conducted at the time of initial credentialing and upon re-credentialing every three years. Policies include provisions for imposing sanctions or termination and notification to the appropriate federal or state agency.

#### ***Adequacy of Provider Networks***

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

##### ➤ Member to Provider Ratio

- At least 1 full time equivalent (FTE) PCP for every 1500 enrollees.
- At least 1 FTE PCP with pediatric training and/or experience for every 1,000 members through the age of 20.
- For enrollees through the age of 20, at least 1 active dentist for every 750 enrollees.

- At least two hospitals that specialize in pediatric care.
  - Department of Behavioral Health core service agencies.
  - The pharmacy network must include at least one (1) twenty-four (24) hour, seven (7) days a week pharmacy.
  - At least one (1) pharmacy that provides home delivery service within four (4) hours; and at least one (1) mail-order service.
- Appointment Availability
- Initial appointments for pregnant women or enrollees desiring family planning services shall be provided within ten (10) calendar days of the enrollee's request.
  - Appointments for initial EPSDT screens shall be offered to new enrollees within sixty (60) days of the enrollee's enrollment date or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child's case indicates a more rapid assessment or a request results from an emergency medical condition.
  - The initial screen shall be completed within three (3) months of the enrollee's enrollment date, unless it is determined that the new enrollee is up-to-date with the EPSDT periodicity schedule. To be considered timely, all EPSDT screens, laboratory tests, and immunizations shall take place within thirty (30) days of their scheduled due dates for children under the age of two (2) and within sixty (60) days of their due dates for children age two (2) and older.
  - Periodic EPSDT screening examinations shall take place within thirty (30) days of a request.
- Travel Distance/ Time
- For all enrollees, at least 2 PCPs within 5 miles of an enrollee's residence or no more than 30 minutes travel time.
  - Laboratories within 30 minutes travel time from a member's residence.
  - At least two (2) pharmacies located within two (2) miles of enrollee's residence.

#### *AmeriHealth District of Columbia*

On a quarterly basis, AHDC analyzes network adequacy and submits the required reports to DHCF. There is documentation of network adequacy that includes the geographic location of providers and members, distance, and travel time. Monitoring activities include reviewing provider records during site reviews; monitoring administrative complaints and grievances; and, conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care.

Review of the December 2013 DHCF report on network adequacy finds that AHDC exceeds expectations for network size for PCPs, Dentists, and PCPs with a pediatric specialty. A review of geo-access reports shows that the AHDC includes evaluation of travel distance to specialty and PCP providers in the data.

Policies are in place allowing female members direct access to women's health specialists. Members with special needs may also directly access specialists. Second opinions may be obtained from within the network; however, if an in-network specialist is not available, AHDC will arrange for the enrollee to obtain a second opinion from an out-of-network provider. In addition, members have the right to choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life threatening medical condition. For after-hours or urgent care, AHDC instructs members to call their PCP's office. If the office is closed the member should leave a message then call the AHDC nurse call line. The nurse will assist the member in getting care.

#### *Health Services for Children with Special Needs*

HSCSN received a focused review of only care coordination activities for 2013. However, data from CY 2012 indicates that HSCSN met required access standards.

#### *MedStar Family Choice*

A review of MSFC's policies and geo-access reports found that 100% of members have access to a PCP or pediatrician within 5 miles of their residences. A review of the DHCF provider network report for December 2013 indicates that MSFC greatly exceeds DHCF's requirements for network adequacy for PCPs, PCPs with a pediatric specialty, and Dentists.

In addition to the geo-access reports, MSFC's provider relations department collects and analyzes data semi-annually on the availability of PCP and OB/GYN appointments for routine, urgent, after-hours, and initial prenatal care appointments in accordance with the standards set by DHCF. The PCP and OB/GYN analysis also includes the time/travel distance by zip code to ensure the DHCF requirements are met. Specialist, hospital, dental, laboratory, mental health/substance abuse and pharmacy access is measured at least annually. If at any time MSFC does not have adequate coverage (i.e. not meeting the requirements of DHCF) the MSFC provider relations department begins the recruitment process for that area. During any period in which MSFC does not have a specialist in the area, the member is permitted to utilize an out-of-network provider after obtaining the proper authorizations.

MSFC also ensures access to members through implementation of policies that allow women to directly access a women's health specialist and direct access to specialist for those with special healthcare needs. Policies are in place permitting members access to a second opinion within the network. If an in-network provider cannot be identified, MSFC will assist in arranging a second opinion from an out-of-network practitioner.

*Trusted Health Plan*

THP employs several methods for monitoring access and availability of providers and services for members. At least annually the health plan collects and analyzes its performance against the DHCF access standards but submits geo-access reports and data to DHCF quarterly. THP's most recent geo-access reports show that members have at least 2 PCPs within 5 miles or 30 minutes of their residences. Additional data is presented for pharmacy, dental, vision, and laboratory services providers. A review of the DHCF December 2013 provider access report shows that THP greatly exceeds network requirements for PCPs, PCPs with pediatric specialty, and Dentists.

THP policies require that practitioners provide coverage to members 24-hours a day, seven (7) days per week on an emergency basis. An answering service is acceptable. However, the policy stipulates that an answering machine must direct calls to an answering service, hospital switchboard, physician beeper, or a direct line to a physician. Messages directing a member to a hospital emergency room or calls directing a member to call back during office hours are not acceptable. THP nurse reviewers make monthly calls after-hours to provider sites to assess the protocol the provider uses for after-hours calls and verifies that the after-hours message contains the appropriate information. Appointment scheduling and wait times are assessed through site visits by reviewing appointment logs and observation of wait times.

THP policies allow for direct access to women's health specialists and family planning services. Policies are also in place allowing direct access to specialists for members with special needs. Second opinions may be obtained through an in-network provider; however, if an in-network provider is not available, THP will assist the enrollee in obtaining a second opinion from an out-of-network provider.

**Timeliness**

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

***Member Materials***

Federal regulations require specific timeframes for dissemination of information to members. Information regarding member rights and responsibilities, covered and non-covered services, complaints, grievances, and appeals processes, and procedures for referrals and authorization of services must be provided to the member



at the time of enrollment, annually, at least 30 days prior to the effective date of any change. The OSR for 2013 includes a thorough review of MCO policies and procedures related to member rights and communication. The focus of these reviews is on content of communications as well as timeliness of those communications.

#### *AmeriHealth District of Columbia*

AHDC met all requirements for timeliness of member materials with the exception of one item. The member rights policy must state that members will be notified at least 30 days prior to a change in policies related to member rights and responsibilities.

#### *Health Services for Children with Special Needs*

HSCSN was not required to undergo a full review in 2013. However, information gathered at the time of the CY 2012 review found that HSCSN was compliant with required timeframes for member communications.

#### *MedStar Family Choice*

MSFC provides all of the requisite member information upon enrollment and annually, however, lack of a policy that describes what information is conveyed to members at least 30 days prior to the effective date of a change resulted in MSFC receiving only a partially met finding for many member rights standards. MSFC must develop a member communication policy that includes notification of policy changes to the member at least 30 days prior to the effective date of a change.

#### *Trusted Health Plan*

THP failed to meet most requirements for timeliness of member communications—largely due to lack of policies ensuring that members are notified of any policy changes at least 30 days prior to the effective date of the change. In addition, THP must revise policies related to advance directives to include provisions for notification to members of changes in the law related to advance directives within 90 days of a change in law.

### ***Utilization Management***

The MCO must have a comprehensive Utilization Management (UM) Program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement. The Utilization Review (UR) Plan must specify criteria for UR/UM decisions. The written UR Plan must have mechanisms in place to detect over-utilization and under-utilization of services. For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that: preauthorization, concurrent review, and appeal decisions are made and supervised by

appropriate qualified medical professionals; efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate; the reasons for decisions are clearly documented and available to the enrollee; there are well publicized and readily available appeal mechanisms for both providers and enrollees; preauthorization and concurrent review decisions are made in a timely manner as specified by the State; appeal decisions are made in a timely manner as required by the exigencies of the situation; and the MCO maintains policies and procedures pertaining to provider appeals. Adverse determination letters must include a description of how to file an appeal and all other required components. The MCO must also have policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

MCOs must meet the following requirements for utilization management:

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

#### *AmeriHealth District of Columbia*

AHDC's policies and procedures provide clear explanations of how the MCO processes authorization requests and the timeframes for doing so. Standard and expedited requests are clearly defined as are reasons for a possible extension. Based on the 2013 OSR, AHDC must:

- Incorporate into its policies requirements for expeditious completion of the decision making process for cases where an extension to the authorization decision timeframe has been implemented and where the enrollee's health condition requires.
- Modify its Notice of Action (NOA) Policy to include language in compliance with the timeliness requirement to notify the member of any termination, reduction, or suspension of services at least 10 days in advance of the effective date.

*Health Services for Children with Special Needs*

As previously noted HSCSN did not undergo a comprehensive review in CY 2013. However, HSCSN was found to be non-compliant with decision making timeframes for standard authorization requests in CY 2012. Because of the special needs of the population served by HSCSN, contractual standards for authorization decisions are more stringent than those for the other MCOs. In 2012, DHCF required that HSCSN complete standard authorizations within 3 calendar days. For 2012, compliance in making timely decisions was assessed at 43% and compliance with notifications was assessed at 33%. As a result HSCSN was required to develop and implement an action plan to address the deficiency.

In 2013, Delmarva approved and monitored HSCSN's progress in implementing the interventions noted within its action plan. In the interim, DHCF revised HSCSN's contract to allow 7 calendar days for standard authorization decision making. As a result of the health plan's action plan and contractual changes, HSCSN was able to meet requirements in 2013. Notably, the last three months demonstrated a positive trend in compliance: 83%, 90%, and 93% (for both timeliness of decisions and notifications).

*MedStar Family Choice*

MSFC policies and procedures conform to the timeliness requirements as stated in the MCO's contract with DHCF. Standard authorization decisions are made within 14 days; expedited decisions within 3 days; and in cases where an extension has been implemented, as expeditiously as the enrollee's health condition requires or by the time the extension expires.

*Trusted Health Plan*

THP's utilization management policies state that standard authorizations will be completed within 7 days and expedited requests within 2 days. These timeframes exceed contractual requirements. However, policies do not state that, in the case of an extension, a decision will be made as expeditiously as the enrollee's health condition requires or by the time the extension expires. In addition, THP's policies do not assure that the NOA will be mailed at least 10 days prior to the effective date of a reduction, suspension, or termination of services.

***Grievance Systems***

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

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

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

#### *AmeriHealth District of Columbia*

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

#### *Health Services for Children with Special Needs*

HSCSN did not undergo a comprehensive review in CY 2013. However, appeals policies and procedures reviewed at the time of the CY 2012 OSR found that the MCO met grievance, appeals, and fair hearing timeliness requirements.

#### *MedStar Family Choice*

MSFC presents a systematic approach to handling complaints, grievances and appeals. Policies and procedures are compliant with contractual requirements for resolution of grievances and appeals, extension of timeframes when necessary, and notification of outcomes to members.

#### *Trusted Health Plan*

THP grievance and appeals policies and the provider handbook state that appeals will be completed within 30 days of request. However, the member handbook informs enrollee's that appeals will be completed within 14 days with a possible 14 day extension of the timeframe if in the best interest of the enrollee. THP is contractually required to complete appeals within 15 days. Also, the MCO may only extend the timeframe by 5 days. Therefore, THP must revise and reconcile its policies and member and provider handbooks to be compliant with contractual requirements.

## Conclusions

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

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

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

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

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

## Status of Prior Year Recommendations

### Recommendations for MCOs

The following recommendations from the CY 2012 ATR are applicable only to HSCSN, the only MCO from CY 2012 still participating in the managed care program:

- Renew efforts to obtain stakeholder involvement in the collaborative PIPs. HSCSN increased participation from internal MCO stakeholders, such as Medical Director and analytic staff, and have engaged in communication with several local asthma programs, such as Impact DC and Breathe DC.
- Identify and leverage current quality improvement efforts underway in the District that support the collaborative aims. HSCSN is working with several stakeholders in the District with a focus on improving outcomes for children with asthma, among these, Impact DC, Breathe DC, and the District Department of Environment. For perinatal efforts, HSCSN works with the National Strong Start, Text 4 Baby, and Healthy Start programs.
- Tie proposed interventions to data points to enable analysis of the effectiveness of the interventions. Implementation of this recommendation cannot be assessed until HSCSN completes development of its PIP submissions for CY 2014.

### Recommendations for DHCF

Understanding that new health plans would begin providing healthcare services to District residents beginning in July 2013, Delmarva offered several recommendations for DHCF to consider in revising its quality strategy:

- Set performance improvement goals for each MCO for key PIP indicators. This will improve MCO accountability and engagement in collaborative efforts. DHCF, in concert with the collaborative work groups, will set MCO specific goals for PIPs in 2015 after collection and analysis of baseline data.
- Require that each collaborative identify at least one intervention that will be conducted jointly by the MCOs. DHCF has implemented this recommendation and, in conjunction with the MCOs, is working to identify joint interventions through the quality work groups.
- Consider expanding the perinatal collaborative indicators to include a new measure of deliveries prior to 39 weeks gestation. DHCF is considering adding an indicator for deliveries prior to 37 weeks and is currently evaluating data sources and potential benchmarks for goal setting.
- Set minimum performance goals for health plans on select HEDIS and CAHPS measures. These should include an array of measures pertinent to the District's enrolled managed care population. In particular, Delmarva recommends that measure goals be set for diabetes and prenatal care. DHCF is evaluating the potential for setting specific goals for a select set of measures, possibly for CY 2015 data. The MCOs do not currently have baseline data available for evaluation in setting reasonable goals.

## Opportunities for Improvement

### Recommendations for MCOs

Although each health plan is committed to delivering high quality care and services to its managed care members, opportunities exist for continued performance improvement. Therefore, the following MCO specific opportunities for improvement have been identified:

#### *AmeriHealth District of Columbia*

- AHDC should revise its QAPI program description to include DHCF reporting requirements.
- AHDC must establish goals for performance measures noted in its work plan once baseline data is available.
- AHDC must revise its policy on member rights to include notification to the member at least 30 days prior to the effective date of any change to policies related to member rights.

#### *Health Services for Children with Special Needs*

- HSCSN must continue to monitor timeliness of authorization decisions.

#### *MedStar Family Choice*

- When data becomes available, assess current performance and set specific goals for performance as a component of the annual work plan.
- In areas related to communication of benefit changes to members, MSFC must revise policies to clearly address notification requirements at least 30 days prior to the effective date of a policy change.

#### *Trusted Health Plan*

- THP must develop an annual work plan that describes performance measures, goals, timeframes, and roles and responsibilities for carrying out the activities. Goals should be specific to measures rather than an overall minimum performance goal for HEDIS.
- THP must strengthen its policies and procedures regarding member rights and responsibilities to ensure appropriate notification to members of changes to policies at least 30 days prior to the effective date of a change.
- THP must review and revise policies and procedures regarding timeframes for NOAs to members at least 10 days prior to the effective date of a denial.
- THP must examine contract language and revise policies and procedures to meet contractual requirements regarding resolution of appeals and permissible timeframes for extensions.

## Recommendations for DHCF

CY 2013 was a year of substantial change for DHCF with the entry of 3 new MCOs into the District Medicaid market. This change in contractors offers DHCF opportunities to create and implement new performance indicators to assess MCO performance.

- Although DHCF has processes in place to monitor the quality of services provided to District residents, DHCF must update its managed care quality strategy to reflect current and planned initiatives to assure that District residents receive high quality care that is accessible, timely, and cost effective. The managed care quality strategy must include performance indicators and measureable goals.



## Improving Perinatal and Birth Outcomes Collaborative Measurement Year 2014

### Study Rationale

According to March of Dimes statistics for 2010, of all births in the District of Columbia (DC), 10.2 percent are born at low birth weight (less than 2,500 g) and 3 percent are born very preterm (less than 32 completed weeks of gestation) placing them at increased risk for neuro-developmental handicaps, respiratory illness, the need for long term hospitalizations and long term learning difficulties. Ten babies out of every 1,000 live births in the District die before their first birthday.<sup>10</sup>

Approximately 6,430 babies were born to women enrolled in the District of Columbia's Medicaid managed care program in 2012. Of these, 228 (3.5%) infants were born at less than 32 weeks gestation and 331 (5.1%) weighed less than 2,500 grams at birth.

Nationally, the rate of infant mortality among African Americans is more than twice that of Caucasians. Much of the discrepancy between infant mortality rates among African Americans and Caucasians can be explained by discrepancies in prematurity and low birth weight rates.<sup>11</sup> African American women are twice as likely to give birth to a low birth weight infant as compared to Caucasian women, and one and a half times more likely to deliver preterm.<sup>12</sup> Other factors contributing to the discrepancy in infant mortality between African Americans and Caucasians include sudden infant death syndrome, infections, congenital abnormalities, and injuries.<sup>13</sup>

Among mothers infected with human immunodeficiency virus (HIV) the rate of perinatal transmission is 25 percent without treatment and 2 percent or less with treatment.<sup>14</sup> Effective means of reducing perinatal HIV transmission to less than two percent are available.<sup>15</sup>

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<sup>10</sup> Retrieved from March of Dimes Peristats on January 10, 2014: <http://www.marchofdimes.com/peristats/Peristats.aspx>

<sup>11</sup> El-Mohandes, A A E, Katz K S, El-Khorazaty N, et al. The effect of a parenting education program on the use of preventive pediatric health care services among low-income, minority mothers: a randomized, controlled study. *Pediatrics*, 2003; 111:1324-1332.

<sup>12</sup> Kaiser Family Foundation State Health Facts

<sup>13</sup> Scott CL, Iyasu S, Rowley D, Atrash HK. Postneonatal Mortality Surveillance-United States, 1980-1984. *MMWR Morb Mort Wkly Rep*. 1998;47(SS-2)

<sup>14</sup> National Institute of Health Public Health Service Task Force. "Recommendations for US of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States" July 8, 2008 Available at <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>

<sup>15</sup> Cooper ER, Charurat M, Mofenson LM, et al. Combination antiretroviral strategies for the treatment of pregnant HIV-1 infected women and prevention of perinatal HIV-1 transmission. *J Acquir Immune Defic Syndr* 2002; 29:484-494.

For this reason, the Center for Disease Control (CDC) has recommended prenatal HIV testing for all pregnant women.<sup>16</sup> In 2006, in the District of Columbia, only 20 percent of HIV infected mothers whose children were perinatally infected had been tested before or during the birth of the child.<sup>17</sup> For 2012, the District's perinatal collaborative results showed that nearly 71% of pregnant women delivering babies in 2012 had received at least one test for HIV during the pregnancy.

Although causes of poor pregnancy outcomes are complex and multifactorial, evidence exists that many are preventable with interventions aimed at reducing risks during pregnancy and improving quality of prenatal care. Early, comprehensive prenatal care has been shown to promote healthier pregnancies by early detection of risk factors, by monitoring symptoms, and by providing health behavior advice and education.<sup>18</sup> Good evidence also suggests that nurse home visiting programs<sup>19</sup> and other programs which include regular home visits with education and parental support<sup>20</sup> can result in earlier and more frequent well-baby visits, and longer intervals between births. By employing multidisciplinary prenatal interventions (e.g., care coordination, nutrition counseling, or psychosocial counseling) targeted toward specific risks (smoking, inadequate weight gain, psychosocial problems), reductions in the rate of low birth-weight births have been achieved.<sup>21</sup>

The DC Department of Health Care Finance (DHCF) measures selected perinatal outcomes as part of a multiyear initiative to improve the health of infants born to mothers in the DC Medicaid program. This collaborative effort began in 2009 using calendar year 2008 data for the baseline. DHCF and the participating managed care organizations (MCOs) will continue this collaborative effort to reduce the rate of adverse perinatal and birth outcomes.

## Collaborative Study Plan

This measure predominantly assesses health care outcomes, as opposed to certain aspects of the delivery (processes) of health care. Because of this, and because nearly all pregnant women and infants in DC

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<sup>16</sup>CDC. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003" MMWR. 2003; 52(15), 329-332.

<sup>17</sup>DC Department of Health HIV/AIDS Fact Sheet. Snapshot HIV/AIDS among children less than 13 years of age in the District of Columbia. November, 2007. Available at [http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration\\_offices/hiv\\_aids/pdf/factsheets/children\\_under\\_13.pdf](http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/factsheets/children_under_13.pdf)

<sup>18</sup> Centers for Disease Control and Prevention. Safe Motherhood: Promoting Health for Women Before, During and After Pregnancy, 2006. 2006. 7-20-0006, cited in: National Committee for Quality Assurance. The State of Health Care Quality 2007: Prenatal and Postpartum Care. Available at: [http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC\\_07.pdf](http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf)

<sup>19</sup> Olds DL, Kitzman H, Hanks C, et al. Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics*; 2007; 120:e832-e845.

<sup>20</sup> El-Mohandes, A. A. E., Katz, K. S., El-Khorazaty, M. N., McNeely-Johnson, D., Sharps, P. W., Jarrett, M. H., et al. (2003). The effect of a parenting education program on the use of preventive pediatric health care services among low-income, minority mothers: A randomized, controlled study. *Pediatrics*, 111(6 I), 1324-1332.

<sup>21</sup> Ricketts, SA, Murray EK, Schwalberg R. Reducing Low Birth weight by Resolving Risks: Results from Colorado's Prenatal Plus Program. *Research and Practice*. 2005;95:1952-1957

Medicaid are enrolled in managed care as opposed to fee-for-service health care, the unit of analysis will be DHCF's managed care program as a whole, as opposed to individual managed care plans. Although individual MCOs that deliver services to DC Medicaid members have and will continue to implement quality improvement (QI) initiatives in perinatal health and report the outcomes of these initiatives to DHCF, individual managed care plan performance on this outcome measure is not publicly reported. Thus, no risk adjustment is required, as is the case when health outcomes are compared across individual providers.

The health plans are expected to measure performance using objective quality indicators, implement system interventions to achieve quality improvement, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements. The following steps will be used to assist the perinatal collaborative stakeholders with defining the collaborative goals:

1. Study Topic: Improve perinatal and birth outcomes among Medicaid women and infants in the District of Columbia.
2. Study Question: Will implementation of interventions that target specific aspects of prenatal care result in an overall decrease in the rate of adverse perinatal and birth outcomes.
3. System-wide intervention: The perinatal collaborative work group will explore opportunities to collaborate with local and national pregnancy programs.
4. Eligible Population:
  - Denominator 1: The eligible population for denominator one will be limited to Medicaid managed care enrollees who had a pregnancy ending in the measurement year. There will be NO continuous enrollment requirement. A member enrolled in the health plan at any time during the measurement year who meets the eligibility criteria will be included in the study.
  - Denominator 2: The eligible population includes all children ages 0 through 365 days during the measurement year.
5. Performance Indicators: The MCOs will report on the following indicators:
  - Indicator 1: Number of neonates delivered during the measurement year with birth weight <2,500 grams.
  - Indicator 2: Number of neonates delivered during the measurement year with gestational age of 32 weeks or less.
  - Indicator 3: Number of women who did not receive an HIV test during the pregnancy prior to giving birth.

- Indicator 4: Number of pregnancies ending in miscarriage or fetal loss (early or late).
- Indicator 5: Number of pregnancies during the measurement year for which the birth outcome is unknown.
- Indicator 6: Rate of adverse perinatal outcomes.
- Indicator 7: Number of infant deaths (age 0 - 365 days) due to any cause during the measurement year.

## Chronic Condition Collaborative Measurement Year 2014

### Study Rationale

National asthma guidelines recommend early treatment and special attention to patients who are at high risk of asthma-related death. Multiple studies have consistently shown that asthma is a readily treatable condition that can be managed in an outpatient setting.<sup>22</sup> Although there is evidence that asthma can be treated in an outpatient setting, data suggests that the emergency department (ED) has typically been used to manage this illness.

Visiting the ED or an acute hospital admission for an asthma exacerbation are key indicators of poorly controlled asthma and risk for future asthma exacerbations. In 2009 there were 2.1 million ED visits in the United States (US) for asthma and 479,300 acute hospital admissions. 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.<sup>23</sup>

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

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<sup>22</sup> March of Dimes, District of Columbia Maternal and Infant Health Overview available at [marchofdimes.com/peristats](http://marchofdimes.com/peristats). Data is from National Center for Health Statistics, 2004 and 2005.

<sup>23</sup> 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](http://www.cdc.gov/nchs/data/series/sr_03/sr03_035.pdf)

The Department of Health Care Finance (DHCF), Chronic Condition Collaborative has been measuring changes in the health outcomes of individuals with asthma, diabetes, congestive heart failure and hypertension since 2008 (baseline year). The chronic condition measure specifications used to assess improvement in health outcomes are ED utilization rates and inpatient hospital admissions for Medicaid and Alliance enrollees with any one or a combination of the aforementioned conditions. In Measurement Year (MY) 2011, Medicaid and Alliance members with chronic conditions represented 34.54% of the Managed Care Organizations' (MCOs) populations.

*MCO Chronic Condition Collaborative data provided by Delmarva Foundation for Medical Care, Inc.*

Diagnosis	FY 2011 Emergency Department (ED) Visits
Asthma	42.42%
Diabetes	34.60%
Congestive Heart Failure	Less than 1% of the MCOs' population
Hypertension	38.80%

ED utilization rates for people living with asthma continue to remain high for children and adults in the District of Columbia (DC). A recent study conducted by the Children's National Medical Center's Impact DC Program found that nearly 68% of emergency department visits for asthma were for children less than eight (8) years of age. Therefore, the Chronic Condition Collaborative work group believes greater opportunity for improvement exists by first targeting children and young adults (2-20) living with asthma. The group recommends expanding the population to Medicaid adults, possibly in year two or three of the initiative.

A focus on asthma for the Chronic Condition Collaborative will increase the likelihood of making a positive impact on the District's asthma population. The goal is to reduce emergency department utilization and inpatient hospital admissions for children with asthma. The hypothesis is that improving medication compliance for those living with asthma will result in better control and consequently decreased utilization of emergency department visits and acute hospital admissions. The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS) performance measures: "*Use of Appropriate Medication for People with Asthma*" and "*Medication Management for People with Asthma*" are intended to help health plans assess whether Medicaid enrollees diagnosed with asthma are receiving appropriate therapeutic medications, and to determine their level of compliance with prescribed asthma medications.

Although the MCOs are expected to use asthma as part of the federally required performance improvement projects (PIPs); using a single condition will not preclude the health plans from monitoring performance, conducting special studies or developing programs and services related to other chronic conditions impacting their populations.

## Collaborative Study Plan

Utilizing a study topic and methodology that the health plans assisted with developing will strengthen the impact the Chronic Condition Collaborative can make on health outcomes, and garner increased stakeholder involvement. Several quality leaders and medical directors who are currently part of the collaborative have expressed their interest and commitment to promoting our overarching aim of lowering ED rates and inpatient hospitalizations for Medicaid children living with asthma.

The health plans are expected to measure performance using objective quality indicators, implement system interventions to achieve quality improvement, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements. The following steps will be used to assist the Chronic Condition Collaborative stakeholders with defining the asthma collaborative goals:

1. Study Topic: Reduce emergency department utilization and inpatient hospital admissions for children with asthma.
2. Study Question: Will improved medication compliance for children with asthma result in better asthma control as evidenced by a reduction of emergency department visits and inpatient hospital admissions?
3. System-wide intervention: The Chronic Condition Collaborative will identify and implement a system-wide intervention that can be used by all Medicaid health plans. With enrollees moving from plan to plan, a system-wide intervention will play a valuable role in sustaining improvement for the DC Medicaid population affected by asthma.

The MCOs must agree to an identified system-wide intervention that can be used for the child asthma population. Examples of system-wide interventions may include:

- using agreed upon educational materials;
- implementing asthma action plans;
- adopting interventions from local or national asthma programs;
- enrolling members in specialized case management classes;
- participating in asthma-specific disease management trainings;
- targeting enrollees with multiple ED visits within a specified time frame; or
- enhance collaborative efforts with primary care providers.

The Chronic Condition Collaborative will explore opportunities to collaborate with local and national asthma programs. Efforts will be made to evaluate activities implemented by the following local programs:

[Breathe DC](#) is committed to improving lung health in the District by serving the disparate communities that are located east of the river.

[DC Control Asthma Now \(DC CAN\)](#) is a DOH public/private partnership committed to reducing the burden of asthma in DC.

[IMPACT DC](#) is pediatric asthma surveillance, research, and intervention project located at Children's National Medical Center and at the Children's Health Project located in the Town Hall Education, Arts, and Recreation Campus (THEARC), and committed to improving pediatric asthma care in the District.

**MCO Case Managers/Outreach Workers** committed to improving asthma outcomes for District Medicaid enrollees.

4. Eligible Population: The eligible population will be limited to Medicaid managed care enrollees age 2 through 20 with a diagnosis of persistent asthma, as defined by the indicator specifications. There will be NO continuous enrollment requirement. A member enrolled in the health plan at any time during the measurement year who meets the eligibility criteria (Attachment 1) will be included in the study.
5. Performance Indicators: The MCOs will report on the following indicators:
  - Indicator 1: Number of children in the eligible population, ages 2 through 20 years, who had one or more ED visits with a principle diagnosis of asthma during the measurement year.
  - Indicator 2: Number of children in the eligible population, ages 2 through 20 years, who had one (1) or more acute hospital inpatient admissions with a principle diagnosis of asthma during the measurement year.
  - Indicator 3: Use of Appropriate Medications for People with Asthma (HEDIS-like) - The number of members in the eligible population, ages 2 through 20 years, who were appropriately prescribed asthma medication during the measurement year.
  - Indicator 4: Medication Management for People with Asthma - The number of members in the eligible population, ages 2 through 20 years, who were dispensed appropriate asthma controller medications that they remained on during the treatment period in the measurement year. Two rates are reported:
    - The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
    - The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.



All indicators will be reported for the following age stratifications:

- 2 through 4 years of age
- 5 through 11 years of age
- 12 through 18 years of age
- 19 through 20 years of age
- Total for all age groups