District of Columbia
Medical Assistance Administration

Medicaid Managed Care Organizations

External Quality Review Report

Health Services for Children with Special Needs

Calendar Year 2005

DELMARVA FOUNDATION
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Section I – Executive Summary

Introduction and Purpose

The District of Columbia Medical Assistance Administration (DC MAA) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted managed care organizations (MCOs). The intent of the Medicaid managed care program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DC MAA has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva has conducted a comprehensive review of Health Services For Children With Special Needs, Inc.(HSCSN/Net) to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to External Quality Review (EQR), is "the degree to which an MCO or PIHP 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" ("Final Rule: EQR," 2003).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).
- **Timeliness**, as it relates to utilization management decisions, is defined by NCQA as when "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" ("Standards and Guidelines," 2003). An additional definition of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the MCOs' progress toward meeting goals of the DC MAA. The annual EQR is a mandated activity in the MCOs' contract and the BBA EQR regulations.

Although Delmarva's task, to assess how well each MCO performs in the areas of quality, access, and timeliness from the systems performance review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified under one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in any one of the four Medicaid MCOs contracting with the DC MAA. Ascertaining whether health plans have met the intent of the BBA and the DC MAA requirements is a major goal of this report.

Background on Plan

The HSC Foundation is the parent corporation for Health Services for Children with Special Needs, Inc. (HSCSN/NET). HSCSN is the only Medicaid Managed Care organization specializing in providing services for the pediatric Supplemental Security Income (SSI) and SSI-eligible populations of Washington, DC. Benefits to beneficiaries and their families include traditional Medicaid benefits and expanded health care services including individualized care management and developmental wraparound services. For the calendar year 2005 HSCSN served approximately 3294 beneficiaries.

Data Sources

This report contains the results of HSCSN performance on the Performance Systems Review (PSR). The PSR was conducted in three main areas consistent with the BBA requirements. The three main systems evaluated included:

- Enrollee Rights.
- Quality Assessment and Performance Improvement (QAPI).
- Grievance System.

The results of this review will be summarized according to the three categories of quality, access, and timeliness. The specific data was gleaned from documents, information and a review of electronic systems provided by the MCO per Delmarva's request.

Purpose

The purpose of the review was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated both DC MAA contractual requirements and the regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing 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. In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems for HSCSN:

- Enrollee Rights.
- Quality Assessment and Performance Improvement.
- Grievance System.

The standards used to assess the MCOs for the CY 2005 review were developed and implemented specifically for the CY 2005 review. It is expected that the MCO will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Methodology

Delmarva reviewed the results of the plans' performance systems review, which consisted of a pre-site desk review and an on-site review at the MCO for the Enrollee Rights, QAPI, and Grievance Systems. This review covered activities performed from January 1, 2005, through December 31, 2005, and focused the BBA requirements and DC MAA contract specific requirements.

Delmarva requested pre-site documentation to conduct a desk review prior to the on-site review. HSCSN provided the requested documentation for the pre-site desk review. Following the desk review, an on-site review was conducted at the MCO office in Washington, DC. At the time of the on-site review additional data were collected through, but not limited to:

- Conducting staff interviews.
- Reviewing the functions of electronic systems (case management, complaint and grievance management, pre-authorization etc).
- Review of complaint, grievance, and appeals case files.
- Review of credentialing and recredentialing files.
- Review of quality improvement committee meeting minutes and activities.

The EQRO assessed quality, access, and timeliness across the three areas using the information provided by the MCO. This report compiles and analyzes this information and summarizes it according to the dimensions of quality, access and timeliness. After discussion of this integrated review, Delmarva provided a preliminary assessment to the DC MAA regarding how well the MCO is providing quality care and services to its beneficiaries.

The DC MAA provided each MCO with a copy of its own report and the opportunity to provide additional information or feedback regarding its MCO specific results. In addition, the DC MAA also required each

MCO to provide a Corrective Action Plan for each standard in the Performance Systems Review that did not receive a review determination of "met." Delmarva incorporated all relevant information into the Final Performance Systems Review Report, including a review of the corrective action plans submitted by each MCO. This report, the Final Performance Systems Review for CY 2005, synthesizes relevant information provided by the MCO and Delmarva's review results and final determinations.

Quality at a Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the DC MAA Medicaid Managed Care Program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medicaid beneficiaries. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of any managed care program. The findings related to quality are reported in the following sections.

Performance Systems Review Findings

Within the performance systems review component of the quality review, HSCSN was assessed specifically in the following areas:

- Quality Assessment and Performance Improvement.
- Grievance Systems.
- Enrollee Rights.

Results are provided by specific area below.

Quality Assessment and Performance Improvement

HSCSN maintains and monitors a network of appropriate providers. The appropriate provider contracts are in place. According to the Quality Evaluation Report for 2005, HSCSN did not conduct the GeoAccess study to assess beneficiaries access to providers was not completed in 2005 as planned.

HSCSN has an established credentialing and recredentialing program and process in place. The Credentialing and Recredentialing policies and procedures do not allow the MCO to discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. These policies also provide for the exclusion from participation of any provider who has been excluded from participation in federal health care programs. The majority of the credentialing/recredentialing requirements were met, except that medical record audits were not being completed as part of the initial on-site review.

HSCSN has policies and procedures in place to ensure that each beneficiary has a primary care provider (PCP) selected by the beneficiary or the enrollment broker if the beneficiary does not select one on his/her

own. Each beneficiary is also assigned to a Care Manager who coordinates all aspects of care for the beneficiary. The Parent and Member Guide and the HSCSN policies include the responsibilities of the PCP and Care Manager for coordinating the healthcare services of each beneficiary.

The Care Management Program and Utilization Management Program documents outline the processes used by HSCSN to coordinate the services the MCO furnishes with other services the beneficiary may be receiving to prevent duplication of activities for its beneficiaries. Policies and procedures are in place to ensure the privacy and confidentiality of beneficiary information during coordination of care. These are compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

All of HSCSN's policies and procedures are specialized for children with special health care needs. The Care Management Program document outlines the procedures to be used by Case Management to develop and implement a care plan. The Initial and Subsequent Care Coordination Plan notes that care plans are required to be completed/updated every six months. HSCSN acknowledges that these have not been completed on a timely basis in 2005, partly due to excessively high case loads. HSCSN must focus efforts on ensuring that case loads are redistributed equitably across disciplines and beneficiary needs. Plans must be implemented to address the timeliness of care plan development and updating in addition to providing adequate staff to perform care coordination services.

HSCSN has policies and procedures regarding the initial and continuing authorization of services. The HSCSN standards for timeliness of issuing a referral are compliant with requirements. All denials of services are required to be made by a health care professional who has the appropriate clinical expertise in treating the beneficiary's condition or disease. The authorization policies and procedures require consultation with the requesting provider when appropriate. HSCSN notifies the provider and beneficiary in writing of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. There was no evidence of policies and procedures to ensure that compensation to individuals (non-HSCSN staff such as physician advisors) who conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. There was no evidence of procedures in place to address the accurate data entry of referrals and inter-rater reliability for staff involved in authorization decisions.

HSCSN's Change in Member Status/Disenrollment policy is in place and meets many of the requirements. The policy specifies the reason a plan can/cannot request disenrollment of a beneficiary. HSCSN procedures must address cases in which DC MAA may fail to make a disenrollment decision. A disenrollment must provide that the effective date of an approved disenrollment be no later than the first day of the second month following the month in which the beneficiary files the request. Policies and procedures must be

updated to include the fact that if the DC MAA fails to make a determination within the timeframes that the disenrollment is considered approved.
HSCSN has the appropriate policies in place for delegation and oversight of delegated providers. The Delegated Credentialing Entities policy outlines the responsibility of the MCO and the delegate. This policy provides the mechanisms for HSCSN to monitor the delegate, including regular reporting by the delegate. The procedure and timeframes for auditing the delegate's performance of delegated duties in contained in the policy. The written delegation agreement outlines the process HSCSN may employ to terminate the delegate if corrective actions are not effective.

HSCSN has developed and/or implemented a variety of clinical practice guidelines (CPGs). These guidelines consider the needs of the beneficiaries, are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field, and are adopted in consultation with contracting health professionals. CPGs are reviewed each year according to the Clinical Practice Guidelines policy. The CPGs are used for making decisions regarding utilization management (UM), beneficiary education, and coverage of services. Although the requirements for CPGs are met, Delmarva recommends that the documentation sheets for the CPGs are updated to contain the Provider Network Council approval date, and that the CPGs guidelines be abbreviated to facilitate easier use of the guidelines.

HSCSN has a Quality and Performance Improvement Program (QPIP) and a Quality Action Plan (QAP) in place. The QPIP includes goals, authority, program and committee structure, staff responsibilities, a description of the Care Coordination Program and Risk Management Program, the perform measurement system, confidentiality and conflict of interest provisions as well as the requirement for an annual program evaluation.

The QAP outlines the QPIP activities, individual(s) responsible for each activity, target dates, measures, expected and actual outcomes, and status. The major issue identified in the area of projects included the need for detailed documentation for the planning and initiation of quality improvement activities. HSCSN must enhance its quality improvement activities by utilizing a standard process for identifying issues, conducting analysis, identifying barriers, matching proven interventions to barriers, measuring results, and then making any necessary changes.

HSCSN also has a health information system in place that is able to provide data on utilization, grievances, and disenrollments. The plan has mechanisms in place to verify the accuracy and timeliness of data, and to screen the data for completeness, logic and consistency. Information is collected in standard formats to the extent feasible and all data collect is made available to DC MAA and CMS. System evaluation identified the need for greater integration of HSCSN's data and information systems to use in coordinating care for its beneficiaries. HSCSN began using the Case Trakker software for utilization and care coordination services

during the latter part of 2005. It is understood that this capability may improve the data available for management of care coordination activities.

Grievance Systems

HSCSN has policies and procedures in place to ensure beneficiary access to complaint, grievance, and appeals systems. Beneficiaries are also notified of their right to access the District Fair Hearing process. These policies and procedures are maintained in an electronic system and summary data is provided to the DC MAA at least quarterly. Information about the grievance and appeals system is reviewed with providers during provider orientation sessions. The policies and procedures allow for a beneficiary to file a grievance (either orally or in writing) for an MCO level appeal and to request a District Fair Hearing at any time during the process. Providers also have access to the complaint, appeals and grievances system and may file on behalf of him/herself or a beneficiary.

HSCSN provides a notice of action (NOA) to the beneficiary and provider in cases of denials. The NOAs did not meet the fifth grade reading level language requirements. The content of the NOAs were not comprehensive to include the circumstances under which an expedited appeal is available. The NOAs did not define the beneficiary's right to a continuation of benefits during the appeal process, nor the potential beneficiary responsibility of payment for services furnished or not furnished during the appeal.

HSCSN's policies, procedures and Parent and Member Guide (Member Handbook) provide that the plan will offer beneficiaries assistance in completing forms for grievances and appeals and will acknowledge each grievance and appeal. Oral inquiries seeking to appeal decisions are treated as appeals and are confirmed in writing by the plan. HSCSN's policies also note that individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making. Health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition or disease must be involved in the decision making process.

HSCSN's appeals policies and procedures do not provide documentation of the following:

- An expedited appeals process and the circumstances under which an expedited resolution is available.
- The beneficiary's right to have benefits continue pending the resolution of an appeal and how the request can be made for continuation of benefits.
- That any oral inquiries seeking to appeal an action are treated as appeals and must be confirmed in writing unless the beneficiary or provider requests an expedited resolution.
- The right of a beneficiary to have a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- To provide a beneficiary and his/her representative an opportunity to examine the beneficiary's case file.
- The beneficiary right to include, as parties to the appeal, the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate.

- That punitive action is not taken against a provider who requests an expedited resolution or supports an appeal.

HSCSN provided its Corporate Compliance Plan and Compliance Investigations policy which addressed the majority of the fraud, waste and abuse contract provisions. HSCSN conducts fraud, waste and abuse training and requires staff attendance. According to these documents, the Vice President of Quality/Compliance and Evaluation Reporting is the designated person to receive confidential reporting of plan violations. The Corporate Compliance Plan does not include the requirement of the plan to report confirmed violations to MAA within 24 hours of being confirmed and does not require any confirmed or suspected fraud and abuse be reported to the DC Office of the Inspector General Fraud Unit, the Medicaid Program Integrity Section of MAA, and the Office of Managed Care.

Enrollee Rights

HSCSN has all but one of the required beneficiary rights and responsibilities contained in its policies and program documents. The Member Handbook and other beneficiary materials include the necessary information to describe the benefits and services available to beneficiaries under the DC MAA managed care program, but do not always include the amount, scope, and duration of benefits.

HSCSN's policies and procedures also include access to interpreters free of charge to beneficiaries for medically related appointments. Written materials are provided in alternative formats such as Braille, large print and audio. Beneficiary enrollment materials are provided in English and Spanish with other languages available on request by the beneficiary. In general, HSCSN attempts to ensure that documents are written at the fifth grade reading level (except as noted in the NOAs). HSCSN's contract with the DC MAA requires materials to be available in Spanish, Korean, Chinese, Vietnamese, and Amharic or Braille/audio format. Beneficiaries can contact Member Services to receive information in these other languages.

Summary of Quality

HSCSN maintains and monitors a network of appropriate providers and contracts are in place. HSCSN has a documented credentialing and recredentialing process. The majority of the credentialing/recredentialing requirements were met, except that medical record audits were not being completed as part of the initial on-site review.

The majority of the components for the quality improvement program are addressed in the plan document. However, quality improvement projects included the need for detailed documentation for the planning and initiation of quality improvement activities. HSCSN must enhance its quality improvement program by utilizing a standard process for identifying issues, conducting analyses, identifying barriers, targeting proven interventions to address barriers, measuring results, and then making any necessary changes after evaluation.

HSCSN has policies and procedures for the utilization management of initial and continuing authorization of services. These must be enhanced to ensure that compensation to individuals who conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. HSCSN must implement policies and procedures to address the accurate data entry of referrals and inter-rater reliability for staff involved in authorization decisions.

The Case Management program is in place to address the special needs of HSCSN beneficiaries, children with special health care needs. Case Trakker was implemented in late 2005 and the plan is now focusing efforts on getting data entered into this system. Efforts should continue to focus on sufficient staffing to complete care plans for beneficiaries on a timely basis, including updates.

Access at a Glance

Access is an essential component of a quality-driven system of care. One of the key components to the DC MAA managed care program is assuring access for all beneficiaries to the services provided by the contracted plans.
The findings related to access are discussed in the following sections.

Performance Systems Review Findings

Delmarva's operational systems review of HSCSN documented the following review requirements in place and operational to provide access:

- Enrollee Rights and Protections.
- Quality Assessment and Performance Improvement.
- Grievance Systems.

Quality Improvement

HSCSN's access and availability standards document compliance with the DC MAA contract:

- Live access to beneficiary services 24/7.
- Primary care providers must be available 24/7.
- Beneficiary access to emergency care immediately.
- Urgent care appointments must be scheduled within 24 hours of request.
- Psychiatric assessment and stabilization services must be available 24/7.
- Initial appointments for pregnant women or person desiring family planning services within 10 days of request.
- Appointments for EPSDT screenings within 30 days of enrollment or earlier if needed to comply with the periodicity schedule.

- Initial appointments for newly enrolled adults within 90 days of enrollment or 30 days of request.
- Routine appointments within 30 days of request.
- Average wait-time in the provider office of no more than one hour after appointment time.
- Access to two PCPs within 30 minutes travel time.
- Access to one pharmacy within two miles and one with at least 24/7 access.
- Ensuring the selection or assignment of a primary care provider (PCP) within 6 days of enrollment.

Compliance with these standards is measured using several different tools. A Geo-Access report is completed quarterly to assess these providers' access and availability requirements. The monitoring of urgent and routine appointments was not accomplished in 2005 according to the QAP.

HSCSN policies and procedures document that beneficiaries have direct access to specialists through either a standing referral or by an approved number of visits. In addition, HSCSN provides for women to have direct access to a women's health specialist within the network for preventive and routine services.

HSCSN has implemented appropriate policies and procedures to document how beneficiaries can receive services out of network if their provider network is unable to provide the necessary services. These policies also include the provision to ensure that the cost to the beneficiary is no greater that it would be if the services were furnished in the network.

HSCSN's policies and procedures note that if HSCSN's network is unable to provide necessary medical services covered under the contract, the plan will pay for these services to be received out-of-network for as long as the MCO is unable to provide them. In addition, policies are in place to coordinate reimbursement with out-of-network providers to ensure that the cost to the beneficiary is no greater than it would be if the services were furnished within the network.

Grievances Systems

HSCSN has policies and procedures in place to give beneficiary access to complaint, grievance, and appeals systems. Beneficiaries are notified of their right to access the District Fair Hearing process. The policies and procedures allow for a beneficiary to file a grievance (either orally or in writing) for a plan level appeal and to request a District Fair Hearing at any time during the process. Providers have access to the complaint, appeals, and grievances system and may file on behalf of him/herself or a beneficiary.

HSCSN provides a NOA to the beneficiary and provider in cases of denials. NOAs did not include the circumstances under which expedited appeal is available or the beneficiary right to continuation of benefits during the appeal process. The NOAs did not note the potential beneficiary responsibility of payment for services furnished or not furnished during the appeal Process.

HSCSN's policies, procedures and Parent and Member Guide (Member Handbook) provide for the plan to offer beneficiaries assistance in completing forms to access the grievances and appeals processes.

In reviewing documentation related to access, HSCSN's appeal process does not provide the following:

- An expedited appeals process or specification of the circumstances under which an expedited resolution is available.
- The beneficiary's right to have benefits continues pending the resolution of the appeal, and how a request for benefits to be continued can be made.
- The beneficiary right of a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- To provide a beneficiary and his/her representative opportunity to access the beneficiary's case file.
- The right to include as parties to the appeal, the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate.

Enrollee Rights

HSCSN's policies and procedures include access to interpreters free of charge to beneficiaries for medically related appointments. Written materials are provided in alternative formats such as Braille, large print and audio. Beneficiary enrollment materials are provided in English and Spanish with other languages available on request by the beneficiary. Documents are written at the fifth grade reading level. HSCSN's contract with the DC MAA requires materials to be available in Spanish, Korean, Chinese, Vietnamese, and Amharic or Braille/audio format. Beneficiaries can contact Member Services to receive information in these other languages.

HSCSN provides its beneficiaries with information on its network providers and includes information in its Parent and Member Guide to describe how to access services both in and out-of-network.

The beneficiary materials include information on how to access the plan's complaint, grievance, and appeals system, the scope of benefits provided to beneficiaries, and how to obtain benefits from out-of-network providers. The Member Handbook also provides information on how after-hours, urgent, and emergent care can be obtained. The Member Handbook documents that pre-authorization is not required for emergency services and that beneficiaries can use any hospital or setting for emergency care. HSCSN includes the specialty referral policy and notes other benefits that cannot be provided by the beneficiary's PCP.

The MCO's beneficiary materials provide information to assist them in setting up advance directives. Additional rights include the ability of beneficiaries to participate in decisions concerning their own health care. There are policy provisions in place to ensure access to open provider and beneficiary communications. The Member Handbook and the HSCSN Participating Provider Agreement note that providers are not prohibited or restricted from advising, advocating on behalf of a beneficiary's health status, medical care, or

treatment options, including any alternative treatments. These documents do not prohibit the provider in advising the beneficiary about the risks, benefits, or consequences of treatment or non-treatment.

Summary of Access

The appropriate access and availability standards are in place and are consistent with contract requirements. Compliance with these standards is measured using several different mechanisms; however, all measures of access were not assessed by HSCSN during 2005.

HSCSN has procedures in place for beneficiary access to complaint, grievance, and appeals systems. These procedures allow both providers and beneficiaries to access the complaint, grievance, and appeals systems.

Beneficiary rights are documented in HSCSN's policies and procedures and provide information about providers of all types of services and plan benefits. The MCO provides beneficiaries and providers information about advance directives and beneficiary-provider communication provisions. HSCSN provides beneficiary materials in both English and Spanish and has procedures in place for beneficiaries to request materials in the required languages of Chinese, Vietnamese, Amharic, Korean or Braille. HSCSN also has procedures in place to give beneficiaries access to interpreter services free of charge for medically related appointments.

HSCSN provides female beneficiaries with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health services. Beneficiaries may obtain a second medical opinion from a qualified health care professional within the network at no cost to the beneficiary. HSCSN provides its beneficiaries with adequate information on network providers, how to obtain contracted services and preauthorization requirements. The plan's beneficiary materials also provide information to assist them in setting up advance directives and to provide for open provider and beneficiary communications.

Timeliness at a Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of DC MAA beneficiaries. Equally important is the timely delivery of those services and the following findings relate to timeliness in the section to follow.

Performance Systems Review Findings

The annual systems performance review for HSCSN included a review of standards that addressed the dimension of timeliness. Specific dimensions related to timeliness were assessed in the following areas:

- Quality Assessment and Performance Improvement.

- Grievance Systems.
- Enrollee Rights and Protections.

Quality Improvement

HSCSN has appropriate access and availability standards that address the scheduling of appointments, and appointment waiting times. The quarterly Geo-Access report assesses driving distance/time to various providers. The monitoring of urgent and routine appointments is required, but was not accomplished by HSCSN in 2005 according to their QAP.

Grievances Systems

The standards require that standard disposition of a grievance, with notice to the affected parties, may not exceed 90 days from the day the plan receives the grievance. HSCSN's internal standard is 14 days which exceeds this requirement.

The standard resolution of an appeal and notice to the affected parties must be no longer than 45 days from the day the plan receives the appeal although this timeframe can be extended. HSCSN's policies and procedures are not clear to document their resolution time frame, nor do the policies address the possibility of timeframe extensions.

The expedited appeal requires the plan to resolve the appeal within three working days after the plan receives the appeal. HSCSN's policies and procedures document their time frame for completion, within 72 hours of request.

HSCSN has policies and procedures documenting their initial and continuing authorization of services. The standards for timeliness in issuing a referral are compliant with requirements. All denials of services are required to be made by a health care professional with the appropriate clinical expertise in treating the beneficiary's condition or disease.

HSCSN has policies and procedures in place for standard authorizations. The policies and procedures do not address the requirement that the plan notify the beneficiary as expeditiously as his/her health condition requires, but not exceed 14 days. Policies also do not address the right of the beneficiary or the provider to extend this time frame up to 14 calendar days if requested.

HSCSN has an expedited authorization process but it does not state that a decision must be made as expeditiously as the beneficiary's condition warrants, but not later than three working days after receipt of the request for service. This policy does not address the ability of the plan to extend the timeframe up to 14 working days if the beneficiary requests an extension, the requirement of the plan to provide written notice to

the beneficiary in cases where an extension is granted, nor the requirement of the plan to carry out its determination as expeditiously as possible, but no later than the date the extension requires.

The denial of request for an expedited resolution requires the transfer of the appeal to the timeframe for standard resolution. Prompt oral notice must be given to the beneficiary with written follow-up within two calendar days. Neither of these requirements is addressed by HSCSN's policies and procedures.

Enrollee Rights

The Enrollee Rights sections of the BBA standards assess the information requirements related to grievances, appeals, and District Fair Hearings. HSCSN's grievance and appeals policies and procedures address the timeframes for grievances and appeals; however, the Parent and Member Guide only notes where to call for more information on complaints, grievances, and appeals and notes beneficiary access to a District Fair Hearing at any time during the process. The Parent and Member Guide does not contain sufficient detail to explain complaints, grievances, and appeals, including the timeframes for each process. Policies and procedures must also note that beneficiary benefits will continue when requested by the beneficiary, if the beneficiary files an appeal or a request for a District Fair Hearing is requested within the timeframes specified for filing.

Summary for Timeliness

All of HSCSN's policies and procedures are specialized for children with special health care needs. The Care Management Program document outlines the procedures to be used by Case Management to develop and implement care plans. The Initial and Subsequent Care Coordination Plan notes a requirement for completion and then updated every six months. This has not been achieved by HSCSN.

As noted in the Quality Improvement section, HSCSN has the appropriate access and availability standards in place for scheduling of appointments and appointment waiting times. According to the QAP, the monitoring of urgent and routine appointments is required, but was not accomplished during 2005.

HSCSN's policies and procedures are consistent with the timeframes for disposing of grievances (90 days) and processing requests for expedited appeals (72 hours). The standard resolution of an appeal and notice to the affected parties must be no longer than 45 days from the day the MCO receives the appeal. This timeframe can be extended, but HSCSN's policies and procedures are not clear regarding the resolution time frame, nor do they address the possibility of timeframe extensions.

HSCSN has policies and procedures for the utilization management of initial and continuing authorization of services. The HSCSN standards for timeliness in issuing a referral are compliant with requirements. Authorization policies and procedures do not contain all required components for timeliness, including

timeframes for notification of beneficiaries/providers, processing of authorizations, and requests for extensions of timeframes.

HSCSN's grievance and appeals policies and procedures address many, but not all of the timeframes for grievances and appeals. The Parent and Member Guide does not include sufficient detail to explain the complaints, grievances, and appeals process, including the timeframes for each.

Overall Strengths

Quality

- HSCSN has a documented Quality Improvement and Performance Plan (QIPP) to document its quality improvement program
- HSCSN has a QAP in place to serve as a work plan.
- The Credentialing and Recredentialing Program is documented and most standards are met.
- There is demonstrated adherence to credentialing and recredentialing timeframes.
- The Case Management program is in place to address beneficiaries with special needs.
- The Case Trakker system, recently implemented, should assist case managers in developing and implementing timely care plans.
- Authorization policies and procedures are in place.
- Appropriate personnel are used to make authorization decisions.
- A defined process is in place to develop and implement clinical practice guidelines.

Access

- HSCSN has a comprehensive set of access and availability standards with, the majority monitored appropriately.
- The complaint, grievance, and appeals systems are in place to ensure beneficiary and provider access.
- Access to open provider-beneficiary communication is provided through policies and in provider contract provisions.
- Beneficiary materials are made available in the required languages with procedures in place for beneficiaries to request materials in the required languages of Chinese, Vietnamese, Amharic, Korean and the Braille format.
- Procedures are in place to ensure that beneficiaries can have interpreter services free of charge for medically related appointments.

Timeliness

- HSCSN has the appropriate standards in place for timeliness of services.
- Appointment wait-time standards are in place.
- Standards for scheduling of appointments are in place.
- Expedited appeals are required to be resolved in 72 hours and are consistent with the standards.
- Grievance policies and procedures meet the 90 day timeframe for disposition of all grievances.

Recommendations

This section offers DC MAA a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for HSCSN are as follows:

- HSCSN acknowledges that care plans have not been completed on a timely basis during 2005, partly due to excessively high case loads. HSCSN must focus efforts on ensuring that case loads are redistributed equitably across disciplines and beneficiary needs. Plans must be implemented to address the timeliness of care plan development and updating.
- HSCSN must ensure that there are policies and procedures that define the requirements of compensation to individuals (non-HSCSN staff such as physician advisors) who conduct utilization management activities; policies are not to be structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.
- HSCSN must ensure that there are procedures in place to address the accurate data entry of referrals and inter-rater reliability for staff involved in authorization decisions.
- HSCSN must review and revise its Member Status/Disenrollment policy to meet all of the requirements of the disenrollment standards.
- Although the requirements for CPGs are met, Delmarva recommends that the documentation sheets for the CPGs be updated to contain the Provider Network Council approval date, and that the CPGs guidelines be abbreviated to facilitate easier use of the guidelines.
- HSCSN must enhance its quality improvement process by utilizing a standard process for identifying issues, conducting analyses, identifying barriers, targeting proven interventions to barriers, remeasurement, and then making any necessary changes to project.
- The template NOAs should be reviewed, revised, and updated to include the multiple requirements for their content. HSCSN should comply with the fifth grade reading level requirements for the notices.
- The Corporate Compliance Plan must be enhanced to include the requirement of the plan to report confirmed violations to MAA within 24 hours of being confirmed. HSCSN is required to report any confirmed or suspected fraud and abuse to the DC Office of the Inspector General Fraud Unit, the Medicaid Program Integrity Section of MAA, and the Office of Managed Care.

- HSCSN has all but one of the required beneficiary rights and responsibilities contained in its policies and program documents. The Member Rights policy and other documents that include member rights should be updated to include the beneficiary right to be free from any form of restraint or seclusion.
- HSCSN must implement mechanisms to assess all required access and availability standards.
- The Initial and Subsequent Care Coordination Plan notes that care plans are required to be completed/updated every six months, but this has not been achieved by HSCSN. HSCSN must focus its effort on completing and documenting care plans on a timely basis.
- As noted in the Quality Improvement section, HSCSN has the appropriate access and availability standards in place for the scheduling of appointments and appointment waiting times. According to the QAP, the monitoring of urgent and routine appointments is required, but was not accomplished by HSCSN in 2005.
- HSCSN must review and revise its grievance and appeals policies to include all BBA requirements contained in the standards. This includes, but is not limited to, timeframes for filing, extensions, processes and timeframes for resolution, notification of beneficiaries and providers, and continuation of benefit provisions.
- HSCSN must revise and update its authorization procedures to include a formalized expedited appeals process that meets all requirements. These procedures must include timeframes for notification of beneficiaries/providers, processing of authorizations, and requests for extensions of timeframes.
- HSCSN must include a more detailed description of the complaints, grievance, and appeals procedures in its Parent and Member Guide, along with associated time frames.

Corrective Action Plan Review Results

HSCSN provided a Corrective Action Plan document to address standards that were not fully met in the CY 2005 review. Fifty-six of the reviewed standards were not fully met. Of these 56 standards, 49 CAPs were deemed "adequate" and 7 CAPs were deemed "not adequate." Some of the CAPs were deemed "not adequate" because HSCSN disagreed with the review findings and did not provide a CAP. It is important that the MCO review all CAP determinations that were not adequate in order to ensure that these standards are addressed prior to the next annual review. The CAP review determinations are summarized in Appendix IIA1, Recommendations-At-A-Glance.

References

Centers for Medicare and Medicaid Services. (2002, June). *Final rule: Medicaid managed care; 42 CFR part 400, et seq. Subpart D—Quality assessment and performance improvement.* Retrieved December 9, 2004, from http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

Centers for Medicare and Medicaid Services. (2003, January). Final rule: EQR of managed care organizations and prepaid inpatient health plans; 42 CFR part 438.300 et seq. Retrieved November 1, 2004, from http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf

Institute of Medicine, Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report.* Retrieved February 24, 2005, from http://www.nap.edu/html/envisioning/ch2.htm

National Committee for Quality Assurance. (2003). Standards and guidelines for the accreditation of MCOs.

Section II – Performance Systems Review

Enrollee Rights and Protections

ER1.0 – Enrollee Rights Policy and Procedure
This standard is met.

Element 1.1 – 438.100 (a) (1–2)
The MCO must have written policies regarding enrollee rights.
This element is met.

Health Services for Children with Special Needs (HSCSN) has a *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04) in place.

ER2.0 – 438.100(b)(2)(ii)–(vi) Content of Enrollee Rights Policy
The enrollee rights and responsibilities policy and procedure must include the enrollee right to:
This standard is partially met.

Element 2.1 – Be treated with respect and with due consideration for his or her dignity and privacy.
This element is met.

The beneficiary's right to be treated with respect and with due consideration for his or her dignity and privacy is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Element 2.2 – Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
This element is met.

The beneficiary's right, to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand, is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Element 2.3 – Participate in decisions regarding his or her health care, including the right to refuse treatment.
This element is met.

The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Element 2.4 – To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
This element is not met.

In order to receive a finding of met in subsequent reviews the Managed Care Organization (MCO) should include in its *Member Rights and Responsibilities* policy the following language: "To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation."

Element 2.5 – Request and receive his or her medical records and request that they be amended of corrected.
This element is met.

The beneficiary's right to request and receive his or her medical records is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04). The right to request that they be amended or corrected is included in the *Member/Authorized Caregiver Request Related to Amendment, Restriction and Disclosure of Protected Health Information* policy and procedure (#HI/14, 5/03). It is recommended that the request to amend or correct be added to the *Member Rights and Responsibilities* policy.

Element 2.6 – Formulate advance directives. (417.436(d)(1)(i)(A)
This element is met.

The beneficiary's right to formulate advance directives is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Element 2.7 – Make decisions regarding health care including the right to accept or refuse medical treatment (417.436(d)(1)(i)(A)
This element is met.

The beneficiary's right to make decisions regarding health care, including the right to accept or refuse medical treatment, is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Element 2.8 – The right to file grievances and appeals (438.10(g)(ii).
This element is met.

The beneficiary's right to file grievances and appeals is included in HSCSN's Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

ER3.0 – Enrollee Information Provisions
This standard is met.

Element 3.1 – 438.100 (b)(2)(i) and 438.10(d)(1)(i)
Enrollees have the right to receive information in accordance with section 438.10, which states that MCOs must provide all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
This element is met.

The beneficiary's right to receive information in a manner and format that may easily be understood is documented in HSCSN's Parent and Member Guide. The *Providing Accessible Communications* policy and procedure (#AD/10, 11/03) states that in an effort to create communications that are clear and understandable for beneficiaries, HSCSN will use plain language written at the fifth grade level as its standard.

Element 3.2 – 438.10(c)(3): The MCO must make its written information available in the prevalent, non-English languages in its particular service area.
This element is met.

The MCO makes its written information available in prevalent non-English languages in its particular service area as defined in HSCSN's Parent and Member Guide.

When requested to do so, the plan will give any newly eligible or current beneficiary written documents in a non-English language required by the District of Columbia Medical Assistance Administration (DC MAA), which includes Spanish, Chinese, Korean, Vietnamese, and Amharic, or Braille. This is also documented in the *Providing Accessible Communications* policy and procedure (#AD/10, 11/03).

ER4.0 – 438.10(c)(4)–(5) Language Services
The MCO must make language services [i.e., oral interpretation services] available to its enrollees: This standard is met.

Element 4.1 – These services must be free of charge to each enrollee
This element is met.

The plan offers language services, that is, oral interpretation services, free of charge to beneficiaries, as documented in HSCSN's Parent and Member Guide. This is also documented in the *Providing Accessible Communications* policy and procedure (#AD/10, 11/03).

Element 4.2 – The MCO must notify its enrollees that oral interpretation is available for any language.
This element is met.

HSCSN notifies its beneficiaries, via the Parent and Member Guide, that oral interpretation is available by calling the Language Line number (toll free). This is also documented in the *Providing Accessible Communications* policy and procedure (#AD/10, 11/03).

Element 4.3 – The MCO must notify its enrollees that written information is available in prevalent languages.
This element is met.

The plan notifies its beneficiaries that written information is available in prevalent non-English languages. This is documented in the Parent and Member Guide. The policy and procedure, *Providing Accessible Communications* (#AD/10, 11/03), states that all vital documents will be translated in prevalent languages such as Spanish, Chinese, Vietnamese, Amharic, and Korean or Braille, upon request or on an as-needed basis.

Element 4.4 – The MCO must notify its enrollees how to access free interpretation services.
This element is met.

The plan notifies its beneficiaries, via the Parent and Member Guide, that interpretation is available by calling the Language Line number (toll free). This is also documented in the *Providing Accessible Communications* policy and procedure (#AD/10, 11/03).

ER5.0 – 438.10(d)(1)(ii) and (d)(2) Alternative Formats for Enrollee Information
Written material must be available in alternative formats.
This standard is met.

Element 5.1 – Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

Written material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency, as documented in the Parent and Member Guide. Braille and oral interpretation and translation services are available to parents and beneficiaries. Also the *Providing Accessible Communications* policy and procedure (#AD/10, 11/03) states that documents are available in large font for the visually impaired.

Element 5.2 – All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
This element is met.

All beneficiaries and potential beneficiaries are informed that information is available in alternative formats, as documented in the Parent and Member Guide. The *Providing Accessible Communications* policy and procedure (#AD/10, 11/03) also addresses this information.

ER6.0 – 438.10(f)(2) and (f)(6) and 438.114 Enrollee Information
The MCO must notify all enrollees of their right to request and obtain the information listed below within a reasonable time after enrollment and at least annually thereafter.
This standard is partially met.

Element 6.1 – Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients.
This element is met.

The names, locations, telephone numbers of current contracted providers in the beneficiary's service area, and the non-English languages that they speak are noted in the HSCSN's Provider Directory. The plan's Case Tracker System electronically tracks providers that are not accepting new patients, and this information is readily available when a beneficiary calls his or her Care Manager to coordinate

appointments. The Provider Directory is included in the new beneficiary enrollment packet. According to the Member and Parent Guide, beneficiaries may also obtain copies by calling Member Services.

Element 6.2 – Any restriction on the enrollee's freedom of choice among network providers.
This element is met.

HSCSN notifies the beneficiary of restrictions among network providers in the Parent and Member Guide. In order for a beneficiary to see a specialist, the beneficiary's primary care provider (PCP) must provide the beneficiary with a referral. The HSCSN Care Manager works with the beneficiary and the PCP's office to make an appointment with a specialty care provider. The process of getting an appointment with a specialist is also described in the Provider Directory on page 5. The Provider Directory is included in the new beneficiary enrollment packet. According to the Parent and Member Guide, beneficiaries may also obtain copies by calling Member Services.

Element 6.3 – Enrollee rights and responsibilities.
This element is met.

Beneficiary rights and responsibilities are documented in HSCSN's Parent and Member Guide. Beneficiary rights and responsibilities are also defined in the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04). All beneficiaries receive the Parent and Member Guide upon enrollment and, according to Member Services, receive an updated Parent and Member Guide on an annual basis. It is recommended that the Parent and Member Guide state that handbooks are updated and distributed on an annual basis.

Element 6.4 – Information on grievance and fair hearing procedures.
This element is met.

Information on grievance and fair hearing procedures is documented in HSCSN's Parent and Member Guide. Grievance information is also covered in the *Grievance* policy and procedure (#QM/11, 6/04).

Element 6.5 – The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is partially met.

The scope of benefits is described in the Parent and Member Guide. However, the amount and duration are not always identified. For example, general dental examinations are limited to two per year; however, the amount and duration are not described for other services, such as vision or mental health.

In order to meet the full intent of this element, the amount and duration need to be described in sufficient detail to ensure that the enrollees understand the benefits to which they are entitled.

Element 6.6 – Procedures for obtaining benefits, including authorization requirements.
This element is met.

The procedures for beneficiaries' obtaining benefits, including authorization requirements, are documented in HSCSN's Parent and Member Guide. If needed, the PCP will refer the beneficiary to a specialist. The HSCSN Care Manager works with the beneficiary and the PCP's office to make an appointment with a specialty care provider. Referrals are also needed for mental health services and substance abuse treatment. The Parent and Member Guide documents that in some special situations a beneficiary does not have to use a network provider, for example, in an emergency. The *Referral Process* policy and procedure (#CM/12, 11/03) also addresses procedures for obtaining benefits, including authorization requirements.

Element 6.7 – The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.
This element is met.

The extent to which beneficiaries obtain benefits, including family planning services, from out-of-network providers is documented in HSCSN's Parent and Member Guide. A network provider is not needed for family planning services.

Element 6.8 – The extent to which, and how, after-hours and emergency coverage is provided, including what constitutes an emergency medical condition, emergency services, and post-stabilization services (with reference to the definitions in 438.114).
This element is met.

The extent to which, after-hours and emergency coverage is provided, and how, are documented in HSCSN's Parent and Member Guide. Beneficiaries are encouraged to work with their Care Manager in coordinating their care; however, in an emergency, beneficiaries are instructed to call 911 or go to the nearest emergency room. Examples of emergencies are provided on page 20 of the Parent and Member Guide. If the beneficiary is not sure if the problem calls for a visit to the emergency room, he or she is instructed to call the PCP for advice. The PCP and Care Manager should be notified as soon as possible after the beneficiary has received care and/or has been stabilized.

Element 6.9 – The fact that pre-authorization is not required for emergency services
This element is met.

Pre-authorization is not required for emergency services. As noted in HSCSN's Parent and Member Guide, in some special situations a beneficiary does not have to use a network provider, such as in an emergency. If life or health is in serious danger, beneficiaries are advised to call 911 or go to the nearest emergency room.

Element 6.10 – The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.
This element is met.

The process and procedures for obtaining emergency services, including the use of the 911 telephone system, are documented in HSCSN's Parent and Member Guide. In an emergency, beneficiaries are instructed to call 911 or go to the nearest emergency room. If the beneficiary is not sure if the problem calls for a visit to the emergency room, he or she is instructed to call the PCP for advice and to notify the PCP as soon as possible after receiving care and/or being stabilized.

Element 6.11 – The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
This element is met.

Locations of emergency settings at which providers and hospitals furnish emergency and post-stabilization services are provided in the MCO's Provider Directory. The addresses and phone numbers of hospitals are listed in the directory.

Element 6.12 – The fact that enrollees have the right to use any hospital or other setting for emergency care.
This element is met.

Beneficiaries have the right to use any hospital or other setting for emergency care. As evidenced in HSCSN's Parent and Member Guide, if life or health is in serious danger, beneficiaries are instructed to go to the nearest emergency room or call 911.

Element 6.13 – The MCOs policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
This element is met.

The MCO's policy on referrals for specialty care and for other benefits not furnished by the beneficiary's PCP is explained in HSCSN's Parent and Member Guide. If needed, the PCP will refer the beneficiary to a specialist. The HSCSN Care Manager works with the beneficiary and the PCP's office to make an appointment with a specialty care provider. The *Referral Process* policy and procedure (#CM/12, 11/03) also addresses referrals for specialty care.

Element 6.14 – Cost sharing, if any
This element is N/A.

There is no cost sharing for beneficiaries enrolled in the DC MAA Managed Care Program.

Element 6.15 – How and where to access any benefits that are available under the State plan, but are not covered under the current contract.
This element is met.

HSCSN's Member Handbook notes that HSCSN "provides all services that DC Medicaid fee-for-service does. HSCSN also has additional benefits that meet the needs of children/young people with special needs and their families." All benefits are listed on pages 52 through 62 of the Member Handbook.

ER7.0 – 438.10(g)(1)(i)–(vii) Information Requirements
MCOs must provide grievance, appeal, and fair hearing information to their enrollees. Grievance, appeal, and fair hearing procedures must be in a State-developed or State-approved description, that must include the following:
This standard is met.

Element 7.1 – Grievances, appeal, and fair hearing procedures.
This element is met.

The MCO describes procedures for filing grievances, appeals, and fair hearings in HSCSN's Parent and Member Guide. Pertinent addresses and phone numbers are provided to the beneficiary, along with a step-by-step timeline for the MCO's responses. This information is also addressed in the policy, *Concern Complaint* and *Grievance* (#QM/11, 6/04).

Element 7.2 – The State Fair Hearing process to include the right to a hearing, the method for obtaining a hearing and the rules that govern representation at the hearing.
This element is met.

The Fair Hearing process is described in HSCSN's Parent and Member Guide. The method for obtaining a hearing and the rules that govern representation at the hearing are also addressed in the *Grievance* policy and procedure (#QM/11, 6/04).

Element 7.3 – The right to file grievances and appeals.
This element is met.

The right to file grievances and appeals is described in HSCSN's Parent and Member Guide. The process is outlined in steps. The MCO also covers this information in its *Grievance* policy and procedure (#QM/11, 6/04).

Element 7.4 – The requirements and time frames for filing a grievance or appeal.
This element is met.

Requirements for filing grievances and appeals are described in HSCSN's Parent and Member Guide. Time frames for filing a grievance or appeal are documented in the *Grievance* (#QM/11, 6/04) policy and procedure. In order to receive a met on subsequent reviews, beneficiary time frames for filing should also be included in the Parent and Member Guide.

Element 7.5 – The availability of assistance in the filing process.
This element is met.

The availability of assistance in the filing process is documented in HSCSN's Parent and Member Guide. The beneficiary or parent may call Member Services to request assistance with filing.

Element 7.6 – The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
This element is met.

In the section of the Parent and Member Guide that addresses grievances and appeals, a local phone number is provided as a contact number. However, in the introduction of the Parent and Member Guide, a toll-free number is provided for beneficiaries out of the area. In order to receive a finding of met in subsequent reviews, the MCO must include this toll-free number where grievances and appeals are addressed and discussed.

Element 7.7 – The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the time frames specified for filing;
This element is met.

Benefits will continue if the beneficiary files an appeal or a request for a District Fair Hearing. The Parent and Member Guide states that all benefit services will continue until a final resolution is made.

Element 7.8 – That the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
This element is met.

The Parent and Member Guide states that any services that are already being provided at the time of the request for an appeal will continue to be paid until a final decision is made.

Element 7.9 – Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
This element is met.

The Parent and Member Guide states that a provider, acting on behalf of the beneficiary and with the beneficiary's written consent, may file an appeal. The provider appeal process is also addressed in the Provider Participation Agreement, under Professional Responsibility (section 9.2).

ER8.0 – 438.114 Emergency and Post-Stabilization Services 438.10(g)(2)
The MCO must address advance directives. The MCO must:
This standard is partially met.

Element 8.1 – Have written policies and procedures concerning advance directives. (417.436(d)).
This element is partially met.

HSCSN addresses advance directives in the MCO's Parent and Member Guide, starting on page 34. In order to receive a finding of met in subsequent reviews, the MCO should have, in addition to the discussion in the Parent and Member Guide, a policy addressing advance directives.

In order to meet the full intent of this element, HSCSN must develop and implement and advance directive policy and procedure.

Element 8.2 – Provide all adult enrollees with written information on advance directives policies, and include a brief description of applicable State law. (438.6(i)(2))
This element is met.

HSCSN provides beneficiaries with written information on advance directives in their Parent and Member Guide. The information covered includes a brief description of the applicable District law.

Element 8.3 – Provide information to individuals concerning their rights under the State law to make decisions concerning medical care including the right to accept or refuse medical treatment and the right to formulate advance directives.
This element is met.

HSCSN provides information to beneficiaries concerning their rights to make decisions about medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives. The rights to participate in decision making, refuse treatment, and receive information on advance directives are described in the Parent and Member Guide.

Element 8.4 – Provide its written policies respecting the implementation of the right to make decisions regarding care and the right to formulate an advance directive.
This element is partially met.

The plan provides information on respecting the beneficiary's right to make decisions regarding care and the right to formulate an advance directive. This is covered in HSCSN's Parent and Member Guide. In order to receive a finding of met in subsequent reviews, in addition to addressing advance directives in the Parent and Member Guide, the MCO should have a policy that addresses the subject.

In order to meet the full intent of this element, HSCSN must develop and implement an advance directive policy and procedure. This policy must include the beneficiary right to make decisions regarding care and the right to formulate an advance directive.

Element 8.5 – Provide for the education of staff concerning its policies and procedures on advance directives.
This element is met.

The plan has provided for education of staff concerning its policies and procedures on advance directives. A New Employee Orientation/Re-Orientation Agenda was provided, as well as a sign-in sheet (dated September 26, 2005) covering the education on Advance Directives.

ER9.0 – Enrollee Information Requirements
This standard is met.

Element 9.1 – 438.10(g)(3) and 438.
Information must be provided to all enrollees, upon request, regarding the structure and operation of the MCO, physician incentive plans (as set forth in § 438.6(h)), and, to the extent available, quality and performance indicators, including but not limited to disenrollment rates and enrollee satisfaction.
This element is met.

Upon request, information about the MCO is provided to beneficiaries. This is addressed in the Parent and Member Guide and in the *Member Rights and Responsibilities* policy and procedure (#MS/10). Beneficiaries have the right to receive information about the plan, its services, and its care providers. Information requested can relate to the structure and operation of the plan, physician incentive plans, and quality and performance indicators, including disenrollment rates and enrollment satisfaction.

ER10.0 – 438.106 (a)–(c) Non-Liability of Enrollee
The MCO must provide that its Medicaid enrollees are not held liable for any of the following:
This standard is met.

Element 10.1 – The MCO's debts in the case of the entity's insolvency.
This element is met.

The plan demonstrates in the Provider Participation Agreement under Reimbursement and Billing, Hold Harmless (section 6.2), that the beneficiaries are not held liable for the plan's debts in the case of the entity's insolvency.

Element 10.2 – Covered services provided to the enrollee, for which the State does not pay the MCO or does not pay the individual health care provider that furnished the services under a contractual, referral, or other arrangement.
This element is met.

The plan demonstrates in the Provider Participation Agreement under Reimbursement and Billing, Hold Harmless (section 6.2), that the beneficiaries are not held liable for covered services provided, for which DC MAA does not pay the plan or does not pay the individual health care provider that furnished the services under a contract, referral, or other arrangement.

Element 10.3 – Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would pay if the MCO provided the services directly.
This element is met.

HSCSN demonstrates in the Provider Participation Agreement under the Reimbursement and Billing, Hold Harmless (section 6.2), that the beneficiaries are not held liable for payment for covered services.

ER11.0 – 438.102 Provider-Enrollee Communications

An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient for the following:

This standard is met.

Element 11.1 – The enrollee's health status, medical care or treatment options including any alternative treatment that may be self-administered

This element is met.

HSCSN does not prohibit or restrict the health care professional from advising or advocating on behalf of a beneficiary in regard to that beneficiary's health status, medical care, or treatment options. This is documented in the Provider Participation Agreement under Professional Responsibility (section 9.2).

Element 11.2 – Any information the enrollee needs in order to decide among all relevant treatment options.

This element is met.

The MCO does not prohibit or restrict any information the beneficiary needs in order to decide among all relevant treatment options. This is addressed in the Provider Participation Agreement under Professional Responsibility (section 9.2).

Element 11.3 – The risks, benefits, and consequences of treatment or non-treatment.

This element is met.

HSCSN does not prohibit or restrict the health care professional from advising the beneficiary about the risks, benefits, and consequences of treatment or non-treatment. This is addressed in the Provider Participation Agreement under Professional Responsibility (section 9.2).

Element 11.4 – The enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatments, and to express preferences about future treatment decisions.

This element is met.

The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatments, and to express preferences about future treatment decisions is described in the Parent and Member Guide. This is also a part of the *Member Rights and Responsibilities* policy and procedure (#MS/10, 6/04).

Grievance Systems

GS1.0 – Documented Processes for Grievances, Appeals and State Fair hearings
This standard is met.

Element 1.1 – 438.402(a)
Each MCO must have a documented system in place for enrollees that includes a grievance process, an appeal process, and access to the State's Fair Hearing system.
This element is met.

HSCSN has a *Concerns and Complaints* policy (#QM/12, 6/04), a *Grievance* policy (#QM/11, 6/04), and a Notification of Denial and Expedited Appeal (#CM/18, 10/05) policies and procedures in place. These policies and procedures address access to the District Fair Hearing process.

GS2.0 – 438.402(b)(1)
The policies and procedures must allow for:
This standard is met.

Element 2.1 – An enrollee to file a grievance, file an MCO level appeal, and may request a State fair hearing.
This element is met.

HSCSN has a Grievance policy and procedure (#QM/11, revised 6/04). This policy outlines the appeal process in Article IX and states that "all members and providers are informed of their right to request an Administrative Hearing with the Office of Administrative Hearings, DC Department of Health and Human Services, at any time in their grievance process."

Element 2.2 – A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.
This element is met.

HSCSN's Grievance policy and procedure (#QM//11, revised 6/04), allows a provider who "supports or assists" a member to file a formal grievance and appeal. The Summary section of the policy notes that "A provider acting on behalf of the beneficiary and with the beneficiary's written consent may file an appeal.

Element 2.3 – A provider to file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.
This element is met.

HSCSN's Grievance policy and procedure (#QM/11, revised 6/04), notes that providers can file a grievance or an appeal, and states that "all members and providers are informed of their right to request an Administrative Hearing with the Office of Administrative Hearings."

GS3.0 – 438.402(b)(2)
The MCO policies and procedures specify a reasonable time frame that may be no less than 20 days and not to exceed 90 days from the date on the MCO's notice of action. Within that time frame—
This standard is met.

Element 3.1 – The enrollee or the provider may file an appeal; and
This element is met.

Article IX, of HSCSN's *Grievance* policy and procedure (#QM/11, revised 6/04), states that "all parties are entitled to appeal the recommended decision of the Grievance Hearing Committee to the CEO and/or the Board by filing a written appeal within 30 days of notice of the recommended decision of the Grievance Committee."

Element 3.2 – In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.
This element is met.

HSCSN's *Grievance* policy and procedure (#QM/11, revised 6/04) addresses the various levels of appeal. In the policy and procedure it is noted that beneficiaries can file for a District Fair Hearing at any point in the grievance and appeal process.

GS4.0 – 438.402(b)(3)
The MCO procedures for filing must state that the enrollee:
This standard is met.

Element 4.1 – May file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO.
This element is met.

HSCSN's *Grievance* policy and procedure (#QM/11, revised 6/04), allows for beneficiary grievances and appeals to be filed orally or in writing.

Element 4.2 – Or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.
This element is met.

Section II.A. of the *Grievance* policy and procedure (#QM/11, revised 6/04), states that a grievance or appeal can be filed by a member or provider to HSCSN or the Medical Assistance Administration either orally or in writing for further consideration. It further states that "unless the member requests an expedited resolution, oral grievances shall be followed by a signed written appeal within 10 days following the oral request, unless resolved in such 10 day period."

GS5.0 – Language and Format Requirements
This standard is partially met.

Element 5.1 – 438.404, 438.404(a) Notice of Action – Language and format requirements
The notice must be in writing and must meet language and format requirements.
This element is partially met.

The Notices of Action (NOAs) that were used in the calendar year 2005 included language that was not at the required fifth grade level and the decision was not always clearly stated. Discussion with the staff noted that the NOAs were currently being revised to meet this standard.

In order to meet the full intent of this standard, HSCSN will be required to demonstrate that the revised NOAs meet DC Medical Assistance Administration (DC MAA) contractual requirements of a fifth grade reading level.

GS6.0 – 438.404(b) Content of the Notice of Action (NOA)
The notice must explain the following:
This standard is partially met.

Element 6.1 – The action the MCO or its contractor has taken or intends to take.
This element is met.

The template of the NOA letters sent to beneficiaries for all denials includes the action(s) the MCO has taken or intends to take according to the requirements.

Element 6.2 – The reasons for the action
This element is met.

The template NOA letters include the reasons for the actions taken or to be taken. The *Notification of Denial and Expedited Appeal* policy and procedure (#CM/18, 10/05), Section III.A., requires that the denial letter documentation include "the reason for the denial detailed sufficiently to allow for the practitioner, facility or beneficiary to understand the reason for denial." Template and actual denial letters reviewed included an adequate description of the reason for denials issued.

Element 6.3 – The enrollee's or the provider's right to file appeal.
This element is met.

Section III.A.d. of the *Notification of Denial and Expedited Appeal* policy and procedure (#CM/18, 10/05) requires beneficiaries and providers to be provided with information on how to file an appeal in the denial letter. The template and actual case denial letters reviewed include this right and the process on how to file an appeal.

Element 6.4 – If the State does not require the enrollee to exhaust the MCO level appeal procedures, the enrollee's right to request a State fair hearing.
This element is met.

The actual denial case files reviewed contained NOAs that stated the beneficiary's right and procedure to request a District Fair Hearing. Although this element does not require the plan procedure to outline the NOA requirements, it is recommended that they be included in HSCSN's *Notification of Denial and Expedited Appeal* policy and procedure to assure that this information remains in the NOAs. This element is met because the required information is included in the NOAs as required by the element.

Element 6.5 – The procedures for exercising the rights specified in this paragraph.
This element is met.

The *Notification of Denial and Expedited Appeal* policy and procedure (#CM/18, 10/05) and the *Grievance* policy and procedure (#QM/11, 6/04) outline the process for filing grievances, appeals, and District Fair Hearings.

Element 6.6 – The circumstances under which expedited resolution is available and how to request it.
This element is not met.

Section II.D.4 of the *Notification of Denial and Expedited Appeal* policy and procedure (#CM/18, revised 3/05 and 10/05) states that "expedited appeal occurs when a question in regard to dissatisfaction with the response to a request for urgent care is a first-level reconsideration determination (formal first-level review) of an acute care denial." The ordering physician is requested to provide pertinent information to HSCSN's Physician Advisor who is an appropriate specialist and not involved in the initial decision, to determine if the service will be covered. The decision will be made within 72 hours."

Section IV.D. of the *Notification of Denial and Expedited Appeal* policy and procedure (#CM/18, 10/05), states that "HSCSN will perform an expedited appeal for urgent care services within seventy-two hours of the request. This includes admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility." It does not explain how to request an expedited resolution.

This policy and procedure does not clearly outline the process for expedited appeals. Discussions with the UM and the Medical Director confirmed that the policy and procedure are not clear. However, the staff was able to verbalize the process and demonstrate through documentation that expedited appeals are accepted and processed.

This element explicitly requires the MCO to include circumstances under which expedited review is available and how to request it. This was not included in any of the NOAs provided for review.

In order to meet the full intent of this element, HSCSN must clearly define its expedited review process and assure that it is included in the NOAs sent to the beneficiaries.

Element 6.7 – The enrollee's right to have benefits to continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
This element is partially met.

Section IV.D. *Notification of Denial and Expedited Appeal* policy and procedure, entitled Procedure, notes that while the beneficiary's appeal is pending, the beneficiary's benefits shall continue until one of the following occurs:

- The beneficiary withdraws the appeal;
- Sixty days pass after HSCSN has mailed the notice, providing the resolution of the appeal to the Beneficiary. Unless the Beneficiary, within the 60-day time frame, has requested a District Administrative Hearing and a decision is reached;
- The District Office of Administrative Hearings issues a hearing decision adverse to the beneficiary; or

- The time period or service limits of a service have been met.

Although this is included in the policy and procedure, the NOAs do not give the beneficiary notice of his/her right to have benefits continue during an appeal. Because the information is not provided in the NOA as required by the element, this element is partially met.

In order to meet the full intent of this element, HSCSN must assure that the NOAs to beneficiaries include their right to have their benefits continue during the appeal and explain how to request that benefits be continued.

GS7.0 -§ 438.210(d) Timeframe for decisions for standard authorizations
For standard service authorization decisions that deny or limit services, decisions must be made within the time frame specified in § 438.210(d). The MCO, policies, procedures and practices must require the following timeframes for decisions:
This standard is not met.

Element 7.1 – For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither document addressed the requirement for the plan to provide notice as expeditiously as the beneficiary's health condition requires and within District-established time frames that may not exceed 14 calendar days following receipt of the request for service.

In order to meet the full intent of this element, HSCSN must address the requirement to provide notice as expeditiously as the beneficiary's health condition requires and within DC MAA–established time frames.

Element 7.2 – Possible extensions of the 14 calendar day timeframe are allowed if the enrollee, or the provider, requests extension; or
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither document addressed the

requirement to allow possible extensions of the 14-calendar-day time frame at the request of a beneficiary or provider.

In order to meet the full intent of this element, HSCSN's policies and procedures must allow possible extensions at the request of the beneficiary or provider.

Element 7.3 – Possible extensions of the 14 calendar day timeframe are allowed if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither document addressed the requirement to allow the plan the possible extensions of the 14-calendar-day time frame if the extension is in the beneficiary's best interest.

In order to meet the full intent of this element, HSCSN's policies and procedures must allow possible extensions at the request of the plan if it is in the best interest of the beneficiary.

GS8.0 – 438.210 and 438.404(c)(4) Expedited Authorization Decisions.
For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision.
This standard is not met.

Element 8.1 – The MCO must have an expedited authorization process policy and procedures in place**.**
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither of these documents includes an expedited authorization process.

In order to meet the full intent of this element, HSCSN must develop and implement a process for expedited authorizations.

Element 8.2 – The procedures and practices require that the MCO provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither of these documents includes procedures and practices requiring that the plan provide notice as expeditiously as the beneficiary's health condition requires and no later than three working days after receipt of the request for service.

In order to meet the full intent of this element, HSCSN must develop and implement procedures to assure that the plan provide notice as expeditiously as the beneficiary's health condition requires and not later than three days after receipt of request for service.

Element 8.3 – The MCO may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP,…justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither of these documents includes procedures and practices to ensure that the plan may extend the three-working-day time period by up to 14 calendar days if the beneficiary requests an extension, or if the MCO justifies a need for additional information and how the extension is in the beneficiary's interest.

In order to meet the full intent of this element, HSCSN must develop and implement procedures to ensure that the plan can extend the three-working-day time frame with justification.

Element 8.4 – If an extension is granted, the MCO policies and procedures must require the MCO to provide written notice to the enrollee of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither of these documents includes procedures and practices to require the plan to provide written notice to the beneficiary of the reason for

the decision to extend the time frame and to inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.

In order to meet the full intent of this element, HSCSN must develop and implement procedures to require the plan to provide written notice to the beneficiary of the reason for the decision to extend the timeframe and to inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.

Element 8.5 – The policy and procedures must require that in cases of extensions, the MCO will issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
This element is not met.

The Utilization Management Plan (#UM/03, 1/05) and the Authorization of Health Services (#CM/02, 12/05) were reviewed to assess compliance with this element. Neither of these documents includes procedures and practices to require that in cases of extensions, the plan will issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

In order to meet the full intent of this element, HSCSN must develop and implement procedures to require that in cases of extensions, the plan will issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

GS9.0 – 438.406.(a)(1)-(3) Handling of Grievances and Appeals
In handling grievances and appeals, the MCO must:
This standard is met.

Element 9.1 – Give enrollees any reasonable assistance in completing forms and taking other procedural steps.
This element is met.

Article E. of the *Grievance* policy (#QM/11, 6/04) notes that HSCSN shall provide reasonable assistance, but not legal representation, to beneficiaries or any provider who supports or assists the beneficiary, upon request, in completing and filing forms and in other procedural matters.

Element 9.2 – Acknowledge receipt of each grievance and appeal.
This element is met.

Article III.3. of the Process Section of the *Grievance* policy (#QM/11, 6/04), states that "The Medical Director or designee will acknowledge the receipt of the documentation in writing, within one business day."

Element 9.3 – Ensure that individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.
This element is met.

Article IV.B. of the Appointment of Grievance Committee section of the *Grievance* policy (#QM/11, 6/04), states that "None of the Committee members shall be individuals who actively participated in the consideration of the matter involved at any previous level."

Element 9.4 – Ensure that health care professionals who have the appropriate clinical expertise in treating the enrollees condition or disease are involved in the decision making process.
This element is met.

The Utilization Management Plan (#UM/03, 1/05) states that "HSCSN Utilization Reviewers, Care Managers and Care Manager Associates comprise the staff performing Utilization Management activities. The positions are filled by nurses, social workers and team members with a bachelor's degree in health related sciences, or the equivalent thereof, per Human Resource guidelines. Persons performing inpatient utilization are licensed personnel in Nursing and Social Work.

The Utilization Reviewer works collaboratively with the Care Coordination department to ensure that HSCSN beneficiaries are receiving the appropriate level of care." In addition, the Utilization Management Plan also states that "the authority to issue denials for services is limited to the Medical Director, the Director of Behavioral Health and Physician Advisors."

GS10.0 – 438.406 (b) (1)–(4)
The policies and procedures for appeals must:
This standard is partially met.

Element 10.1 – Provide that oral inquiries seeking to appeal an action are treated as appeals and must be confirmed in writing, unless the enrollee or provider requests expedited resolution.
This element is met.

Article IX, Appeals, of the *Grievance* policy (#QM/11, 6/04) states that "Oral inquiries seeking to appeal an action are treated as appeals and must be confirmed in writing, unless parties request expedited resolution."

Element 10.2 – Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
This element is met.

Article IX, Appeals, of the *Grievance* policy (#QM/11, revised 6/04) outlines the process for a hearing. This process allows beneficiaries to present evidence, provide witnesses, and be able to have representation from an attorney and provide a written statement at the close of the hearing. It specifically states that "Parties are provided a reasonable opportunity to present evidence, and allegations of fact or law in person as well as in writing."

Element 10.3 – Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
This element is met.

Article IX, Appeals, of the *Grievance* policy (#QM/11, revised 6/04) states that "The complainant or representative is given the opportunity to examine the case file, before or during the appeals process, including medical records and any other documents/records considered during this process."

Element 10.4 – Include, as parties to the appeal, the enrollee and his or her representative, or the legal representative of a deceased enrollee's estate.
This element is partially met.

The *Grievance* policy (#QM/11, revised 6/04) includes beneficiaries and their representatives as parties to the appeal. The policy does not address the legal representative of a deceased beneficiary's estate.

In order to meet the full intent of this element, HSCSN policies must include and allow the legal representative of a deceased beneficiary's estate to act as a party to an appeal.

GS11.0 – § 438.408 and (b)(1)–(3) Resolution and Notification: Grievances and Appeals
The MCO or PIHP must dispose each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established time frames that may not exceed time frames specified in this section.
This standard is partially met.

Element 11.1 – For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State, but may not exceed 90 days from the day the MCO receives the grievance.
This element is met.

Article VII of the *Grievance* policy (#QM/11, 6/04) states that "Within 14 days after the filing of the grievance, the Grievance Committee shall conduct its deliberations and shall render a recommendation."

Element 11.2 – Standard resolution of appeals.
For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO receives the appeal. This timeframe may be extended under paragraph (c) of this section.
This element is partially met.

Article X.B. of the *Grievance* policy (#QM/11, 6/04) states that for appeals, "The CEO or the Board's decision including a statement of the basis for the decision shall be communicated to all parties by certified mail within five business days."

This section of the policy does not note whether or not the five business days is from the time the appeal was filed or resolved. In addition, the policy does not address time frame extensions for the appeal process.

In order to meet the full intent of this element, HSCSN must clarify the time frames for the standard resolution of appeals and must address time frame extensions.

Element 11.3 – Expedited resolution of appeals. For expedited resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO receives the appeal. This timeframe may be extended under paragraph (c) of this section.
This element is partially met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) states that "HSCSN will perform an expedited appeal for urgent care services within 72 hours or request. This includes admissions,

continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility."

This policy and procedure does not address the availability to extend time frames for expedited appeals.

In order to meet the full intent of this element, HSCSN must include the ability of the plan to extend the timeframes for resolution.

GS12.0 – 438.408(c)(1) Extensions
The MCO policies and procedures can allow for the extension of timeframes. The MCO may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:
This standard is partially met.

Element 12.1 – The enrollee requests the extension; or
This element is partially met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. The *Grievance* policy (#QM/11, 6/04) notes that the "14 business day time period may be extended by up to 14 days if in the best interest of the member." It does not address the requirement that a beneficiary be entitled to request the extension.

In order to meet the full intent of this element, HSCSN must include the right of and process for a beneficiary to request an extension.

Element 12.2 – The MCO shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
This element is partially met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. The *Grievance* policy (#QM/11, 6/04) notes that the "14 day business day period may be extended by up to 14 days if in the best interest of the member." It does not address the requirement that the plan must justify that there is a need for additional information and explain how the delay is in the beneficiary's interest.

In order to meet the full intent of this element, HSCSN must include in its policies the requirement that the plan must justify that there is a need for additional information and explain how the delay is in the beneficiary's interest

GS13.0 – Extension Requirements
This standard is not met.

Element GS13.1 – 438.408(c)(2) Requirements following extension
If the MCO extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these documents addresses the written notice requirement.

In order to meet the full intent of this element, HSCSN must include in its policies and procedures a provision that the beneficiary must be given written notice of any time frame extension that the beneficiary did not request.

GS14.0 – Format of Resolution of Notice
This standard is met.

Element 14.1 – 438.408(d)(1) Format of notice – Grievance Resolution
The MCO will notify the enrollee of the disposition of the grievance.
This element is met.

Article XI of the *Grievance* policy (#QM/11, 6/04) outlines what must be included in the NOA that is delivered to all parties. The enrollee and provider are notified of the outcome of the grievance.

GS15. 0 – 438.408(d)(2) (2) Notification of the Outcome of Appeals.
Enrollees must be notified of the outcome of appeals.
This standard is met.

Element 15.1 – For all appeals, the MCO must provide written notice of disposition.
This element is met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Article XI of the *Grievance* policy (#QM/11, 6/04) outlines what must be included in the NOA's content that is delivered to all parties. It is assumed,

on the basis of standard templates for NOAs that were provided for review, that this is "delivered" in the form of written notice.

Although this element is met, it is recommended that HSCSN include the requirement for written notice to the beneficiary or his/her representative in its policies and procedures.

Element 15.2 – For notice of expedited resolution, the MCO must also make reasonable efforts to provide oral notice.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither document addressed the requirement to make reasonable efforts to provide oral notice in the case of expedited appeal.

In order to meet the full intent of this element, HSCSN must make reasonable efforts to provide oral notice for expedited resolutions. This must be included in the *Notification of Denial and Expedited Appeal* policy.

GS16.0 – 438.408(e)(1) Content Of Notice of Appeal Resolution.
The written notice of the resolution must include the following:
This standard is met.

Element 16.1 – The results of the resolution process.
This element is met.

The template NOAs provided for review included the results of the resolution process. The sample denial and appeal cases reviewed as part of the CY 2005 review included NOAs that provided the documentation of the results of the resolution process.

Element 16.2 – The date it was completed.
This element is met.

The date of completion was noted as a field in the template NOAs provided for review. The sample denial and appeal cases reviewed as part of the CY 2005 review included NOAs that included the dates the cases were completed.

GS17.0 -438.408(e)(2) Content of Notice of Appeal Resolution.
The written notice of the resolution must include the following for appeals not resolved wholly in favor of the enrollee.
This standard is partially met.

Element 17.1 – The right to request a State fair hearing, and how to do so,
This element is met.

The beneficiary's right to request a District Fair Hearing was included in the template NOAs provided for review and in the NOAs reviewed as part of the appeals and denial sample for CY 2005.

Element 17.2 – The right to request to receive benefits while the hearing is pending, and how to make the request; and
This element is not met.

This information was not included in the template NOAs provided for review or included in the actual NOAs in the denials and appeals files reviewed as part of the appeals and denials sample for CY 2005.

In order to meet the full intent of this element, HSCSN must include in its NOAs the right to request to receive benefits while the hearing is pending and how to make the request.

Element 17.3 – That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.
This element is not met.

In accordance with HSCSN's contract with DC MAA (contract modification 8), an enrollee will not be held liable for the cost of benefits received during an appeal even if the decision upholds the plan's action. Therefore, the NOAs must state that HSCSN in not permitted to recoup costs of benefits provided during the appeal.

In order to meet the full intent of this element, HSCSN must state in its NOAs that beneficiaries will not be held liable for the cost of benefits even if the hearing upholds the plan's decision.

GS18.0 – Resolution of Expedited Appeals
This standard is partially met.

Element 18.1 – 438.410(a) § 438.410 Expedited resolution of appeals.
The MCO must have a documented expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
This element is partially met.

The Notification of Denial and Expedited Appeal policy (#CM/18, 10/05) and the Grievance policy (#QM/11, 6/04) were reviewed to assess compliance with this element. These policies and procedures briefly mention that expedited appeal is available, but they do not thoroughly outline the procedure. However, the Notification of Noncertification Decision letter (page 14 of the Notification of Denial and Expedited Appeal Policy) states that expedited appeal is available and that "if you or your physician feels that the non-certification of the requested service will seriously jeopardize your health, and the services are imminent or ongoing, you, your authorized representative, or your physician may request expedited appeal."

In order to meet the full intent of this element, HSCSN must detail the expedited appeal process in the appropriate documents and must define the cases in which expedited appeal can be requested.

GS19.0 – Punitive Action
This standard is partially met.

Element 19.1 – 438.410(b) Punitive Action.
The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
This element is partially met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these two documents addresses this element. However, the *Grievance* policy does not state that there are no penalties for filing a grievance.

In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies that punitive action is not to be taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

GS20.0 – 438.410(c)(1)–(2) Action Following Denial of a Request for Expedited Resolution.
If the MCO denies a request for expedited resolution of an appeal, it must assure that its policies and procedures require:
This standard is not met.

Element 20.1 – Transfer of the appeal to the timeframe for standard resolution.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these documents addresses the transfer of an expedited appeal to the standard resolution time frame.

In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies and procedures the process used to transfer an expedited appeal to the standard resolution time frame.

Element 20.2 – Prompt oral notice to the enrollee of the denial, and follow up within 2 calendar days with a written notice.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the Grievance policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these documents addresses the prompt oral notice to the beneficiary of the denial and required follow-up within two calendar days with a written notice.

In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies and procedures the process used to provide prompt oral notice to the beneficiary of the denial and required follow-up within two calendar days with a written notice.

GS21.0 – Provision of Grievance System Information
This standard is met.

Element 21.1 – 438.414
The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.
This element is met.

The complaint, grievance, and appeal process is contained in the HSCSN Provider Manual. Providers are also informed of the availability of the grievance process at the time of provider orientation.

GS22.0 – Record Keeping and Reporting of Grievances
This standard is met.

Element 22.1 -438.416 Recordkeeping and reporting requirements.
The MCOs must maintain records of grievances and appeals and provide reports to the State.
This element is met.

HSCSN must provide quarterly and ad hoc reports to the DC MAA. These reports contain aggregate numbers on complaints, grievances, and appeals. According to staff, these quarterly reports have been provided to the DC MAA as required.

GS23.0 – 438.420(b) Continuation of Benefits
The MCO must continue the enrollee's benefits if:
This standard is not met.

Element 23.1 – The enrollee or the provider files the appeal timely
This element is not met.

Article IV.H. entitled Procedure, in the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) outlines instances when beneficiary benefits will be continued. This section of the policy does not address this element.

In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the plan will continue beneficiary benefits if the beneficiary or the provider files the appeal timely.

Element 23.2 – The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
This element is not met.

Article IV.H. entitled Procedure, in the *Notification of Denial and Expedited Appeal policy* (#CM/18, 10/05)outlines instances when beneficiary benefits will be continued. This section of the policy does not address this element.

In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the plan will continue beneficiary benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

Element 23.3 – The services were ordered by an authorized provider
This element is not met.

Article IV.H. entitled Procedure, in the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) outlines instances when beneficiary benefits will be continued. This section of the policy does not address this element.

In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the plan will continue beneficiary benefits if the services were authorized by an authorized provider.

Element 23.4 – The original period covered by the original authorization has not expired
This element is not met.

Article IV.H. entitled Procedure, in the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) outlines instances when beneficiary benefits will be continued. This section of the policy does not address this element.

In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the plan will continue beneficiary benefits if the original period covered by the original authorization has not expired.

Element 23.5 – The enrollee requests an extension of benefits
This element is not met.

Article IV.H. entitled Procedure, in the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) outlines instances when beneficiary benefits will be continued. This section of the policy does not address this element.

In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the plan will continue beneficiary benefits if the beneficiary requests an extension of benefits.

GS 24.0 – 438.420(c) Duration of Continued or Reinstated Benefits
If, at the enrollee's request, the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
This standard is partially met.

Element 24.1 – The enrollee withdraws the appeal.
This element is met.

Article IV.H. of the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05), states that "while the member's appeal is pending," the member's benefits shall continue until "the enrollee withdraws the appeal."

Element 24.2 – Ten days pass after the MCO mails the notice, providing the resolution of the appeal against the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
This element is partially met.

Article IV.H. of the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05), states that "while the member's appeal is pending, the member's benefits shall continue until "60 days pass after HSCSN has mailed the notice, providing resolution to the Member. Unless the Member, within the 60 day time frame, has requested a District Administrative Hearing with continuation of benefits until a District Administrative Hearing decision is reached."

In order to meet the intent of this element this procedure must be revised to be consistent with the time frames in this element.

Element 24.3 – A State fair hearing office issues a hearing decision adverse to the enrollee.
This element is met.

Article IV.H. of the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05), states that while the beneficiary's appeal is pending, the beneficiary's benefits shall continue until "The District Office of Administrative Hearing issues a hearing decision adverse to the member."

Element 24.4 – The time period or service limits of a previously authorized service have been met.
This element is met.

Article IV.H. of the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) states that while the beneficiary's appeal is pending, the beneficiary's benefits shall continue until "the time period or service limits of a service has been met."

GS25.0 – Enrollee Responsibility for Services During Appeal
This standard is met.

Element 25.1 – 438.420(d) Enrollee responsibility for services furnished while the appeal is pending.
If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of section 431.230.
This element is met.

In accordance with HSCSN's contract with DC MAA (contract modification 8), an enrollee will not be held liable for the cost of benefits received during an appeal even if the decision upholds the MCOs action. Therefore, the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05), which states that "If the final resolution of the appeal is adverse to the Member, HSCSN will not recover payment for continuation of benefits furnished during the pending appeal," meets the intent of this element.

GS26.0 – Services Not Furnished During Appeal
This standard is not met.

Element 26.1 – §438.424(a).Services not furnished while appeal is pending.
If the MCO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these two documents addresses this element.

In order to meet the full intent of this element, HSCSN must include in its appeal policies the requirement that if the District Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the plan must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

GS27.0 – Services Furnished During Appeal
This standard is not met.

Element 27.1 – §438.424 (b) Services furnished while the appeal is pending.
If the MCO, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations.
This element is not met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) and the *Grievance* policy (#QM/11, 6/04) were reviewed to assess compliance with this element. Neither of these two documents addresses this element.

In order to meet the full intent of this element, HSCSN must include in its policies that if the plan or the District Fair Hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the plan or the DC MAA must pay for those services, in accordance with District policy and regulations.

GS28.0 – Fraud and Abuse Detection (from DC MAA Contract Provisions)
H8.3.1.1–1.9 Fraud and Abuse Compliance Plan
The contractor must have a written Fraud and Abuse Compliance Plan. This plan must include the following provisions:
This standard is met.

Element 28.1 – The MCO shall ensure that all officers, directors, managers and employees know and understand the provisions of the fraud and abuse compliance plan.
This element is met.

HSCSN conducted a fraud, waste, and abuse training session for its staff in 2005. Sign-in sheets were provided to document attendance at this meeting.

Element 28.2 – The written plan shall contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract
This element is met.

The Corporate Compliance Program (#AD/16, dated 3/8/04) and the *Compliance Investigations* policy (#QM/16, 9/04) establish the procedures designed by HSCSN to prevent and detect potential or suspected abuse and fraud.

Element 28.3 – The plan shall contain provisions for the confidential reporting of plan violations to the designated person (e.g., MCO Fraud and Abuse Compliance Officer or hotline)
This element is met.

Section G of the Corporate Compliance Plan (#AD/16, dated 3/8/04), notes that employees can report violations to their supervisor, the Compliance Officer at (202) 454-1245, or make a report anonymously, by calling the HSC Health Care System compliance hotline at (202) 454-1243.

Element 28.4 – The plan shall contain provisions for the investigation and follow-up of any compliance plan reports
This element is met.

The *Compliance Investigations* policy and procedure (#QM/16, dated 9/04), outlines the process used to investigate potential fraud, waste, and abuse issues. Documentation related to specific investigations was provided for review and follows the process outlined in the *Compliance Investigations* policy and procedure.

Element 28.5 – The fraud and abuse compliance plan shall ensure that the identities of individuals reporting violations of the plan are protected
This element is met.

The Corporate Compliance Plan (#AD/16, dated 3/8/04), states that "a confidential disclosure process will be established to make communications anonymous and confidential to the extent possible throughout any resulting investigation. However, there may be a point where an employee's identity may become known or may have to be revealed in certain instances. No employees shall experience retribution as a result of reporting."

Element 28.6 – The plan shall contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations
This element is met.

HSCSN's fraud and abuse compliance issues are coordinated between the HSC Corporate Compliance Manager and the Compliance Manager for HSCSN. The Corporate Compliance Committee meets quarterly and is charged with monitoring for suspected and potential fraud, waste, and abuse.

The Corporate Compliance Plan in conjunction with the *Compliance Investigations* policy and procedure (#QM/16, dated 9/04) provides the processes used to report and investigate fraud and abuse compliance plan violations. The Corporate Compliance Officer provides oversight of this process for the HSC Foundation. HSCSN's new employee orientation includes an introduction to the Corporate Compliance Plan and discussion on fraud, waste, and abuse. In addition, employees are required to complete an annual training on fraud, waste, and abuse. Documentation of both training sessions was presented for review.

Although all components of this element are addressed in the various documents presented for review, it is recommended that all relevant policies and procedures be included in the overall HSCSN Compliance Plan.

Element 28.7 – The compliance plan shall require that confirmed violations be reported to MAA within 24 hours of being confirmed
This element is partially met.

There have been confirmed violations of HSCSN's fraud, waste, and abuse policy and plan in 2005. Although this component is not addressed in the Corporate Compliance Plan (#AD/16, dated 3/8/04), HSCSN provided notice to the DC MAA within 24 hours of confirmation as required by contract. This element is deemed partially met because the reporting requirement has been met.

In order to meet the full intent of this element, HSCSN must incorporate the process for reporting confirmed violations to DC MAA within 24 hours into its Corporate Compliance Plan.

Element 28.8 – The plan shall require any confirmed or suspected fraud and abuse under state or federal law be reported to the District of Columbia Office of the Inspector General Medicaid Fraud Unit, The Medicaid Program Integrity Section of MAA, and the Office of Managed Care
This element is partially met.

The Corporate Compliance Plan and *Compliance Investigations* policy (#QM/16, dated 9/04) do not specifically state the entities to whom the confirmed or suspected abuse will be reported. However, documentation was provided to demonstrate that cases were reported to the required agencies in calendar year 2005. One case resulted in an investigation by the Office of the Inspector General (OIG).

In order to meet the full intent of this element, HSCSN must include the specific entities to who it will report confirmed or suspected fraud and abuse cases. This includes the DC Office of the Inspector General Medicaid Fraud Unit, The Medicaid Program Integrity Section of MAA, and the Office of Managed Care.

Element 28.9 – The written plan shall ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.
This element is met.

Section G of the *Corporate Compliance Plan* (#AD 16, dated 3/8/04) notes that employees can report violations to their supervisor or the Compliance Officer at (202) 454-1245, or make a report anonymously, by calling the HSC Health Care System compliance hotline at (202) 454-1243. It further states that "Employees who report in good faith possible compliance issues will not be subjected to retaliation or harassment as a result of their report. Concerns about possible retaliation or harassment should be reported to the Compliance Officer. A confidential disclosure process will be established to make communications anonymous and confidential to the extent possible throughout any resulting investigation. However, there may be a point where an employee's identity may become known or may have to be revealed in certain instances. No employees shall experience retribution as a result of reporting."

Element 28.10 – H.8.3.4 Designated Compliance Officer
The MCO must designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
This element is met.

Corporate Compliance Plan (#AD/16, dated 3/8/04), designates the Vice President of Quality/Compliance and Evaluation Reporting as the Corporate Compliance Officer. The primary responsibilities of the Corporate Compliance Officer are outlined in the Corporate Compliance Plan.

Quality Assessment and Performance Improvement Project

QA1.0 – 438.206(b)(1)
The MCO, consistent with its scope of contracted services, meets the following requirements:
This standard is partially met.

Element 1.1 – Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. This includes a formalized network analysis.
This element is met.

Network Composition and Capability (#PA/09, reviewed 1/19/06) outlines the data sources used to identify needs for providers. The Health Services for Children with Special Needs (HSCSN) Provider Participation Agreement was reviewed to document that written agreements are in place. According to the Quality Action Plan (QAP) 2005, the GeoAccess analysis will be completed quarterly and provided to the Performance Outcomes and Improvement Committee (POIC). POIC meeting minutes for May documented that the first quarter access standards were met.

Element 1.2 – In establishing and maintaining the network, the MCO must evaluate the specific provider access requirements in its contract with the DC MAA.
This element is partially met.

The QAP for 2005 and Network Analysis for the fourth quarter were reviewed. However, the Quality Evaluation Report for 2005 stated that the GeoAccess analysis to compare beneficiaries to providers was not done in 2005; HSCSN has a vendor to do this for 2006.

In order to meet the full intent of this standard, HSCSN must continue with its plans to have a vendor perform the GeoAccess study for 2006. These reports must be completed quarterly as outlined in the QAP.

Element 1.3 – 438.206(b)(2)
The MCO provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. (This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.)
This element is met.

The HSCSN Member and Parent Guide informs female beneficiaries that they are entitled to direct access to a women's health specialist.

Element 1.4 – 438.206(b)(3)
The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

Article II A of HSCSN's *Second Opinions* policy (#CM/13, 2/02) outlines the procedures for obtaining second opinions. This policy states, "Members have the right to second opinions. As stated in the Member Handbook – A Parent & Member Guide, if an HSCSN beneficiary refuses or disagrees with a recommended Plan of Treatment (POT) or procedure, including disagreement based on services not included in the POT, she/he may receive a second opinion. The Medical Director must preauthorize the provider who is to render the second opinion." As this policy notes, this information is also included in the Parent and Member Guide.

QA2.0 – 438.206(b)(4)
The State must ensure, through its contracts, that each MCO, and consistent with the scope of its contracted services, meets the following requirements:
This standard is met.

Element 2.1 – If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee for as long as the MCO is unable to provide them.
This element is met.

Article VII.3 of the *Authorization of Out of Network Services* policy (#CM 04, 11/03) outlines the process for beneficiaries to secure authorization for out-of-network services.

Element 2.2 – Requires out-of-network providers to coordinate with the with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
This element is met.

Article VII.3 of the *Authorization of Out of Network Services* (#CM/04, 11/03) policy states that the Care Manager will "Inform the provider that HSCSN pays District of Columbia's Medicaid rate for services, unless special rates are negotiated in advance, and/or HSCSN is provided with provider's state Medicaid

payment schedule." The *Access to Out of Area Covered Services* policy (#CM/01, 8/03) also states that "Upon location of provider/services, the Care Manager will inform vendor/provider that they will be reimbursed at the DC Medicaid rate. They may submit their State's Medicaid rate for services with the claim for consideration."

QA3.0 – Credentialing and Recredentialing
This standard is met.

Element 3.1 – The State must ensure, through its contracts, that each MCO, and each PIHP consistent with the scope of the PIHP's contracted services, meets the following requirements. Demonstrates that its providers are credentialed as required by § 438.214.
This element is met.

The HSCSN Provider Participation Agreement, Section 2.1 Licensure and Certification, requires that: Provider hereby represents and warrants that it has all licenses and certifications required by law to provide the Provider Services under this Agreement. Provider shall maintain all such licenses and certificates throughout the term of this Agreement and, upon request, shall furnish to HSCSN evidence of such licensure or certification. Provider and all health care providers, including physicians, employed by or associated with Provider, for the term of this Agreement, shall meet all credentialing requirements as may be established by HSCSN from time to time. Provider shall assure that all credentialing information is true and complete as of the date such information is submitted to HSCSN. Neither Provider nor any health care provider employed by or associated with Provider, including physicians, shall provide any Covered Services to Covered Individuals, and Provider shall not be entitled to compensation therefore, unless Provider or such other health care providers are fully in compliance with HSCSN's credentialing requirements at the time the Covered Services are rendered. All of the terms of this Agreement, unless clearly inapplicable, shall apply to all physicians associated with, employed by and/or contracted with Provider, and it shall be Provider's obligation to ensure such compliance.

Provider represents and warrants that all employees and others providing services under this Agreement on Provider's behalf have and shall maintain all licenses or certifications required by law to provide Covered Services.

The HSCSN's Board of Directors is required to appoint a Credentialing Committee to conduct review of Credentialing and Recredentialing (C/R) files and to provide technical knowledge review that focuses on quality of care, particularly for participating and non-participating status on exception cases. The Credentialing Committee is a committee of the Board of Directors. The Board of Directors delegates to the Medical Director the C/R of ancillary health specialists and specified mental health specialists. The

review of Credentialing Committee Meeting minutes for 2005 demonstrates that HSCSN has a C/R program in place to ensure that providers are credentialed prior to serving its beneficiaries.

QA4.0 – 438.206(c)(1)
The MCO must assure access and timeliness of services. The MCO must:
This standard is partially met.

Element 4.1 – Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services;
This element is partially met.

The Provider Participating Agreement, Section 3.8. Coverage, notes that a provider must be available 24 hours per day, seven days per week (24/7). The Provider Manual, Section 2.2. Access Standards, outlines the required access standards for primary care providers (PCPs) including availability of appointment times (urgent, routine, emergent), availability 24/7, office wait-times, etc. The *Access to Covered Services* policy (#CM/19, 6/04) also describes the required access and availability standards. *The Access to Out of Area Covered Services* policy (#CM/01, 8/03) notes that triage for out-of-area services is available 24/7.

Although the required access standards are published by HSCSN, there was no evidence provided that these standards were assessed for compliance in 2005. The QAP 2005 noted that monitoring of actual urgent and routine appointment times for beneficiaries was not completed in 2005.

In order to meet the full intent of this element, HSCSN must develop and implement a mechanism to assess compliance with the required standards.

Element 4.2 – Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
This element is partially met.

HSCSN assesses the hours of operation at the time of C/R. There was no evidence provided to ensure that hours of operation are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries.

In order to meet the full intent of this element, HSCSN must develop and implement a mechanism to ensure that the network providers offer hours of operation that are no less than the hours of operation

offered to commercial beneficiaries or comparable to Medicaid fee-for -service, if the provider serves only Medicaid beneficiaries.

Reconsideration:
HSCSN requested a re-review of this element. HSCSN's response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: We respectfully remind the reviewer that HSCSN is a Medicaid Plan. We collect hours of operations on the current credentialing and re-credentialing application. The hours of operations are also housed in Casetrakker.
Supporting documentation submitted:

- Credentialing Application and Re-Credentialing Update Form
- Policy CR/04- Criteria, Verification and Time Limits.
- Delmarva Final Review Determination

The reviewer understands that this is a Medicaid plan. The intent of this element is to ensure that the providers contracted with HSCSN offer the same or more hours of operation for the HSCSN members. It is acknowledged that the Credentailing and Re-Credentialing Update Form and Policy CR/04 address hours of operation. However, there is no mention or documentation to support that HSCSN has determined that its contracted providers of operation are no less that the hours offered to commercial enrollees or Medicaid fee-for-service beneficiaries. A simple documented statement that the hours of operation for the provider are the same for all patient types, regardless of funding source, are the same would be acceptable on the Credentialing Applications and Re-Credentialing Update Form or other appropriate document(s). This element remains partially met.

Element 4.3 – Makes services available 24 hours a day, 7 days a week when medically necessary.
This element is met.

Section 1.8 of the Provider Manual and the Provider Agreement both note that all contracted providers must provide coverage 24/7. *The Access to Covered Services* policy (#CM/19, 6/04) outlines the required access standards found in HSCSN's contract with DC MAA, which includes 24/7 access to PCPs. This is also included the Coverage section (3.8) of the Provider Participation Agreement.

Element 4.4 – Establish mechanisms to ensure compliance
This element is partially met.

The *Access to Covered Services* policy (#CM/19, 6/04) includes the provider access standards. The QAP for 2005 includes the improvement activity, "monitor actual urgent and routine appointment time for members." According to the "Completed" column of this work plan, the monitoring was not implemented. In regard to behavioral health and timeliness in crisis intervention, the QAP 2005 notes that they "were unable to track Emergency Room (ER) visits with time from intervention to disposition because of Care Management failure to input the initial time of the ER Visit in CaseTrakker (HSCSN's electronic case management system)."

The Consumer Assessment of Health Plan Services (CAHPS) survey and a provider survey were administered in 2005. HSCSN is still awaiting the results. HSCSN should be able to obtain important access information from these surveys.

In order to meet the full intent of this element, HSCSN must implement its plans to assess provider compliance with its published access standards

Element 4.5 – Monitor providers regularly to determine compliance
This element is partially met.

As noted in the component above, HSCSN had plans to monitor provider compliance against many access standards. However, according to the QAP 2005, these plans were not implemented. Although the CAHPS survey and a provider survey were conducted, there has not been adequate time to compile and analyze the results.

In order to meet the full intent of this standard, HSCSN must implement its activities to monitor provider compliance to access standards.

Element 4.6 – Take corrective action if there is a failure to comply.
This element is met.

Although many of the access standards have not been assessed for compliance, HSCSN tracks compliance with the requirement that all high-risk newborns receive a visit from an RN within 48 hours after discharge. HSCSN has implemented a Corrective Action Plan (CAP) for this standard of care.

QA5.0 – Cultural Considerations
This standard is met.

QA5.1 – 438.206(c)(2) Cultural considerations
The MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

The *Providing Accessible Communication* policy (#AD/10, 11/03) outlines the processes used to address issues of cultural competency. HSCSN provided template letters and other beneficiary communications that were in Spanish. Correspondence verifies that documents are available in the five required languages. The Parent and Member Guide and the Provider Contract both describe beneficiary access to interpreters without charge. HSCSN staff also participated in the cultural competency training offered by the DC MAA.

QA6.0 – 438.208(b)(1)–(4) – Coordination and Continuity of Care
The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet State requirements and must do the following:
This standard is met.

Element 6.1 – Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.
This element is met.

The requirement that each beneficiary have a person or entity designated as primarily responsible for coordinating the beneficiary's health care is acknowledged in several documents. The Provider Agreement notes that "primary care physician" signifies:

a Participating Provider selected by a Covered Individual and approved by HSCSN to render primary medical care to that Covered Individual, or, if that Covered Individual has not made such a selection and had it approved by HSCSN within a reasonable time (to be prescribed by HSCSN) a Participating Provider selected by HSCSN to provide primary medical care to that Covered Individual.

Section 4.0 of this agreement requires the PCP to cooperate with HSCSN's Care Management program. Section III of the Utilization Management (UM) Plan outlines the Care Coordination Program, including the requirement that the beneficiary's plan of treatment (POT) is approved by the PCP. The Case Trakker system allows HSCSN to include all these requirements in the beneficiary's electronic case file.

Element 6.2 – Coordinate the services the MCO or PIHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.
This element is met.

The *Coordination of Benefits* policy (#CM 23, 11/03) describes the process used to coordinate all beneficiary services. Section III of the UM Plan (#UM/03 1/05) also describes the role and function of the Care Manager in coordinating enrollee care and services. The Participating Provider Agreement, Section 7.0, Coordination of Benefits requires that:

Provider agrees it will assist Covered Individuals to process forms needed to pursue claims for coordination of benefits with other health care plans and coverage including, but not limited to, private and public programs that provide coverage, as their primary or secondary purpose, for health care services or for recovery from third parties.

Upon Provider becoming aware that the Coverage Plan appears to be secondary coverage to another health care plan (according to the applicable rules for coordination of benefits), Provider shall seek payment from the other plan first, consistent with the applicable Coverage Plan and HSCSN administrative rules for the coordination of benefits in the Provider Guide or elsewhere and, as applicable, the claim submitted by Provider to HSCSN shall be pended. The Coverage Plan issued by HSCSN pursuant to the Child and Adolescent Supplemental Security Income Program (CASSIP) Agreement shall always be considered payor of last resort for purposes of the coordination of benefits.

A review of the Case Trakker system provided documentation that individual beneficiary services are being documented in an electronic file.

Element 6.3 – Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.
This element is met.

Section III of the UM Plan for 2005 (#UM/03, 1/05) outlines the roles and responsibilities of the Care Manager in developing a POT in conjunction with other service providers. This includes coordinating transition and discharge planning functions, prior and continued authorization review, completing referrals, and monitoring ongoing care. There are various policies to address specific case coordination issues. For example, the *Transition to Adult Level Care and Services* (#CM/14, 11/03) addresses the process used to collect and review necessary information to transition care for this special population.

Element 6.4 – Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
This element is met.

The Provider Participation Agreement addresses confidentiality of beneficiary information. Specifically, Article 2.4. Confidential Information states that:

Provider shall maintain all individually identifiable information relating to Covered Individuals under the Federal Social Security Act, District of Columbia codes, statutes and laws and other regulations promulgated there under from time to time. All such information shall only be used for a purpose directly connected with performance of the Provider's obligations hereunder.

In addition, Article 8.3 notes, "all requests for information shall be subject to applicable confidentiality laws and Provider shall not provide access to medical records without prior written consent of the Covered Individual or an authorized party."

The HSCSN Code of Conduct (6/03), Section V. Safeguarding Privacy, outlines the internal processes staff is required to follow to ensure that beneficiary confidentiality is maintained. The Code of Conduct is compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements for maintaining beneficiary confidentiality.

Element 6.5 – 438.208(c)(1)
The MCO must implement mechanisms to identify persons with special health care needs to MCOs, as those persons are defined by the State.
This element is met.

By definition, HSCSN serves only children and youth with special needs. HSCSN contracts with the District of Columbia, Department of Health (DOH), Medical Assistance Administration (MAA) (hereinafter referred to as "DC MAA") to provide health care services to its Medicaid-eligible population under 22 years of age who are enrolled in the CASSIP. Therefore, by definition, HSCSN serves only children and youth with special needs. These children and young adults are usually screened and identified as having special needs prior to enrolling with HSCSN. Identification and referral of beneficiaries to HSCSN are accomplished by other MCOs, the DC MAA, and other community resources. All children and youth enrolled in HSCSN are assigned a PCP and a Care Manager to coordinate their care.

Element 6.6 – 438.208(c)(2) Assessment.
The MCO must implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.
This element is partially met.

In interviews, care management staff stated that staffing problems have driven the care manager caseloads too high – from 50 to 130 cases, depending upon their severity or intensity. In the demonstration of Case Trakker, a case manager team leader pulled up cases and caseloads for case managers. At the time of the on-site review, there were nine Registered Nurses (RNs) with two in orientation; seven social workers, and 16 care manager associates.

Care manager Associates are now required to have a college degree in a health-related field, but this was not the case prior to January 2006, when only 60 college credits in any field were required.

All beneficiaries below 18 months of age, as well as those with complicated medical cases, are assigned to an RN. A 14-year-old with Attention Deficit Hyperactivity Disorder (ADHD) who requires few services might be assigned a care manager associate. All three provider groups receive the same care manager training by HSCSN. Although new care managers are being oriented, the approximately 32 care managers would equate to a caseload of 100 beneficiaries per case worker if distributed evenly.

Cases for one specific RN (and RNs have the more complex cases) totaled 85, according to the information pulled from the system. The system was unable to pull up the severity levels of all cases for a specific case manager. However, during the exit interview the director of this division stated that recently all cases were reviewed, as were the caseloads and the severity level of cases, with each care manager. The division found that severity levels in cases first enrolled are often high but then decrease, so the number of beneficiaries with a severity level of three (highest) is less than what the records show. Nevertheless, the caseloads are recognized as still being too high for children with special health needs.

The caseload per care manager for this population exceeds any standard known to the reviewer. For complex medical or social clients, a caseload of 25 is often considered maximum. For this vulnerable population and especially for the high-intensity cases, a lower caseload per case manager would help ensure that beneficiaries have ongoing assessment for care needs and that those needs are met.

In order to meet the full intent of this element, HSCSN must continue the process of recruiting and training more Care Management staff. HSCSN must continue the evaluation of case severity levels and

assigning Care Managers to ensure adequate staffing to appropriately coordinate care for this group of vulnerable children and to ensure that Care Managers have the time to complete care plans in timely fashion.

QA7.0 – 438.208(c)(3) – Treatment Plans
If the State requires MCOs to produce a treatment plans for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:
This standard is partially met.

Element 7.1 – (i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
This element is met.

Page 10 of the Participating Provider agreement outlines the HSCSN requirement of initiating and maintaining a POT for each beneficiary. This POT must be approved by the beneficiary's PCP. These requirements are also outlined in Section III of the UM Plan (#UM/03, 1/05). Plans of Treatment are now being entered into the Case Trakker system to provide an electronic record of care and services for each individual beneficiary.

Element 7.2 – (ii) Approved by the MCO or PIHP in a timely manner, if this approval is required by the MCO or PIHP; and
This element is partially met.

The Plan of Treatment section (1.5) of the Provider Manual notes that PCPs are required to sign the beneficiary Plan of Treatment. During interviews, the case management team leader explained that these plans are not always timely, and this was demonstrated in the review of actual cases.

In order to meet the full intent of this element, HSCSN must comply with its policies and procedures requiring a new POT to be formally revised and approved annually.

Reconsideration:
HSCSN requested a re-review of this element. The HSCSN response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: HSCSN does have a policy to ensure compliance with this element. The Corporate Code of Conduct is a document that is signed by the employee. Supporting documentation submitted:

Policy AD/18-Code of Conduct. This policy is reviewed annually reviewed with every employee and signed by employee.

Delmarva Final Review Determination: Delmarva reviewed Policy AD/18 as part of its on-site review. As noted in the Preliminary Report, The HSCSN Code of Conduct for staff notes that no decisions can be made for personal gain and that "in general, any money, property or favor offered or given to induce someone to forego normal business or professional considerations in making decisions that affect the HSC Health Care System constitutes improper use of a resource." This addresses HSCSN employees. There was no documentation provided to ensure that external consultants (e.g. physician advisors used in appeals) are held to the same standard. If this provision is contained in provider contracts, this should be provided for review. This element remains partially met.

Element 7.3 – (iii) In accord with any applicable State quality assurance and utilization review standards.
This element is partially met.

The *Initial and Subsequent Care Coordination Plan* policy (#CM/09, 11/05) notes that Care Coordination Plans are required every six months and are due 15 days before the current care plan expires. A problem was noted in the Quality Evaluation Report 2005, in that Care Coordination Plans were not completed in a timely manner. During interviews, the case management team leader explained that the higher intensity-level cases were usually completed on time because these were handled by RNs and there was so much activity on the cases that it was easier to do new care coordination plans. However, the children who required less activity were usually the ones who did not have a care coordination plan developed in a timely manner. This at least allows the neediest beneficiaries to have a care coordination plan developed.

In order to meet the full intent of this element, HSCSN must comply with its policies and procedures requiring a new care coordination plan every six months. HSCSN must focus efforts on development and completion of these plans in a timely manner according to policy.

QA8.0 – Direct Access to Specialist
This standard is met.

Element 8.1 – 438.208(c)(4) Direct access to specialists.
For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's conditions and identified needs.
This element is met.

The Parent and Member Guide notes that beneficiaries have direct access to specialists. The *Referral Process* policy (#CM/12, 11/03) states, "With the exception of severe psychotic episodes where the treating psychiatrist can coordinate Member's mental health care, all specialty care physician services, elective inpatient and outpatient services, including ambulatory surgery, require referral by the beneficiaries' designated PCP. All referrals are coordinated through the PCP and the HSCSN Care Management Department. The HSCSN Care Manager may refer any concerns to the Medical Director."

The *Authorization of Health Services* policy (#CM/02, 12/05) addresses this requirement by noting the authorization process for both routine and monthly and ongoing authorizations for specialist services.

QA9.0 – 438.210 (b)(1) and (3) – Coverage and Authorization of Services
The MCO and its subcontractors must have in place, and follow, written policies and procedures that include:
This standard is met.

Element 9.1 – Procedures for the processing of requests for initial and continuing authorizations of services.
This element is met.

The UM Plan, Section II.A., provides a description of how criteria are reviewed and approved. These criteria are considered when authorizing services. The Authorization of Health Services policy (#CM/02, 12/05) provides the procedures used by case managers to authorize routine, monthly, and ongoing authorizations for all types of services.

Element 9.2 – That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is met.

Section II.B of the UM Plan, Utilization Review Staffing Functions, states that "If the Utilization Reviewer has concerns about the quality, the level, or the necessity of care, authorization of services is pended and referred immediately to the Medical Director for an evaluation and decision to authorize or deny payment for services." A review of the authorization procedures in place confirm that this policy is followed when authorizing care.

QA10.0 – 438.210(b)(2) – Authorization of services
The MCO must have mechanisms in place to:
This standard is partially met.

Element 10.1 – Ensure consistent application of review criteria for authorization decisions; and
This element is partially met.

The UM Plan (#UM/03, 1/05) explains the process and criteria (InterQual) used for issuing authorization decisions. There was no evidence provided to ensure that any type of inter-rater reliability or other procedures are in place to address consistent application of review criteria.

In order to meet the full intent of this element, HSCSN must develop and implement a mechanism to ensure the consistent application of review criteria.

Element 10.2 – Consult with the requesting provider when appropriate.
This element is met.

Section II, Determinations, of the *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) notes that "Whenever possible, HSCSN professionals will attempt to prevent denials through proactive and timely communication and care planning with attending practitioners and hospitals." The *Authorizations of Health Services* policy (#CM/02, 12/05) requires the discussion of services and authorizations with the beneficiary's PCP if documentation or related reports do not appear to support medical necessity. It also requires consulting with the PCP when developing and/or updating the beneficiary's Care Coordination Plan.

QA11.0 – 438.210(c) – Coverage and Authorization of Services
This standard is partially met.

Element 11.1 – 438.210(c) Notice of adverse action
The MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
This element is met.

The *Notification of Denial and Expedited Appeal* policy (#CM/18, 10/05) notes that the provider and enrollee must receive a written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Element 11.2 – Each contract must provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
This element is partially met.

The HSCSN Code of Conduct for staff notes that no decisions can be made for personal gain. There was no evidence provided to document that non-HSCSN staff conducting UM activities have this provision in their contracts.

Reconsideration:
HSCSN requested a re-review of this element. The HSCSN response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: HSCSN does have a policy to ensure compliance with this element. The Corporate Code of Conduct is a document that is signed by the employee. Supporting documentation submitted:

Policy AD/18-Code of Conduct. This policy is reviewed annually reviewed with every employee and signed by employee.

Delmarva Final Review Determination: Delmarva reviewed Policy AD/18 as part of its on-site review. As noted in the Preliminary Report, The HSCSN Code of Conduct for staff notes that no decisions can be made for personal gain and that "in general, any money, property or favor offered or given to induce someone to forego normal business or professional considerations in making decisions that affect the HSC Health Care System constitutes improper use of a resource." This addresses HSCSN employees. There was no documentation provided to ensure that external consultants (e.g. physician advisors used in appeals) are held to the same standard. If this provision is contained in provider contracts, this should be provided for review. This element remains partially met.

QA12.0 – 438.214(b)(2), (c)
The MCO has written policies and procedures for selection and retention of providers and those policies and procedures include, at a minimum, that the MCO:
This standard is partially met.

Element 12.1 – Must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO or the PIHP.
This element is partially met.

HSCSN has a documented process for C/R. Compliance with this standard was assessed by review of the following policies:

- Credentialing Committee (#CR/02, 8/05)
- C/R Time Periods (#CR/03, 8/05)
- Criteria, Verification and Time Limits (#CR/04, 8/05)
- Scope of Providers Credentialed (#CR/06, 8/05)

The policies and procedures are consistent with requirements. In order to assess HSCSN's compliance with its policies, 10 credentialing and 10 recredentialing records were reviewed. The following findings were noted:

- One of the recredentialing records was completed two years and five months after previous credentialing
- Beneficiary complaints were checked during the recredentialing process, according to interviews, but complaints were not noted on the checklist or documented in any way in the record
- Quality reviews for recredentialing consist primarily of the site review and medical record audit. Plans have been made to do more provider profiling in the future. HSCSN's policy is to do a site visit every two years for a clinic (not for every provider). Many site visits were done more than a year prior to the recredentialing process of a provider, diluting even further the accuracy of quality review for providers working in a clinic with several providers.
- One of the site visits for recredentialing was done over two years before the approval date for recredentialing.

Additional findings/recommendations included in the Quality Evaluation Report for 2005 indicated that during a JCAHO mock scenario, it was noted that medical record audits were not being done for the initial site visit; plans were subsequently made to do this. Since little provider profiling is done for quality issues, the medical record review is also the primary item for HSCSN's quality review for the recredentialing process and would be more informative if done within the 180 days before approval. In addition, HSCSN is in the process of automating many of its functions for data collection, and automation can facilitate its plans for doing more provider profiling for the recredentialing process. HSCSN provided a template that represents what the plan hopes to implement for provider profiling and includes claims, number of complaints, number of critical events and sentinel events, number of mortalities (with and without QOC concerns), quality audits and results, and corrective action plans (CAPs). HSCSN's exceptional and relatively small population of beneficiaries makes meaningful provider profiling difficult to analyze, but the reviewer encourages the plan to continue with plans to have more quality review information on their providers.

In order to meet the full intent of this element, HSCSN must:

- Include on the recredentialing checklist "member complaints" to document that this is always checked during the C/R process.
- Continue its efforts to collect and review more quality review information on their providers.

Element 12.2 – Provider selection policies and procedures (consistent with 438.12) do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

This element is met.

Although HSCSN's population is made up of entirely high-risk populations and/or those that require costly treatment, HSCSN has incorporated non-discrimination clauses in Section 3.10 of its Provider Participation Agreement, which states:

Provider shall provide Provider Services to Covered Individuals in the same manner that Provider provides services to other patients, subject to the terms and conditions of this Agreement including, without limitation, utilization review requirements, and shall not discriminate in the treatment of a Covered Individual on the basis of personal appearance, family responsibility, physical disability, education, political affiliation, place of residence, race, color, national origin, ancestry, religion, sex, marital status, health status, sexual orientation, age, social or economic condition, or the income or payment source for the patient's treatment. Provider shall accept Covered Individuals as patients, and shall not discriminate or differentiate among them consistent with Section 4.3, below, including individuals who have or are currently receiving care from Provider for whom payment is being made on a self-pay basis or through other third-party payor programs.

Element 12.3 – May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

This element is met.

HSCSN has a documented process for C/R. Compliance with this element was verified by review of the following policies:

- Criteria, Verification and Time Limits (#CR/04, 8/05)
- Scope of Providers Credentialed (#CR/06, 8/05)

These policies outline the credentialing requirements and the scope of each type of provider that can be credentialed for participation in the HSCSN network.

Element 12.4 – May not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
This element is met.

The HSCSN *Contractor Screening* policy (#PA/15, 10/04) states that: It is the policy of HSC Health Care System ("HSC System") to make reasonable inquiries into the background of contractors. HSC System will not knowingly contract with any person or entity which has been (a) convicted of a criminal offense related to health care, or (b) listed by a federal agency as debarred, suspended, excluded or otherwise ineligible to participate in any federal program.

This policy outlines the procedures that are used by HSCSN to verify that all providers credentialed and recredentialed have not been excluded from participation in Federal health care programs.

QA13.0 – 438.56 – Disenrollment
The MCO must have disenrollment policies and procedures in place. These policies and procedures must:
This standard is partially met.

Element 13.1 – Specify the reasons for which the MCO may request disenrollment of an enrollee.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 32 of the Member and Parent Guide outline the disenrollment procedures. This policy outlines various reasons for disenrollment including voluntary, just cause, unable to locate, and ineligibility. The policy clearly states that involuntary disenrollment may occur at the request of HSCSN if due to a pattern of disruptive behavior that has nothing to do with a medical condition, fraudulent or deceptive service utilization, and/or chronic non-compliance, and that such disenrollments must still be approved by the DC MAA.

Element 13.2 – Provide that the MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs
This element is partially met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that involuntary disenrollment may occur at the request of HSCSN if due to a pattern of disruptive behavior that has nothing to do with a medical condition, fraudulent or deceptive service utilization, and/or chronic non-compliance. This

policy does not address diminished mental capacity or uncooperative behavior resulting from the beneficiaries' special needs.

In order to meet the full intent of this element, HSCSN must address in policy MS 02 the requirement that it cannot request disenrollment on grounds of diminished mental capacity or uncooperative or disruptive behavior resulting from the beneficiary's special needs.

Element 13.3 – Specify the methods by which the MCO assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that the DC MAA must approve justification for all disenrollments, including those requested by the plan. Per the policy, all disenrollments are sent to the DC MAA for approval.

QA14.0 – 438.56(c) – Disenrollment Requested by the Enrollee.
If the State chooses to limit disenrollment, the MCO policies and procedures must provide that a recipient may request disenrollment as follows:
This standard is partially met.

Element 14.1 – For cause at any time.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, P31 states that a beneficiary may request disenrollment at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the plan, will inform the enrollment broker of any changes in enrollment.

Element 14.2 – Without cause, during the 90 days following the date of the individual's initial enrollment with the MCO or the date the State sends the recipient notice of the enrollment, whichever is later.
This element is partially met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) states that just cause is required when the disenrollment request falls within two to six months of enrollment. Nowhere in the policy is it stated that it can be without cause during the first 90 days of enrollment. However, the Parent and Member Guide, page 31, states that the beneficiary may choose to disenroll at any time and for any reason.

In order to meet the full intent of this standard, HSCSN must align its *Change in Member Status/Disenrollment* policy with the DC MAA contract language and the language in the Parent and Member Guide. The elements below also would be clearer with the policy stating exactly when enrollees can request disenrollment without cause. HSCSN should also delete the enrollment broker name, as this is outdated.

Element 14.3 – Without cause, at least once every 12 months thereafter.
This element is met.

The Parent and Member Guide, page 31, states that the beneficiary can choose to disenroll at any time and for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) does not state this specifically, nor does it state that the beneficiary can request disenrollment at these times without cause. However, the enrollment vendor is required to send beneficiaries this notice 60 days before each anniversary of their enrollment date, and therefore it is clear that beneficiaries can request a change in MCOs at any time, and at least annually.

Element 14.4 – Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that a beneficiary may request disenrollment at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the plan will inform the enrollment broker of any changes in enrollment.

Element 14.5 – When the State imposes the intermediate sanction specified in § 438.702(a)(3).
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that a beneficiary may request at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the MCO, will inform the enrollment broker of any changes in enrollment.

Element 14.6 – 438.56(d)(1)
Policies and procedures for disenrollment must require the recipient (or his or her representative) to submit an oral or written request to the State agency (or its agent); or to the MCO if the State permits the MCOs to process disenrollment requests.
This element is met.

Page 31 of the Parent and Member Guide explains the process a beneficiary would use to request disenrollment. This includes the right of the beneficiary to request disenrollment either orally or in writing. As noted in The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05), all disenrollment requests must be approved by DC MAA, which provides the disenrollment information to the enrollment broker.

QA15.0 – 438.56(d)(2)
Policies and procedures for disenrollment must specify the following conditions for disenrollment with cause.
This standard is partially met.

Element 15.1 – The enrollee moves out of the MCO's, PIHP's… service area.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that a beneficiary may request disenrollement at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the MCO, will inform the enrollment broker of any changes in enrollment.

Element 15.2 – The plan does not, because of moral or religious objections, cover the service the enrollee seeks.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that a beneficiary may request disenrollment at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the MCO, will inform the enrollment broker of any changes in enrollment.

Element 15.3 – The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that beneficiaries can request disenrollment for any reason and that DC MAA must approve all requests.

Element 15.4 – Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.
This element is met.

The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) and page 31 of the Parent and Member Guide, Disenrollment, state that a beneficiary may request disenrollment at any time for any reason. The *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) notes that DC MAA, not the MCO, will inform the enrollment broker of any changes in enrollment.

Element 15.5 – The MCO may either approve a request for disenrollment or refer the request to the State.
This element is met.

According to its contract with the DC MAA, only DC MAA can approve disenrollment. HSCSN's *Change in Member Status/Disenrollment* policy (#MS/02, 12/05 states that when HSCSN receives a request for disenrollment, this is forwarded to DCMAA. The process for notifying DC MAA is outlined in the policy.

Element 15.6 – If the MCO or the State agency (whichever is responsible) fails to make the disenrollment determination so that recipient can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.
This element is not met.

Neither the Parent and Member Guide nor the *Change in Member Status/Disenrollment* policy (#MS/02, 12/05) addresses this requirement.

In order to meet the full intent of this element, HSCSN must include this requirement in its policies and procedures.

Element 15.7 – 438.56(e)(1)–(2) – Disenrollment timeframes
Disenrollment policies and procedures must note that regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO files the request.
This element is met.

Section VI of the *Change in Member Status/Disenrollment* policy (#MS/02, 12/05), Voluntary Disenrollment, states that a disenrollment shall be effective on the first day of the following month if the request form is dated on or prior to the 15th of that month, but in no case shall it be effective later than the first day of the second month after the request is made. Page 31 of the Parent and Member Guide also notes this requirement.

QA16.0 – 438.230(a)(1)–(b)(1) – Delegation and Oversight
This standard is met.

Element 16.1 – 438.230 – Subcontractual relationships and delegation.
The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor. There is evidence that before any delegation, each MCO and PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.
This element is met.

The Delegated Credentialing Entities policy (#MS/05, 8/05) outlines the responsibilities of HSCSN in the delegation process. This policy states that HSCSN is responsible for assessing the credentialing processes of potential providers both before contracting, and, at a minimum, annually or more frequently as indicated thereafter when granting the provider the status as a delegated provider. Actual delegated provider audits and letters to the delegate requesting follow-up were provided for review to document that this process in place.

Element 16.2 – 438.230(b)(2)
There is a written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and
This element is met.

Article II, Delegate Responsiblities, of the *Delegated Entities* policy (#MS/05, 8/05) specifies the responsibilities of the delegated entity. The HSCSN Memorandum of Understanding (MOU) for Delegated Credentialing Certification Terms and Conditions details the responsibilities of both HSCSN and the delegated provider.

Element 16.3 – There is a written agreement that provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is met.

Article D. of the *Delegated Entities* policy (#CR/05, 8/05) states that "HSCSN retains the right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making."

Element 16.4 – 438.230(b)(3)
The MCO or PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.
This element is met.

The HSCSN Memorandum of Understanding (MOU) for Delegated Credentialing Certification Terms and Conditions (undated) and the *Delegated Entities* policy (#CR/05, 8/05) both require each delegate to undergo a formal recredentialing audit at least annually. The schedule of receredentialing audits was provided as documentation that this occurred in 2005. In addition, letters sent to delegates following such audits were provided for review. These letters outlined the compliance of the delegates with expected standards and included requests for corrective actions where necessary.

Element 16.5 – 438.230(b)(4)
If any MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.
This element is met.

The HSCSN MOU for Delegated Credentialing Certification Terms and Conditions agreement (undated) and the *Delegated Entities* policy (#CR/05, 8/05) both require each delegate to undergo a formal recredentialing audit at least annually. Letters sent to delegates following such audits were provided for review. These letters outlined the compliance of the delegates with expected standards and included requests for corrective actions where necessary. Follow-up visits were scheduled with non-compliant

delegates for six months to monitor implementation of any expected corrective action requested by HSCSN.

QA17.0 – 438.236(b)(1)–(b)(4) – Practice Guidelines

Adoption of practice guidelines: **Each MCO adopts practice guidelines that meet the following requirements:**

This standard is met.

Element 17.1 – Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

This element is met.

The *Clinical Practice Guidelines* policy (#QM/15, 9/05) states that "HSCSN's Medical Director or a Quality Council member will identify the need for a treatment guideline to address clinical issues important to the treatment of special needs and high-risk children." The *Clinical Practice Guidelines* were reviewed and include guidelines taken from accepted sources such as the American Academy of Pediatrics, American Diabetes Association, Maryland Department of Health and Mental Hygiene the Agency for Healthcare Research and Quality (AHRQ), and the National Clearinghouse of Standards.

Element 17.2 – Consider the needs of the MCO's enrollees

This element is met.

The *Clinical Practice Guidelines* were reviewed and include guidelines taken from accepted sources such as the American Academy of Pediatrics, American Diabetes Association, Maryland Department of Health and Mental Hygiene, AHRQ, and the National Clearinghouse of Standards. Specific guidelines include but are not limited to sickle cell disease, asthma, ADHD, diabetes, and obesity.

Element 17.3 – Are adopted in consultation with contracting health care professionals.

This element is met.

The *Clinical Practice Guideline* policy (#QM/15, 9/05) states that "Once the Medical Director has approved a guideline, it is then reviewed at the Provider Network Quality Council meeting. The Council members will make recommendations for approval and adoption of the guideline."

Element 17.4 – Are reviewed and updated periodically as appropriate.

This element is met.

The *Clinical Practice Guideline* policy (#QM/15, 9/05) states that practice guidelines will be reviewed at least every two years. The separate sheet preceding each practice guideline was not current for any of the guidelines. Most sheets showed dates for approval by the Provider Network Council between March and September 2003. Asthma guidelines had an approval date of November 13, 2002. However, during the exit interview, staff produced a sheet with each of the guidelines listed and a date for approval within 2005, making all guidelines current and compliant with the two- year approval period.

The guidelines themselves dated back to 2000, 2001, and 2003 and were taken from primary sources and included in their entirety as the practice guidelines. No notations had been made that indicated that anything had been changed from the original publication date.

Although this component is met, the *Clinical Practice Guideline* policy (#QM/15, 9/05) documentation sheets attached to practice guidelines should be updated and contain the date that the Provider Network Council approves them. More recent primary source guidelines are available for some of the practice guidelines. Since some of the guidelines are lengthy articles, providers might find a more abbreviated version would facilitate utilization.

Element 17.5 – 438.236(c) – Practice Guidelines
The MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

Article I of the *Clinical Practice Guideline* policy (#QM/15, 9/05) states:

When the Quality Council approves a guideline, the Provider Newsletter is updated to inform Providers of the new guideline. The Provider Manual will include the same information. All adopted guidelines will also be posted on the HSCSN website. The providers will be informed that they may obtain a copy of the guidelines by accessing the specified website or requesting a copy from Provider Affairs. Current guidelines are listed in the Provider Manual and newly adopted guidelines will be added as the manuals are published/republished.

Element 17.6 – 438.236(d) – Practice Guidelines
Application of guidelines. Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
This element is met.

Guidelines are taken straight from primary source and not modified by HSCSN. HSCSN also uses InterQual criteria to make utilization decisions. The clinical practice guidelines (CPGs) that are in place include, but are not limited to, asthma, sickle cell disease, diabetes, immunizations, pregnancy, sexually transmitted disease, and dental care.

QA18.0 – Quality Assessment and Performance Improvement Program
This standard is met

Element 18.1 – 438.240 Quality assessment and performance improvement program
The MCO must have a documented ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.
This element is met.

HSCSN has Quality and Performance Improvement Program 2005 (#QM/13, 1/05) in place. The QAP 2005 provides the work plan for the activities of the Quality and Performance Improvement Program 2005 to be completed.

QA19.0 – 438.240(b)(1) and (d(1)–(d)(2)
The MCO must conduct performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:
This standard is partially met.

Element 19.1 – Measurement of performance using objective quality indicators.
This element is met.

The Quality and Performance Improvement Program (#QM/13, 1/05) and the QAP 2005 were reviewed. These documents delineate the quality measures used in the 2005 Quality and Performance Improvement program for HSCSN. Measures are in the areas of asthma, childhood and adolescent immunization status, specialty care, diabetes care, ER, inpatient mental health/substance abuse, outpatient mental health, residential treatment, other institutional care, pharmacy, quality management, provider profiling, serious incident summaries, identification of children with special needs, and beneficiary satisfaction. The measures are included in the QAP work plan and include HEDIS®[1] measures. The measures included in the work plan are objective quality indicators.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Element 19.2 – Implementation of system interventions to achieve improvement in quality.
This element is met.

Review of QAP 2005 in conjunction with Quality and Performance Improvement Plan (#QM/13, 1/05) included the interventions, timetables for implementation, and outcomes. The core measures selected by HSCSN were used to implement interventions for programmatic initiatives for 2005.

Element 19.3 – Evaluation of the effectiveness of the interventions.
This element is met.

The review of the completed QAP 2005 with outcomes and the HSCSN Report Card for 2005 provided a summary of the outcomes (indicator rates). The POIC meeting minutes for 2005 demonstrated an ongoing review of evaluation of improvement efforts. The "Completed/Status" column of the QAP 2005 provides a brief summary including status of the project or project steps, corrective actions that were required, developed, and/or implemented, and barriers encountered. The POIC meeting minutes document evidence of discussion about the work plan.

Element 19.4 – Planning and initiation of activities for increasing or sustaining improvement.
This element is partially met.

The MCO's quality improvement activities do not use a standard process for identifying issues, analyzing them, identifying barriers, targeting proven interventions to barriers, measuring, and then making any changes/revisions based on the outcomes. Problems are identified and recorded, but documentation does not indicate that they are always being addressed in a timely fashion.

In order to meet the intent of this element, the MCO must assure that planning and initiation of activities for increasing or sustaining improvement are more structured. This could include the use of a standard format/template for each project (e.g., Quality Improvement Activity (QIA) form for each project) like that used for the DC MAA–required improvement projects on obesity and residential treatment.

Element 19.5 – Reporting the status and results of each project to the State as requested.
This element is met.

The Quality and Performance Improvement Program (#QM/13, 1/05) identifies the projects and indicators that the plan will use. This includes the projects mandated by DC MAA. HSCSN was required to develop and implement projects in the areas of pediatric obesity and residential treatment. These

projects were developed and implemented and provided to the DC MAA for review and evaluation for CY 2005.

Element 19.6 – 438.240(d)(2)
The MCO must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
This element is partially met

HSCSN has completed the minimum requirements for the DC MAA–selected projects. The projects for CY 2004 were submitted timely for review in 2005. These were reviewed by Delmarva and feedback was provided to the MCO through the DC MAA. HSCSN must ensure that it continues its quality improvement efforts and documents them appropriately on the QIA form. There was no timetable specified for completion of the current required projects.

Reconsideration:
HSCSN requested a re-review of this element. The HSCSN response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: Timetables are incorporated into our annual evaluation. Supporting documentation provided:

- Annual QI Evaluation

Delmarva Final Review Determination: While it is acknowledged that the Annual QI Evaluation includes a summary of the annual project progress, as stated in the preliminary report findings, there were no timetables specified for *completion* of the projects undertaken. Delmarva reiterates the need for HSCSN to specify expected project completion dates in its project QIAs. This element remains partially met.

In order to meet the full intent of this element, HSCSN must document the project timetables to ensure that the project will be completed in a reasonable time (and according to DC MAA requirements).

QA20.0 – 438.240(b)(2) – Quality Assessment and Performance Improvement Program
Basic elements of an MCO and PIHP quality assessment and performance improvement program. At a minimum, the MCO must submit performance measurement data at least annually. The MCO must:
This standard is partially met.

Element 20.1 – Measure and report to the State its performance, using standard measures required by the State, including those that incorporate the requirements of 438.204(c) and 438.240(a)(2) [Note: 438.204(c) and 438.240(a)(2) are included below.]
This element is met.

The Quality and Performance Improvement Program (#QM/13, 1/05) notes the requirement for providing required indicators and documentation to DC MAA. HSCSN completed and submitted its quarterly reports to DC MAA as required in 2005. These reports include the required measures in areas such as complaints, grievances, enrollment, indicator results, etc.

Element 20.2 – Submit to the State, data specified by the State, that enables the State to measure the MCO's performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.
This element is partially met.

The Quality Report for 2005 stated that HSCSN was unable to collect accurate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data, correct immunization data, and lead values. All these are required by DC MAA and also were in the outstanding CAPs for 2005. A plan has been made to do medical record audits for HEDIS® reports, and the plan believes this will improve the EPSDT rates. The blood lead levels could not be obtained from the Department of Health (DOH), and plans have been made to get these values directly from their lab vendors. Immunization levels are low for the 0–4 age group, and HSCSN believes that the data from the Immunization Registry is not complete. Therefore, HSCSN plans to get this data from its own system in 2006.

In order to meet the full intent of this element, HSCSN must demonstrate (and document) the strategies it has included in the CAPs. This should help in the collection and accurate reporting of EPSDT and lead measures.

QA21.0 – Mechanisms for Utilization of Services
This standard is partially met.

Element 21.1 – 438.240(b)(3)
The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.
This element is partially met.

The Quality Management Plan 2005 lists what HSCSN planned to monitor during 2005. In 2005, HSCSN reviewed data and medical records for utilization. However, these concentrated solely on

overutilization. One of the objectives in the QAP 2005 was to evaluate underutilization of service to beneficiaries. However, the report states that this was not done in 2005.

In order to meet the full intent of this element, HSCSN must have a process for evaluating underutilization and document its results and their analysis.

QA22.0 – Mechanism to Assess Quality of Care
This standard is met.

Element 22.1 – 438.240(b)(4)
The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
This element is met.

Because HSCSN's entire enrollment is children and youth with special needs, HSCSN's quality initiatives should focus on care furnished to its beneficiaries with special needs. The Quality and Performance Improvement Plan (#QM/13, 1/05) and the QAP 2005 provide an overview of the quality initiatives and indicators of performance. Some of the activities documented and indicators collected related to appropriateness of care for 2005 include, but are not limited to:

- An ongoing project in the area of residential treatment length of stay
- Appropriate immunizations and blood lead level screening
- ESPDT rates
- Completion rate of RN visits for high-risk newborns within 48 hours of discharge
- Timeliness of plans of treatment/care coordination plans
- Appropriate use of behavioral services to ensure timeliness to crisis intervention
- Development and implementation of an obesity project
- Development of an asthma program
- Assessment and monitoring of pharmacy utilization

These activities, although not all have been completed according to timelines, demonstrate that there are mechanisms in place to address appropriateness and quality of care.

QA23.0 – Evaluation of Quality Assessment and Performance Improvement
This standard is partially met.

Element 23.1 – 438.240(e)(2)

The MCO must have a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

This standard is met.

The HSCSN Quality/Compliance, Evaluation, and Reporting Annual Reports for 2004 and 2005 were presented to the Board of Directors and were reviewed by Delmarva. Highlights from the 2005 reports are as follows:

- Nineteen performance measures for programmatic initiatives did not meet expectations of HSCSN due to competing priorities
- Blood lead level data could not be obtained from DOH registry, and plans have been made to get this directly from vendor labs
- EPSDT data could not be collected; plans for 2006 have been made to get data directly from providers and to automate instead of collecting the data manually
- Forty-eight-hour visits by nurses after delivery were not done timely; the plan is trying to find a vendor(s) with adequate staffing to perform this in a timely manner
- Care coordination plans were not done in a timely manner due to inadequate staffing; as for 2006 CAPs, the notation was that the policy had been changed
- The asthma program did not get implemented in 2005, but plans are to do this in 2006
- The website for quality initiative information for providers was not maintained
- Plans to review utilization of services by beneficiaries (to determine underutilization) was not done, but the new Director of Care Management has been employed and plans for improvement in this area have been made
- A beneficiary safety/risk management committee with defined criteria, purpose, and targeted monitoring activities was to be established but did not meet until the fourth quarter of 2005, when a Risk Management consultant was obtained and monthly meetings established
- An objective was to have denials meet BBA requirements (language and timeliness), and a consultant has been obtained to redesign the process, which should have been implemented by March 2006
- HSCSN did not meet its objective of paying 100% of clean claims within 30 days. For 2006 it is changing its authorization process to decrease administrative time required
- HSCSN's objective to maintain a network using GeoAccess methodology was not accomplished, and a vendor has been obtained to do this in 2006
- One objective was to meet all standards of external quality review, with a notation that HSCSN "only reached 100% for Quality standards." The CAP noted that "Leadership needed to build survey expectations into work flows, so that system is always survey ready and meeting standards…."

Five outstanding CAPs are in place and include "Coordination of Care compliance with contract standards." During interviews, staff explained that due to turnover the staffing had been low in this area and caseloads varied from a high of 130 to 50 per case manager, depending upon the need and complexity of a case. They are aware that these caseloads do not meet standards, especially for children with special needs. Care coordination plans have not been done in a timely fashion and this has been noted.

The HSCSN Report Card for 2005 also noted that:

- Immunizations for age 0–4 years was low (not higher than 41.9 % and no data listed after October 2005). The explanation is that the DC Immunization Registry data is not accurate and HSCSN plans to collect these data within its system.
- An objective to decrease claims being sent to CM for authorization in order to make timely payment was not met. The corrective plan was to omit authorization of ER visits for January 2006 in order to decrease the number of claims going to CM.

HSCSN has several challenges in improving their Quality Improvement Program and QI efforts. The plan is working to improve its data information system, which could facilitate the improvement process. The inability of their present system to collect many data elements has limited them in many ways. While standards can still be met without the planned changes in the information system, the resources for manually collecting some of these measures would be significant.

In order to meet the full intent of this element, quality improvement efforts could be enhanced with more attention to utilizing a standard process for identifying issues, analyzing them, listing barriers, matching proven interventions to barriers, measuring, and then making any changes. Problems are identified and recorded but documentation does not indicate that they are always being addressed in a timely fashion.

Reconsideration:

HSCSN requested a re-review of this element. The HSCSN response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: HSCSN currently uses the Quality Action Plan to quarterly review and evaluate the effectiveness of its QA/PI Program. The format incorporates identification and analyses of issues, barriers and outcomes. Supporting documentation: submitted:
QAP

Delmarva Final Review Determination: It is acknowledged that the Quality Action Plan includes the improvement activities to be undertaken in the review year. The flow of activities for major QA/PI initiatives (e.g. immunization rates, EPSDT rates, blood lead screening rates etc) are difficult to follow in the QAP format. It is recommended that the major initiatives are reported/updated in the Quality Action Plan, but that a quality improvement project document be initiated for each of these initiatives like is done for the performance improvement projects (PIPs) required by the DCMAA. Documentation in a standardized format will allow the MCO and outside reviewers to follow project progress. In addition, this will provide documentation of additional important information such as numerators, denominators, barriers, interventions, tracking and trending of data.

The process in place for the CY 2005 review allows the MCO to identify problems timely, but as noted in the preliminary report, the issues identified are not always addressed in a timely manner. The approach appears to be fragmented with project data and information dispersed across several documents, but not documented in one single source.

POIC meeting minutes note a review of the "Indicator Report Card." In total, the Quality Action Plan, the Indicator Report Card, and the Annual QA/PI Report, provide documentation that there are mechanisms in place to assess the QA/PI program.

The information required to minimally meet this standard has been provided and the review determination is changed from partially met to met. However, in order to maintain this review determination of met in future reviews, HSCSN must ensure that its major quality improvement initiatives described above are documented in a format that records the major project aspects such as indicators, measurement, barrier analysis, interventions and timetable for completion of the project.
Theo original review determination was "partially met," but has been changed to "met."
The review determination is changed from partially met to met.

QA24.0 – 438.242(a) – Health Information Systems
This standard is partially met.

Element 24.1 – The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances, and disenrollments for other than loss of Medicaid eligibility.
The review determination for this standard has been changed from partially met to met.

Although HSCSN's information system is able to collect the types of data used in beneficiary services, quality, credentialing and UM, there is little opportunity for integration. Interviews with staff confirmed

this finding. Specifically, provider profiling is an important task that HSCSN would like to implement. The data across the different modules and databases are providing a barrier for HSCSN in completing this task. It is acknowledged that HSCSN is focusing efforts on getting the Case Trakker system loaded with current beneficiary information, and it is hoped that this will assist the MCO in integrating at least some of the patient-level data.

In order to meet the full intent of this element, HSCSN must put processes in place to ensure that data can be extracted and integrated to provide more comprehensive and meaningful reports, such as, provider profiling.

Reconsideration:
HSCSN requested a re-review of this element. The HSCSN response to the preliminary review determination and Delmarva's final review determination are summarized below.

HSCSN Response: HSCSN utilizes the Casetrakker nsystem for Care Management and Utilization Management. There is a data warehouse that is supported within our Microsoft SharePoint System. SharePoint is a system that handles HSCSN's reporting needs.

Delmarva Final Review Determination: It is acknowledged that HSCSN has systems in place to collect data. However, at the time of the review, Casetrakker was still being updated with beneficiary information, which did not allow for the staff to provide up to date information on all beneficiaries. In addition, staff acknowledged the difficulties in integrating data across the different modules. Again, Delmarva acknowledges HSCSN's priorities in getting the patient-level data current so that profiling can be accomplished. This element remains partially met.

QA25.0 – 438.242(b) – Health Information Systems
This standard is met.

Element 25.1 – The MCO's health information systems must be able to collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.
This element is met.

HSCSN collects utilization data from providers on the CMS (HCFA) 1500 and UB 92 forms. In addition, HSCSN also has its own encounter data form that is used to collect data on additional services not collected on the CMS 1500 or UB 92 forms.

Element 25.2 – The MCO's health information systems must be able to ensure that data received from providers is accurate and complete by;
This element is met.

a) Verifying the accuracy and timeliness of reported data;
This component is met.

HSCSN has several information management policies and procedures in place that address this element. These include:

- The Information Management Plan (#HI/21, 12/03)
- Security of Information policy (HI/11, 4/05)
- Information Systems-Software Licensing, Software Downloads (HI/19, 4/02)

These policies in total explain the process used to verify the accuracy and timeliness of data when entered and/or received.

b) Screening the data for completeness, logic, and consistency; and
This component is met.

HSCSN has several information management policies and procedures in place that address this element. These include:

- The Information Management Plan (#HI/21, 12/03)
- Security of Information policy (#HI/11, 4/05)
- Information Systems – Software Licensing, Software Downloads (#HI/19, 4/02)

These policies in total explain the process used to verify the accuracy and timeliness of data when entered and/or received.

c) Collecting service information in standardized formats to the extent feasible and appropriate.
This component is met.

HSCSN is able to submit and receive enrollment data from the DC MAA enrollment broker. Encounter data are received and processed using the CMC (HCFA) 1500 and the UB92 forms. Claims are processed through the HSC electronic system.

d) Making all collected data available to the State and to CMS.
This component is met.

DC MAA requires each MCO/plan to submit a standardized quarterly report and an annual evaluation of its quality management program. These have all been submitted for the 2005 review year and include the data required by the DC MAA.

Appendix IIA1 - Recommendations At-A-Glance

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1.0 – Enrollee Rights Policy and Procedure.					
1.1	438.100 (a) (1-2) The MCO must have written policies regarding enrollee rights.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER2.0 – 438.100(b) (2) (ii) – (vi) Content of Enrollee Rights Policy. The enrollee right and responsibilities policy and procedure must include the enrollee right to:					
2.1	Be treated with respect and with due consideration for his or her dignity and privacy.	X			
2.2	Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.	X			
2.3	Participate in decisions regarding his or her health care, including the right to refuse treatment.	X			
2.4	To be free from and form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.			X	In order to receive a finding of met in subsequent reviews, the Managed Care Organization (MCO) should include in its Member Rights and Responsibilities policy the following language: "To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation." HSCSN CAP Response: HSCSN "must obtain directions and assistance from reviewer in understanding the creation of this element." Delmarva Response: HSCSN should refer to the BBA regulations regarding enrollee rights which state the requirement to have this included as an enrollee right. CAP Determination: Not adequate.
2.5	Request and receive his or her medical records and request that they be amended of corrected.	X			
2.6	Formulate advance directives (417.436(d)(1)(i)(A).	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
2.7	Make decisions regarding health care including the right to accept or refuse medical treatment (417.436(d) (1)(i)(A)	X			
2.8	The right to file grievances and appeals 9438.10(g)(ii).	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER3. 0 – Enrollee Information Provisions.					
3.1	438.100 (b)(2)(i) and 438.10(d)(1)(i) Enrollees have the right to receive information in accordance with section 438.10 which states that MCOs must provide all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.	X			
3.2	4368.10(c) (3) The MCO must make its written information available in the prevalent, non-English languages in its particular service area.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
ER4.0 – 438.10(c) (4) - (5) Language Services. The MCO must make language services [i.e., oral interpretation services] available to its enrollees:					
4.1	These services must be free of charge to each enrollee.	X			
4.2	The MCO must notify its enrollees that oral interpretation is available for any language.	X			
4.3	The MCO must notify its enrollees that written information is available in prevalent languages.	X			
4.4	The MCO must notify its enrollees how to access free interpretation services.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER5.0 – 438.10(d) (1)(ii) and (d)(2) Alternative Formats for Enrollee Information. Written material must be available in alternative formats.					
5.1	Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs for those who, for example, are visually limited or have limited reading proficiency.	X			
5.2	All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER6.0 – 438.10(f)(2) and (f)(6) and 438.114 Enrollee Information. The MCO must notify all enrollees of their right to request and obtain information listed below within a reasonable time after enrollment and at least annually thereafter.					
6.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients.	X			
6.2	Any restrictions on the enrollee's freedom of choice among network providers.	X			
6.3	Enrollee rights and responsibilities.	X			
6.4	Information on grievance and fair hearing procedures.	X			
6.5	The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.		X		In order to meet the full intent of this element, the amount and duration need to be described in sufficient detail to ensure that the enrollees understand the benefits to which they are entitled. HSCSN CAP Response: Member Handbook will reflect updates at next publication for 2007. Delmarva Response: Because the revisions will only be completed for 2007, this element will remain partially met for the 2006 review. HSCSN must ensure that the revisions include sufficient information regarding benefits and services. CAP Determination: Adequate.
6.6	Procedures for obtaining benefits, including authorization requirements.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.7	The extent to which, enrollees may obtain benefits, including family planning services, from out-of-network providers.	X			
6.8	The extent to which, and how, after-hours and emergency coverage are provided including what constitutes and emergency medical condition, emergency services, and post-stabilization services (which reference to the definitions in 438.114)	X			
6.9	The fact that pre-authorization is not required for emergency services.	X			
6.10	The process and procedure for obtaining emergency services, including use of the 911 telephone system or its local equivalent.	X			
6.11	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.	X			
6.12	The fact that enrollees have the right to use any hospital or other setting for emergency care.	X			
6.13	The MCOs policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	X			
6.14	Cost sharing, if any.	N/A			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
6.15	How and where to access any benefits that are available under the State plan, but are not covered under the contract.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
ER7.0 – 438.10(g) (1)(i) – (vii) Information Requirements – Grievance and Appeals. MCOs must provide grievance, appeal and fair hearing information to their enrollees. Grievance, appeal and fair hearing procedures must be in a State-developed or State-approved description, that must include the following:					
7.1	Grievances, appeal, and fair hearing procedures.	X			
7.2	The State Fair Hearing process to include the rights to a hearing, the method for obtaining a hearing and the rules that govern representation at the hearing.	X			
7.3	The right to file grievances and appeals.	X			
7.4	The requirements and timeframes for filling a grievance or appeal.	X			
7.5	The availability of assistance in the filing process.	X			
7.6	The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.	X			
7.7	The fact that, when requested by the enrollee benefits will continue if the enrollee files an appeal of request for State fair hearing within the time frames specified for filing.	X			
7.8	That the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
7.9	Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER8.0 – 438.114 Emergency and Post-Stabilization Services 438.10(g) (2). The MCO must address advance directives. The MCO must:					
8.1	Have written and procedures concerning advance directives (417.436(d)).		X		In order to meet the full intent of this element, HSCSN must develop and implement an advance directives policy. HSCSN CAP Response: An advance Directives policy (MS/17) has been drafted. Delmarva Response: HSCSN must ensure that this policy addresses the major advance directives (not just living wills). This policy must be reviewed and approved by the appropriate committees prior to the next review. CAP Determination: Adequate.
8.2	Provide all adult enrollees with written information on advance directives policies, and include a brief description of applicable State law. (438.6(i)(2).	X			
8.3	Provide information to individuals concerning their rights under the State law to make decisions concerning medical care including the right to accept or refuse medical treatment and the right to formulate advance directives.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
8.4	Provide its written policies respecting the implementation of the right to make decisions regarding care and the right to formulate and advance directive.		X		In order to meet the full intent of this element, HSCSN must develop and implement an advance directives policy. This policy must include the beneficiary right to make decisions regarding care and the right to formulate an advance directive. HSCSN CAP Response: An Advance Directives policy (MS/17) has been drafted. Delmarva Response: HSCSN must ensure that this policy addresses the major advance directives (not just living wills). This policy must be reviewed and approved by the appropriate committees prior to the next review. CAP Determination: Adequate.
8.5	Provide for the education of staff concerning its policies and procedures on advance directives.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER9.0 – Enrollee Information Requirements.					
9.1	438.10(g)(3) and 438. Information must provided to all enrollees, upon request, regarding the structure and operation of the MCO, physician incentive plans, quality, and to the extent available, performance indicators (including, but not limited to disenrollment rates and enrollee satisfaction.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER10.0 -438.106 (a) – (c) Non-Liability of Enrollee. The MCO must provide that is Medicaid enrollees are not held liable for any of the following:					
10.1	The MCO's debts in the case of the entity's insolvency.	X			
10.2	Covered services provided to the enrollee, for which the State does not pay the MCO of or does not pay the individual health care provider that furnished the services under a contractual, referral or other arrangement.	X			
10.3	Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would pay if the MCO provided the services directly.	X			

Performance Rating – District of Columbia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER11.0 - 438.102 Provider-Enrollee Communications. An MCO may not prohibit, or otherwise restrict. A health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient for the following:					
11.1	The enrollee's health status, medical care or treatment options including any alternative treatment that may be self-administered.	X			
11.2	Any information the enrollee needs in order to decide among all relevant treatment options.	X			
11.3	The risks, benefits, and consequences of treatment or non-treatment.	X			
11.4	The enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatments, and to express preferences about future treatment decisions.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS1.0 – Documented Processes for Grievances, Appeals and State Fair Hearings.					
1.1	438.402(a) Each MCO and PIHP must have a documented system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS2.0 – 438.402(b)(1) The policies and procedures must allow for:					
2.1	An enrollee to file a grievance, an MCO level appeal, and may request a State fair hearing.	X			
2.2	A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.	X			
2.3	A provider to file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS3.0 - 438.402(b)(2) The MCO policies and procedures specify a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's notice of action. Within that timeframe—					
3.1	The enrollee or the provider may file an appeal.	X			
3.2	In a State that does not require exhaustion of MCO level appeals, the enrollee may request a State fair hearing.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS4.0 - 438.402(b)(3) The MCO procedures for filing must state that the enrollee:					
4.1	May file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO.	X			
4.2	Or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS5.0 - Language and Format Requirements.					
5.1	438.404 Notice of Action:- 438.404 (a) Language and format requirements. The notice must be in writing and must meet language and format requirements.		X		In order to meet the full intent of this standard, HSCSN will be required to demonstrate that the revised Notice of Actions (NOAs) meet DC Medical Assistance Administration contractual requirements of a fifth grade reading level. HSCSN CAP Response: Current NOA satisfies this element and was approved by MAA. CAP Review Determination: Delmarva noted that the NOAs used in calendar year 2005 included language that was not at the required fifth grade level and the decision was not always clearly stated. Discussion with the staff noted that the NOAs were currently being revised to meet this standard. It is assumed that the "current" NOA mentioned in the CAP was revised following the on-site review. CAP Determination: Adequate. HSCSN should note that even though the template was approved by DC MAA, the MCO must ensure that the review determinations written by HSCSN on the letter are at are below the fifth grade level.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS6.0 - 438.404(b) Content of the Notice of Action (NOA). The notice must explain the following:					
6.1	The action the MCO or its contractor has taken or intends to take.	X			
6.2	The reasons for the action.	X			
6.3	The enrollee's or the provider's right to file an MCO appeal.	X			
6.4	If the State does not require the enrollee to exhaust the MCO level appeal procedures, the enrollee's right to request a State fair hearing.	X			
6.5	The procedures for exercising the rights specified in this paragraph.	X			
6.6	The circumstances under which expedited resolution is available and how to request it.			X	In order to meet the full intent of this element, HSCSN must clearly define its expedited review process and assure that it is included in the NOAs sent to the beneficiaries. HSCSN CAP Response: The current NOA will be modified to clarify the definition of when an expedited appeal is needed. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.7	The enrollee's right to have benefits to continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.		X		In order to meet the full intent of this element, HSCSN must assure that the NOAs to beneficiaries include their right to have their benefits continue during the appeal and explain how to request that benefits be continued. HSCSN CAP Response: Modification to the NOA will include a statement reflecting this item. The MCO will modify its policy to include this element. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and updating the policy should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS7.0 - 438.210(d) Timeframe for Decisions for Standard Authorizations. For standard service authorization decisions that deny or limit services, decisions must be made within the time frame specified in §438.210(d). The MCO, policies, procedures and practices must require the following timeframes for decisions:					
7.1	For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.			X	In order to meet the full intent of this element, HSCSN must address the requirement to provide notice as expeditiously as the beneficiary's health condition requires and within DC MAA established time frames. HSCSN CAP Response: HSCSN will modify its policy to state "not to exceed 14 calendar days for standard authorization decisions." Delmarva Response: The time frames for implementation and completion are acceptable. A revision of the policy should address the concern identified. CAP Determination: Adequate.
7.2	Possible extensions of the 14 calendar day timeframe are allowed if the enrollee, or the provider, requests extension.			X	In order to meet the full intent of this element, HSCSN's policies and procedures must allow possible extensions at the request of the beneficiary or provider. HSCSN CAP Response: The policy will be revised to include possible extensions of the 14 calendar day timeframe are allowed if the enrollee, or the provider, requests extension. Delmarva Response: The time frames for implementation and completion are acceptable. A revision of the policy should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
7.3	Possible extensions of the 14 calendar day timeframe are allowed if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.			X	In order to meet the full intent of this element, HSCSN's policies and procedures must allow possible extensions at the request of the MCO if it is in the best interest of the beneficiary. HSCSN CAP Response: the policy will be revised to address possible extensions of the 14 calendar day timeframe are allowed if the MCO justifies (to the District agency upon request) a need for additional information and how the extension is in the enrollee's interest. Delmarva Response: The time frames for implementation and completion are acceptable. A revision of the policy should address the concern identified. CAP Determination: Adequate .

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS8.0 - 438.210 and 438.404(c)(4) Expedited Authorization Decisions. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision.					
8.1	The MCO must have an expedited authorization process policy and procedures in place.			X	In order to meet the full intent of this element, HSCSN must develop and implement a process for expedited authorizations. HSCSN CAP Response: HSCSN has modified policy CM/03 to include expedited authorizations. Delmarva Response: The time frames for implementation and completion are acceptable. A revision of the policy should address the concern identified. Policy CM/03 was not in the CAP packet and therefore a determination cannot be made on the adequacy of the policy. A revision of the policy with the appropriate language should address this concern. CAP Determination: Adequate.
8.2	The procedures and practices require that the MCO provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.			X	In order to meet the full intent of this element, HSCSN must develop and implement procedures to assure that the MCO provide notice as expeditiously as the beneficiary's health condition requires and not later than three days after receipt of request for service. HSCSN CAP Response: HSCSN states that it will modify its current policy to satisfy this element. Delmarva Response: A revision of the policy should address the concern identified. The policy to be revised was not included in HSCSN's CAP and therefore a determination cannot be made on the adequacy of the policy. A revision of the policy with the appropriate language should address this concern. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
8.3	The MCO, may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.			X	In order to meet the full intent of this element, HSCSN must develop and implement procedures to ensure that the MCO can extend the three-working-day time frame with justification. HSCSN CAP Response: HSCSN states it will modify the current policy and procedure to include this element. Delmarva Response: The policy to be revised was not included in HSCSN's CAP and therefore a determination cannot be made on the adequacy of the policy. A revision of the policy with the appropriate language should address this concern. CAP Determination: Adequate.
8.4	If an extension is granted, the MCO policies and procedures must require the MCO to provide written notice to the enrollee of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.			X	In order to meet the full intent of this element, HSCSN must develop and implement procedures to require the MCO to provide written notice to the beneficiary of the reason for the decision to extend the timeframe and to inform the beneficiary of the right to file a grievance if he or she disagrees with that decision. HSCSN CAP Response: HSCSN states it will modify "existing policy to reflect this language." Delmarva Response: The policy to be revised was not included in HSCSN's CAP and/or not referenced. Therefore a determination cannot be made on the adequacy of the policy. A revision of the policy with the appropriate language should address this concern. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
8.5	The policy and procedures must require that in cases of extensions, the MCO will issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.			X	In order to meet the full intent of this element, HSCSN must develop and implement procedures to require that in cases of extensions, the MCO will issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires. HSCSN CAP Response: HSCSN will modify its NOA to include this statement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS9.0 - 438.406.(a)(1)-(3) Handling of Grievances and Appeals. In handling grievances and appeals, the MCO must:					
9.1	Give enrollees any reasonable assistance in completing forms and taking other procedural steps.	X			
9.2	Acknowledge receipt of each grievance and appeal.	X			
9.3	Ensure that individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.	X			
9.4	Ensure that health care professionals who have the appropriate clinical expertise in treating the enrollees condition or disease are involved in the decision making process.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS10.0 - 438.406 (b) (1)-(4) Appeals Policies. The policies and procedures for appeals must:					
10.1	Provide that oral inquiries seeking to appeal an action are treated as appeals and must be confirmed in writing, unless the enrollee or provider requests expedited resolution.	X			
10.2	Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	X			
10.3	Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.	X			
10.4	Include, as parties to the appeal, the enrollee and his or her representative, or the legal representative of a deceased enrollee's estate.		X		In order to meet the full intent of this element, HSCSN policies must include and allow the legal representative of a deceased beneficiary's estate to act as a party to an appeal. HSCSN CAP Response: The current NOA will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS11.0 - §438.408 and (b)(1)-(3) Resolution and Notification: Grievances and Appeals. The MCO or PIHP must dispose each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established time frames that may not exceed time frames specified in this section.					
11.1	For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State, but may not exceed 90 days from the day the MCO receives the grievance.	X			
11.2	Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO receives the appeal. This timeframe may be extended under paragraph (c) of this section.		X		In order to meet the full intent of this element, HSCSN must clarify the time frames for the standard resolution of appeals and must address time frame extensions. HSCSN CAP Response: The NOA will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. HSCSN should ensure that this is also included in its policies and procedures. CAP Determination: Adequate. HSCSN should ensure this is also included in the appropriate polices and procedures.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.3	Expedited resolution of appeals. For expedited resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.		X		In order to meet the full intent of this element, HSCSN must include the availability of the MCO to extend the timeframes for resolution. HSCSN CAP Response: The current NOA and policy and procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. Revisions of the NOA and policies/procedures using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS12.0 - 438.408(c)(1) Extensions. The MCO policies and procedures can allow for the extension of timeframes. The MCO may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:					
12.1	The enrollee requests the extension.		X		In order to meet the full intent of this element, HSCSN must include the right of and process for a beneficiary to request an extension. HSCSN CAP Response: The NOA, policies and procedures will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. Revisions of the NOA and policies/procedures using the appropriate language should address the concern identified. CAP Determination: Adequate.
12.2	The MCO shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.		X		In order to meet the full intent of this element, HSCSN must include in its policies the requirement that the MCO must justify that there is a need for additional information and explain how the delay is in the beneficiary's interest HSCSN CAP Response: A policy and procedures will be implemented to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of any revisions. The CAP states that the MCO will implement a procedure. It is recommended that the MCO include this requirement in its current procedures. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS13.0 – Extension Requirements.					
13.1	Requirements438.408(c)(2) Requirements following extension. If the MCO extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.			X	In order to meet the full intent of this element, HSCSN must include in its policies and procedures a provision that the beneficiary must be given written notice of any time frame extension that the beneficiary did not request. HSCSN CAP Response: HSCSN will create a letter to address this requirement and implement a new policy and procedure. The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of any revisions. The CAP states that the MCO will implement a procedure. It is recommended that the MCO include this requirement in its current procedures. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS14.0 – Format of Resolution Notice.					
14.1	438.408(d)(1) (d) Format of notice-Grievance Resolution. The MCO will notify the enrollee of the disposition of the grievance.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS15.0 - 438.408(d)(2) (2) Notification of the Outcome of Appeals. Enrollees must be notified of the outcome of appeals.					
15.1	For all appeals, the MCO must provide written notice of disposition.	X			
15.2	For notice of expedited resolution, the MCO must also make reasonable efforts to provide oral notice.			X	In order to meet the full intent of this element, HSCSN must make reasonable efforts to provide oral notice for expedited resolutions. This must be included in the Notification of Denial and Expedited Appeal policy. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS16.0 - 438.408(e)(1) Content of Notice of Appeal Resolution. The written notice of the resolution must include the following:					
16.1	The results of the resolution process.	X			
16.2	The date it was completed.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS17.0 - 438.408(e)(2) Content of Notice of Appeal Resolution. The written notice of the resolution must include the following for appeals not resolved wholly in favor of the enrollee.					
17.1	The right to request a State fair hearing, and how to do so.	X			
17.2	The right to request to receive benefits while the hearing is pending, and how to make the request.			X	In order to meet the full intent of this element, HSCSN must include in its NOAs the right to request to receive benefits while the hearing is pending and how to make the request. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.
17.3	That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.			X	In order to meet the full intent of this element, HSCSN must state in its NOAs that beneficiaries will not be held liable for the cost of benefits even if the hearing upholds the MCO's decision. HSCSN CAP Response: HSCSN will revise the NOA to state member will not be held liable. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS18.0 - 438.410 Expedited resolution of appeals.					
18.1	(a) §438.410 - The MCO must have a documented expedited review process for appeals, when the MCO or PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function.		X		In order to meet the full intent of this element, HSCSN must detail the expedited appeal process in the appropriate documents and must define the cases in which expedited appeal can be requested. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS19.0 – Punitive Action					
19.1	438.410(b) Punitive Action. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.		X		In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies that punitive action is not to be taken against a provider who requests an expedited resolution or supports a beneficiary's appeal. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS20.0 - 438.410(c)(1)-(2) Action following denial of a request for expedited resolution. If the MCO or PIHP denies a request for expedited resolution of an appeal, it must assure that its policies and procedures require					
20.1	Transfer of the appeal to the timeframe for standard resolution.			X	In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies and procedures the process used to transfer an expedited appeal to the standard resolution time frame. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.
20.2	Prompt oral notice to the enrollee of the denial, and follow up within 2 calendar days with a written notice.			X	In order to meet the full intent of this element, HSCSN must include in its grievance and appeals policies and procedures the process used to provide prompt oral notice to the beneficiary of the denial and required follow-up within two calendar days with a written notice. HSCSN CAP Response: The current NOA and policy/procedure will be modified to include this requirement. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the NOA and policy/procedure using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS21.0 – Provision of Grievance System Information.					
21.1	438.414 The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS22.0 – Record Keeping and Reporting Grievances.					
22.1	438.416 Recordkeeping and reporting requirements. The MCO must maintain records of grievances and appeals and provides reports to the State.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS23.0 - 438.420(b) Continuation of Benefits. The MCO must continue the enrollee's benefits if:					
23.1	The enrollee or the provider files the appeal timely.			X	In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the MCO will continue beneficiary benefits if the beneficiary or the provider files the appeal timely. HSCSN CAP Response: HSCSN states that the current NOA satisfies this element. Delmarva Response: The revised template NOA was not provided and therefore the reviewer cannot comment on the appropriateness of the NOA. This CAP is deemed adequate based on the MCOs statement that this has been addressed. CAP Determination: Adequate.
23.2	The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.			X	In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the MCO will continue beneficiary benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. HSCSN CAP Response: HSCSN states that the current NOA satisfies this element. Delmarva Response: The revised template NOA was not provided and therefore the reviewer cannot comment on the appropriateness of the NOA. This CAP is deemed adequate because the MCO has provided a statement that this has been addressed. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
23.3	The services were ordered by an authorized provider.			X	In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the MCO will continue beneficiary benefits if the services were authorized by an authorized provider. HSCSN CAP Response: HSCSN will modify current policy to reflect this language. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. CAP Determination: Adequate.
23.4	The original period covered by the original authorization has not expired.			X	In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the MCO will continue beneficiary benefits if the original period covered by the original authorization has not expired. HSCSN CAP Response: HSCSN will modify current policy to reflect this language. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
23.5	The enrollee requests and extension of benefits.			X	In order to meet the full intent of this element, HSCSN must include in its procedures the fact that the MCO will continue beneficiary benefits if the beneficiary requests an extension of benefits. HSCSN CAP Response: HSCSN will modify current policy to reflect this language. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. The CAP states that the MCO will implement a procedure. It is recommended that the MCO include this requirement in its current procedures. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS24.0 - 438.420(c) Duration of Continued or Reinstated Benefits. If, at the enrollee's request, the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:					
24.1	The enrollee withdraws the appeal.	X			
24.2	Ten days pass after the MCO mails the notice, providing the resolution of the appeal against the enrollee, within the 10-day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.			X	In order to meet the intent of this element this procedure must be revised to be consistent with the time frames in this element. HSCSN CAP Response: HSCSN's new policy meets this standard within the element. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. Although the policy was not provided, the CAP is deemed adequate because the MCO stated that this policy has been revised. CAP Determination: Adequate.
24.3	A State Fair Hearing Office issues a hearing decision adverse to the enrollee.	X			
24.4	The time period or service limits of a previously authorized service has been met.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS25.0 – Enrollee Responsibility for Services During Appeal.					
25.1	438.420(d) Enrollee Responsibility for Services Furnished While the Appeal is Pending : If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of section 431.230.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS26.0 – Services Not Furnished During Appeal.					
26.1	438.424(a) Services not furnished while appeal is pending: If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.			X	In order to meet the full intent of this element, HSCSN must include in its appeal policies the requirement that if the District fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires. HSCSN CAP Response: The current policy and procedure revised recently provides a statement to address this requirement. An additional statement to honor the fair hearing decision will be included in the policy. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. Although the policy was not provided, the CAP is deemed adequate because the MCO stated that this policy has been revised. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS27.0 – Service Furnished During Appeal.					
27.1	438.424 (b) Services furnished while the appeal Is Pending: If the MCO, or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services in accordance with State policy and regulations.			X	In order to meet the full intent of this element, HSCSN must include in its policies that if the MCO or the District fair hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the MCO or the DCMAA must pay for those services, in accordance with District policy and regulations. HSCSN CAP Response: HSCSN will modify the appeals policy and procedure to reflect this benefit. Delmarva Response: The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. The time frames for implementation and completion are acceptable. A revision of the policy using the appropriate language should address the concern identified. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS28.0 – Fraud and Abuse Detection (from DC MAA MCO Contract). H.8.3.1.1–H.8.3.1.9 Fraud and Abuse Compliance Plan. The contractor must have a written Fraud and Abuse Compliance Plan. This plan must include the following provisions:					
28.1	The MCO shall ensure that all officers, directors, managers and employees know and understand the provisions of the fraud and abuse compliance plan.	X			
28.2	The written plan shall contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract.	X			
28.3	The plan shall contain provisions for the confidential reporting of plan violations to the designated person (e.g., MCO Fraud and Abuse Compliance Officer or hotline).	X			
28.4	The plan shall contain provisions for the investigation and follow-up of any compliance plan reports.	X			
28.5	The fraud and abuse compliance plan shall ensure that the identities of individuals reporting violations of the plan are protected.	X			

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
28.6	The plan shall contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations.	X			
28.7	The compliance plan shall require that confirmed violations be reported to [DC] MAA within 24 hours of being confirmed.		X		In order to meet the full intent of this element, HSCSN must incorporate the process for reporting confirmed violations to DCMAA within 24 hours into its Corporate Compliance Plan. HSCSN CAP Response: Policies were revised to reflect recommendation by Delmarva February 2006. Delmarva Response: The revised polices/corporate compliance plan were not available for review and therefore the reviewer cannot comment on the revisions made to these documents. The CAP is determined to be adequate based on the statement by the MCO that this has been addressed. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
28.8	The plan shall require any confirmed or suspected fraud and abuse under state or federal law be reported to the District of Columbia Office of the Inspector General Medicaid Fraud Unit, The Medicaid Program Integrity Section of [DC] MAA, and the Office of Managed Care.		X		In order to meet the full intent of this element, HSCSN must include the specific entities to which it will report confirmed or suspected fraud and abuse cases. This includes the DC Office of the Inspector General Medicaid Fraud Unit, the Medicaid Program Integrity Section of MAA, and the Office of Managed Care. HSCSN CAP Response: Policies were revised to reflect recommendation by Delmarva in February 2006. Delmarva Response: The revised polices/corporate compliance plan were not available for review and therefore the reviewer cannot comment on the revisions made to these documents. The CAP is determined to be adequate based on the statement by the MCO that this has been addressed. CAP Determination: Adequate.
28.9	The written plan shall ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.	X			
28.10	H.8.3.4 Designated Compliance Officer. The MCO must designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA1.0 - 438.206(b)(1) The MCO, consistent with its scope of contracted services, meets the following requirements:					
1.1	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. This includes a formalized network analysis.	X			
1.2	In establishing and maintaining the network, the MCO must evaluate the specific provider access requirements in its contract with the DC MAA.		X		In order to meet the full intent of this standard, HSCSN must continue with its plans to have a vendor to conduct the GeoAccess study for 2006. These reports must be completed quarterly as outlined in the Quality Action Plan. HSCSN CAP Response: HSCSN has initiated a contract with Ingenix to complete quarterly evaluation of enrollee access. Target implementation date is 6/06. Delmarva Response: HSCSN should review its contract requirements to ensure that the contractor evaluates all required provider access requirements. CAP Determination: Adequate.
1.3	- 438.206(b)(2) The MCO provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. (This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.)	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
1.4	- 438.206(b)(3) The MCO must provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA2.0 - 438.206(b)(4) The State must ensure, through its contracts, that each MCO, and consistent with the scope of its contracted services, meets the following requirements:					
2.1	If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee for as long as the MCO is unable to provide them.	X			
2.2	Requires out-of-network providers to coordinate with the with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA3.0 - Credentialing and Recredentialing.					
3.1	438.206(b)(3) The State must ensure, through its contracts, that each MCO, and each PIHP consistent with the scope of the PIHP's contracted services, meets the following requirements. The MCO must demonstrate that its providers are credentialed as required by § 438.214.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA4.0 - 438.206(c)(1) The MCO must assure access and timeliness of services. The MCO must:					
4.1	Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.		X		In order to meet the full intent of this element, HSCSN must develop and implement a mechanism to assess compliance with the required standards. HSCSN CAP Response: Provider contracts contain this requirement for compliance with timely access to care and services. HSCSN had designed a report for the tracking and monitoring of appointment requests compared to claims data. Case management will generate reports. Delmarva Response: Target dates for completion are realistic. HSCSN must ensure that the reports are available and data are compared to access standards. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
4.2	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for service, if the provider serves only Medicaid enrollees.		X		HSCSN reviews the hours of operation at the time of credentialing, but there is no evidence that credentialing staff check this against hours of operation offered to Medicaid fee-for-service or commercial beneficiaries. In order to meet the full intent of this element, HSCSN must include a mechanism to ensure that hours of operation for its providers are comparable for all patients. HSCSN CAP Response: HSCSN stated it was a Medicaid plan and that it collects hours of operation on current credentialing and recredentialing applications, and maintains this information in Casetrakker. Delmarva Response: The reviewer acknowledges that this is a Medicaid plan. However, the concern is that HSCSN does not have a mechanism in place to compare/check to determine that the hours its members are offered are comparable to those offered to other populations (commercial, private pay etc). CAP Determination: Not Adequate.
4.3	Makes services available 24 hours a day, 7 days a week when medically necessary.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
4.4	Establish mechanisms to ensure compliance.		X		In order to meet the full intent of this element, HSCSN must implement its plans to assess provider compliance with its published access standards. HSCSN CAP Response: HSCSN "respectfully requests clarification." Delmarva Response: The full report includes a complete explanation of the requirements. Specifically, it notes "The Access to Covered Services policy (#CM/19, 6/04) includes the provider access standards. The QAP for 2005 includes the improvement activity, "monitor actual urgent and routine appointment time for members." According to the "Completed" column of this work plan, the monitoring was not implemented. In regard to behavioral health and timeliness in crisis intervention, the QAP 2005 notes that they "were unable to track Emergency Room (ER) visits with time from intervention to disposition because of Care Management failure to input the initial time of the ER Visit in CaseTrakker." The CAP should contain a response of how and when the monitoring of urgent and routine appointments will begin. CAP Determination: Not Adequate.
4.5	Monitor providers regularly to determine compliance.	X			
4.6	Take corrective action if there is a failure to comply.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5.0 – Cultural Considerations.					
5.1	438.206(c)(2) Cultural Considerations The MCO must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA6.0 - 438.208(b)(1)-(4) Coordination and Continuity of Care. The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet State requirements and must do the following:					
6.1	Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.	X			
6.2	Coordinate the services the MCO or PIHP furnishes to the enrollee with the services the enrollee receives from any other MCO.	X			
6.3	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.	X			
6.4	Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	X			
6.5	438.208(c)(1) The MCO must implement mechanisms to identify persons with special health care needs to MCOs, as those persons are defined by the State.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.6	- 438.208(c)(2) Assessment. The MCO must implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.		X		In order to meet the full intent of this element, HSCSN must continue the process of recruiting and training more Care Management staff. HSCSN must ensure that mechanisms are in place to equitably distribute case loads based on severity. HSCSN must also implement mechanisms to ensure that care plans are updated every six months to be in accordance with its own policies. HSCSN CAP Response: Policy CM/05 modified to current operations. Delmarva Response: The report stated that "HSCSN must continue the evaluation of case severity levels and assigning Care Managers to ensure adequate staffing to appropriately coordinate care for this group of vulnerable children and to ensure that Care Managers have the time to complete care plans in a timely fashion." Modifying a policy does not ensure that these important staffing issues are being addressed. HSCSN must be able to provide documentation that qualified staff are being /have been recruited and that care plans are being completed in a timely manner. CAP Determination: Not Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA7.0 - 438.208(c)(3) Treatment plans. If the State requires MCOs to produce a treatment plans for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:					
7.1	(i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee.	X			
7.2	(ii) Approved by the MCO in a timely manner, if this approval is required by the MCO and		X		In order to meet the full intent of this element, HSCSN must comply with its policies and procedures requiring a new care plan to be formally revised and approved annually. HSCSN CAP Response: "Meets current policy." Delmarva Response: The statement "meets current policy" does not provide the reviewer adequate information to determine whether or not care plans are now being revised and approved annually per policy. HSCSN must be able to demonstrate its ability to comply with the treatment plan revision timeframes. CAP Determination: Not Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
7.3	(iii) In accord with any applicable State quality assurance and utilization review standards.		X		In order to meet the full intent of this element, HSCSN must comply with its policies and procedures requiring a new Care Coordination Plan every six months. HSCSN must focus efforts on development and completion of these plans in a timely manner according to policy. HSCSN CAP Response: Implementing tracking system with reports in CaseTrakker. The implementation time frame is 7/06 with a completion date of 7/07. Delmarva Response: CaseTrakker is capable of providing such reports. HSCSN should be able to assess timeliness to completion with these reports. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA8.0 - Direct access to specialists.					
8.1	438.208(c)(4) Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's conditions and identified needs.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9.0 - 438.210 (b)(1) and (3) Coverage and Authorization of Services. The MCO and its subcontractors must have in place, and follow, written policies and procedures that include:					
9.1	Procedures for the processing of requests for initial and continuing authorizations of services.	X			
9.2	That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA10.0 - 438.210(b)(2) Authorization of Services. The MCO must have mechanisms in place to:					
10.1	Ensure consistent application of review criteria for authorization decisions; and		X		In order to meet the full intent of this element, HSCSN must develop and implement a mechanism to ensure the consistent application of review criteria. HSCSN CAP Response: HSCSN will develop an audit tool and monitor monthly. HSCSN will develop a quiz to ensure consistent interpretation of data. Delmarva Response: This response is a start, but HSCSN should research inter-rater reliability and gold standard methods for ensuring consistent application of review criteria rather than a "quiz." Actual case files can be used. CAP Determination: Adequate with additional recommendations.
10.2	Consult with the requesting provider when appropriate.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA11.0 - 438.210 (c) Coverage and Authorization of Services.					
11.1	438.210 (c) Notice of adverse action: The MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.	X			
11.2	Each contract must provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.		X		In order to meet the full intent of this element, HSCSN must ensure that it has policies and procedures in place stating that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. HSCSN CAP Response: HSCSN's "current policy meets this element." Delmarva Response: The MCO referred to policy AD/18. Delmarva reviewed Policy AD/18, HSCSN Code of Conduct, as part of its on-site review. The Code of Conduct is for staff and notes that no decisions can be made for personal gain and that "in general, any money, property or favor offered or given to induce someone to forego normal business or professional considerations in making decisions that affect the HSC Health Care System constitutes improper use of a resource." This addresses HSCSN employees. There was no documentation provided to ensure that external consultants (e.g. physician advisors used in appeals) are held to the same standard. CAP Determination: Not Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA12.0 - 438.214 (b)(2), (c): The MCO has written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the MCO:					
12.1	Must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO or the PIHP.		X		In order to meet the full intent of this element, HSCSN must: ➢ Including on the recredentialing checklist "member complaints" to document that this is always checked during the C/R process. ➢ HSCSN must continue its efforts to collect and review more quality review information on their providers. HSCSN CAP Response: HSCSN does include concerns and complaints checklist on re-credentialed providers. Delmarva's comments were more of a recommendation. Delmarva Response: Delmarva reviewed 10 credentialing and 10 recredentialing files at the time of the on-site reviews. The preliminary report noted that "Beneficiary complaints were checked during the recredentialing process, according to interviews, but complaints were not noted on the checklist or documented in any way in the record." Because the complaint data/information was not noted in the files, the reviewer made the determination that HSCSN should follow its policies and procedures and document the complaints in the files. CAP Determination: HSCSN disagreed with the review determination and did not submit a CAP. Therefore the CAP determination is "Not Adequate." HSCSN must ensure that this issue is addressed prior to the next review.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
12.2	Provider selection policies and procedures, (consistent with 438.12) do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
12.3	May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.	X			
12.4	May not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13.0 - 438.56 Disenrollment. The MCO must have disenrollment policies and procedures in place. These policies and procedures must:					
13.1	Specify the reasons for which the MCO may request disenrollment of an enrollee.	X			
13.2	Provide that the MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.		X		In order to meet the full intent of this element, HSCSN must address the requirement that it cannot request disenrollment because of diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs in policy MS 02. HSCSN CAP Response: HSCSN has added language and updated the Change in Member Status/Disenrollment Policy. The specific language was not provided and therefore the reviewer cannot comment on the appropriateness of the revision. A revision of the policy using the appropriate language should address the concern identified. CAP Determination: Adequate.
13.3	Specify the methods by which the MCO assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA14.0 - 438.56(c) Disenrollment requested by the enrollee. If the State chooses to limit disenrollment, the MCO policies and procedures must provide that a recipient may request disenrollment as follows:					
14.1	For cause, at any time.	X			
14.2	Without cause, during the 90 days following the date of the individual's initial enrollment with the MCO or the date the State sends the recipient notice of the enrollment, whichever is later.		X		In order to meet the full intent of this standard, HSCSN must align its Change in Member Status/Disenrollment policy with the DC MAA contract language and language in the Parent and Member Guide. The elements below also would be clearer with the policy stating clearly when enrollees can request disenrollment without cause. HSCSN should also delete the enrollment broker name as this is outdated. HSCSN CAP Response: HSCSN updated its Member Status/Disenrollment policy (MS/02). Delmarva Response: The policy revisions should address the concern. HSCSN will need to demonstrate that this process is in place at the next review. CAP Determination: Adequate.
14.3	Without cause, at least once every 12 months thereafter.	X			
14.4	Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.	X			
14.5	When the State imposes the intermediate sanction specified in §438.702(a)(3).	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
14.6	438.56(d)(1) Policies and procedures for disenrollment must require the recipient (or his or her representative) to submit an oral or written request to the State agency (or its agent); or to the MCO if the State permits the MCOs to process disenrollment requests.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA15.0 - 438.56(d)(2) Policies and procedures for disenrollment must specify the following conditions for disenrollment with cause.					
15.1	The enrollee moves out of the MCO's, PIHP's... service area.	X			
15.2	The plan does not, because of moral or religious objections, cover the service the enrollee seeks.	X			
15.3	The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.	X			
15.4	Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.	X			
15.5	The MCO may either approve a request for disenrollment or refer the request to the State.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.6	If the MCO or State agency (whichever is responsible), fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.			X	In order to meet the full intent of this element, HSCSN must include this requirement in its policies and procedures. HSCSN CAP Response: HSCSN updated its Member Status/Disenrollment policy (MS/02). Delmarva Response: The policy revisions should address the concern. HSCSN will need to demonstrate that this process is in place at the next review. CAP Determination: Adequate.
15.7	438.56(e)(1)-(2) Disenrollment timeframes. Disenrollment policies and procedures must note that Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, files the request.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA16.0 - 438.230(a)(1)-(b)(1) Delegation and Oversight.					
16.1	§438.230 Subcontractual relationships and delegation. The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor. There is evidence that before any delegation, each MCO and PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.	X			
16.2	438.230(b)(2) There is a written agreement that specifies the activities and report responsibilities delegated to the subcontractor.	X			
16.3	There is a written agreement that provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			
16.4	- 438.230(b)(3) The MCO or PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
16.5	- 438.230(b)(4)If any MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA17.0 - 438.236(b)(1)-(b)(4) Practice Guidelines. Adoption of practice guidelines. Each MCO adopts practice guidelines that meet the following requirements:					
17.1	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
17.2	Consider the needs of the MCO's enrollees.	X			
17.3	Are adopted in consultation with contracting health care professionals.	X			
17.4	Are reviewed and updated periodically as appropriate.	X			
17.5	438.236(c) Practice Guidelines The MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
17.6	- 438.236(d) Practice Guidelines Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA18.0 - Quality Assessment and Performance Improvement Program.					
18.1	438.240 Quality Assessment and Performance Improvement Program: The MCO must have a documented ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA19.0 - 438.240 (b)(1) and (d(1)-(d)(2). The MCO must conduct performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:					
19.1	Measurement of performance using objective quality indicators.	X			
19.2	Implementation of system interventions to achieve improvement in quality.	X			
19.3	Evaluation of the effectiveness of the interventions.	X			
19.4	Planning and initiation of activities for increasing or sustaining improvement.		X		In order to meet the intent of this element, the MCO must assure that planning and initiation of activities for increasing or sustaining improvement are more structured. This could include the use of a standard format/template for each project (e.g. Quality Improvement Activity (QIA) form) like that used for the DC MAA required projects on obesity and residential treatment. HSCSN CAP Response: HSCSN will draft a standard format/template for the monitoring and reporting of improvement activities. Delmarva Response: As in the preliminary report, the reviewer suggests using standard forms that have been tested (NCQA's QIA form). CAP Determination: Adequate.
19.5	Reporting the status and results of each project to the State as requested.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
19.6	438.240(d)(2) The MCO must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.		X		In order to meet the full intent of this element, HSCSN must document the project timetables to ensure that the project will be completed in a reasonable time (and according to DC MAA requirements). HSCSN CAP Response: HSCSN stated that "timetables are incorporated into our Quality annual evaluation." Delmarva Response: While it is acknowledged that the Annual QI Evaluation includes a summary of the annual project progress, as stated in the preliminary report findings, there were no timetables specified for completion of the projects undertaken. Delmarva reiterates the need for HSCSN to specify expected project completion dates in its project QIAs CAP Determination: Not Adequate. HSCSN did not provide a formal CAP to address this standard.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
QA20.0 - 438.240(b)(2) Quality Assessment and Performance Improvement program. Basic elements of an MCO quality assessment and performance improvement program. At a minimum, the MCO must submit performance measurement data at least annually. The MCO must:					
20.1	Measure and report to the State its performance, using standard measures required by the State, including those that incorporate the requirements of 438.204 (c) and 438.240(a)(2)[Note: 438.204(c) and 438.240(a0(2) are included below.]	X			
20.2	Submit to the State, data specified by the state, that enables the State to measure the MCO's performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.		X		In order to meet the full intent of this element, HSCSN must demonstrate (and document) the strategies it has included in the CAPs. This should help in the collection and reporting accuracy for EPSDT and lead measures. HSCSN CAP Response: Strategies are being developed to better ensure that immunizations occur in the 0-4 age group. Delmarva Response: There were no specific steps addressed to address the issues identified. The MCO should have provided specific steps (e.g. linking with the immunization registry, completion of medical record reviews etc) CAP Determination: Not Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA21.0 – Mechanism for Utilization of Services.					
21.1	438.240(b)(3) The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.		X		In order to meet the full intent of this element, HSCSN must have a process for evaluating underutilization and document its results. HSCSN CAP Response: HSCSN is creating a tool to capture utilization of services that will be generated from the members Plan of Care (POC). They will use URAC standards of Care Management. Delmarva Response: Delmarva recommends that data from CaseTrakker be used in this effort if this is not the planned data source. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA22.0 – Mechanism to Access of Care.					
22.1	438.240(b)(4) The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA23.0 – Evaluation of Quality Assessment and Performance Improvement.					
23.1	438.240(e)(2) The MCO must have a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.	X			

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA24.0 – 438.242(a) Health Information Systems.					
24.1	The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances, and disenrollments for other than loss of Medicaid eligibility.		X		In order to meet the full intent of this element, HSCSN must put processes in place to ensure that data can be extracted and integrated to provide more comprehensive and meaningful reports (e.g. provider profiling). HSCSN CAP Response: HSCSN plans to use the CaseTrakker system to generate reports to address this standard. The timeframe for implementation is 12/06. Delmarva Response: The CaseTrakker system is capable of generating reports needed to address this standard and that will be useful to HSCSN. However, it is important that HSCSN ensure that its beneficiary POCs are in CaseTrakker and up-to-date to maximize its usefulness. CAP Determination: Adequate.

Performance Rating – District of Columbia Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA25.0 – 438.242(b) Health Information Systems.					
25.1	The MCO's health information systems must be able to Collect data on beneficiary and provider characteristics as specified by the State, and on services furnished to beneficiaries through an encounter data system or other methods as may be specified by the State.	X			
25.2	The MCO's health information systems must be able to ensure that data received from providers is accurate and complete by:	X			
(a)	Verifying the accuracy and timeliness of reported data;	X			
(b)	Screening the data for completeness, logic, and consistency; and	X			
(c)	Collecting service information in standardized formats to the extent feasible and appropriate.	X			
(d)	Making all collected data available to the State and to CMS.	X			

Section III - Performance Improvement Projects

Introduction

As part of the annual External Quality Review (EQR), Delmarva conducted a review of Performance Improvement Projects (PIPs) submitted by each MCO contracting with the District of Columbia Medical Assistance Administration (DCMAA). According to its contract with DCMAA, each MCO is required to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to the contract, the PIPs must include the measurement of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

For the current review period, calendar year (CY) 2005, the PIP validation protocols and tools established in 2003 were used. Reviewers evaluated each project submitted using the CMS validation tools. This included assessing each project across ten steps. These ten steps include:
Step 1: Review the Selected Study Topics
Step 2: Review the Study Questions
Step 3: Review the Selected Study Indicator(s)
Step 4: Review the Identified Study Population
Step 5: Review Sampling Methods
Step 6: Review the MCO's Data Collection Procedures
Step 7: Assess the MCO's Improvement Strategies
Step 8: Review Data Analysis and Interpretation of Study Results
Step 9: Assess the Likelihood that Reported Improvement is Real Improvement, and
Step 10: Assess Whether the MCO has Sustained its Documented Improvement.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Health Services for Children with Special Needs PIPs

Health Services for Children with Special Needs (HSCSN) provided two PIPs for review: (1) Obesity and (2) Residential Facility Treatment. The MCO was mandated to perform PIPs on these topics by DCMAA based on their identification as high risk, high cost conditions. These PIPs were evaluated using the Validating Performance Improvement Projects protocol, commissioned by the Department of Health and Human Services, CMS, which allows assessment among 10 different project activities.

The Obesity PIP targeted the MCO's pediatric members between the ages of 6 – 19. The indicators for this PIP were derived from the Obesity Study completed by Delmarva Foundation for the District of Columbia in CY 2002. The MCO reviewed medical records for inclusion of body mass index (BMI) and nutritional counseling for the targeted obese population. Interventions implemented included:

- Providing education to providers regarding use of BMI to identify children who are overweight/obese;
- Providing a CME event on obesity in the Medicaid population for Medical Directors and Primary Care Providers; and
- Providing Primary Care Providers with an Obesity Toolkit.

At the time of PIP submission, baseline measurements had been performed for each indicator.

The Residential Treatment Facility PIP was targeted to the MCO's population with mental health disorders. The MCO sought to decrease the average length of stay for inpatient programs and to decrease readmission

rates within 30 days. Over one half of the membership is diagnosed with mental health disorders. Interventions included:

- Prior ongoing interventions such as creating and maintaining a quality and utilization management position to monitor all members in residential treatment and hiring a psychiatrist as director of behavioral health programs; and
- Establishing a behavioral health team.

At the time of PIP submission, remeasurement 5 had been performed for each indicator.

Results

This section presents an overview of the findings of the Validation Review conducted for each PIP submitted by the MCO. Each MCO's PIP was reviewed against all 27 components contained within the ten standards. The results of the ten activities assessed for each PIP submitted by Health Services for Children with Special Needs Plan are presented in Table 2 below.

Table 2. 2005 Performance Improvement Project Review for Health Services for Children with Special Needs

Activity Number	Activity Description	Review Determination	
		Identification of Overweight/Obesity	Residential Treatment Facilities
1	Assess the Study Methodology	Met	Met
2	Review the Study Question(s)	Met	Met
3	Review the Selected Study Indicator(s)	Met	Met
4	Review the Identified Study Population	Met	Met
5	Review Sampling Methods	Partially Met	Not Applicable
6	Review Data Collection Procedures	Met	Met
7	Assess Improvement Strategies	Met	Met
8	Review Data Analysis and Interpretation of Study Results	Unmet	Partially Met
9	Assess Whether Improvement is Real Improvement	Not Applicable	Met
10	Assess Sustained Improvement	Not Applicable	Met

Conclusions and Recommendations

Conclusions

For the Obesity Project, the MCO received a review determination of "Met" for six (6) activities. Activity 5, Review Sampling Methods, was "Partially Met," as the sample did not contain a sufficient number of enrollees. Activity 8, Review Data Analysis and Interpretation of Study Results, was "Unmet," as numerical results were not presented accurately and clearly. Activity 9, Assess Whether Improvement is Real Improvement, and Activity 10, Assess Sustained Improvement, were "Not Applicable" because the MCO had only performed a baseline measurement for each indicator.

For the Residential Treatment Facilities Project, the MCO received a review determination of "Met" for eight (8) elements. Activity 5, Review Sampling Methods, was "Not Applicable" as sampling was not utilized. Activity 8, Review Data Analysis and Interpretation of Study Results, was "Partially met," as the analysis did not include a thorough interpretation of the latest results, including planned follow-up activities addressing identified barriers. No elements were "Unmet" for this project.

Recommendations

Based on a review of each of the two PIPs provided by the MCO, the following recommendations are made to improve the PIP process and performance.

Identification of Overweight/Obesity

- Sample a sufficient number of enrollees. A sample size of 500 was described in the study; however, only 51 charts were reviewed.
- Numerators and denominators should be described accurately and clearly. There were instances where the numerators and denominators were reversed. Also, "unknown" was used to describe a numerator in the data results table.
- The MCO used results from a 2002 Obesity Study completed by Delmarva Foundation as their baseline measurement and then used plan results gathered in 2005 as their first remeasurement. Using results gathered by Delmarva Foundation is not acceptable for the MCO's baseline measurment. Therefore, the MCO's 2005 results were reviewed as baseline.

Decreasing the Average Length of Stay of HSCSN Members in Residential Facilities

- Provide a more focused qualitative analysis for the latest remeasurement year. Provide an interpretation based on the latest results discussing planned follow-up activities addressing identified barriers.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: Date of evaluation: 6/19/2006

Demographic Information	
MCO/PHP Name or ID:	Health Services for Children with Special Needs
Project Leader Name:	Nancy Doellgast
Telephone Number:	292-454-1254
Name of Quality Improvement Project:	Obesity Study
Dates in Study Period: 01/2005 to: 12/w005 Phase: Remeasurement 1	

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	Y, N, or N/A	Comment	Cites and Similar References
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	The obesity rate among pediatric enrollees in DC Medicaid is 36%, which is greater than the national average.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	The MCO addressed obesity by measuring the body mass index (BMI) among pediatric members and implementing interventions/follow-up.	QAPI RE2Q1QI A S1A2
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	The MCO included all eligible members in the study.	QAPI RE2Q1 QIA S1A2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	The obesity rate among pediatric enrollees in DC Medicaid is 36%, which is greater than the national average.	QIA S1A3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	The MCO's indicators to address pediatric obesity were objective, clearly defined, and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	The MCO's indicators appropriately measured changes in health status for pediatric obesity.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	The MCO describes a retrospective review of records for Medicaid children enrolled in the plan between the ages of 6 and 19 years old who had at least one office visit with their PCP in the calendar year.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The MCO 's data collection methodology included a random sample of all members in the study.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	**Y**	The MCO documented that random sampling was utilized with a 95% confidence level, 5% margin of error.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	**Y**	The MCO used random sampling, removing bias.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:	**Random**		
5.3 Did the sample contain a sufficient number of enrollees?	**N**	It does not appear that a sufficient number of enrollees were sampled. Section C3 indicates a sample size of 500; however, it appears that only 51 charts were reviewed.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Sample a sufficient number of enrollees.			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The design clearly specified the data to be collected via medical record review.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	Y	The MCO's study design clearly specified the sources of data, medical/treatment records.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	The MCO's study design specified manual data collection via medical record review.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	N/A	The 2005 data is considered baseline and there are no remeasurements.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	Y	The MCO documented a quantitative and qualitative analysis for the measures studied.	QAPI RE5Q1.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: The MCO has indicated the results of a 2002 study, completed by Delmarva Foundation, are baseline; these results are not acceptable as baseline. The 2005 results provided by the MCO are being counted as baseline. In future project submissions, use the 2005 results as baseline.			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	The interventions implemented by the MCO appear to be system-level and address barriers identified.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	**N**	Numerators and denominators were not presented accurately. A mix up was determined when verifying the rates. For Indicator #3 a rate of 0.1% is not acceptable when the numerator is listed as "unknown."	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	**N/A**	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QAPI RE7Q2 QIA S1C4 QIA S2.1
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	**N/A**	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QIA S2.2
Assessment Component: **Not Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: List numerators and denominators accurately. "Unknown" is not acceptable in in a quantitative analysis. Provide a qualitative analysis.			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	N/A	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	N/A	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	N/A	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QIA S3.2
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QIA S2.3
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N/A	To date, only a baseline measurement has been calculated. Results from the 2002 Delmarva Foundation study are not being counted as the baseline measurement.	QAPI RE2SQ3 QIA II, III
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths:
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): PCPs had never been instructed to utilize BMI and lack conversion tools. PCPs need education re: strategies and interventions to address weight issues with their patients.
4. Action taken by MCO (Barrier Analysis): Implemented physician education on the use of BMI to identify overweight/obese children. A CME event was held on obesity in the Medicaid population. Provided physicians with an "Obesity Toolkit."
5. Recommendations for the next submission: • Sample a sufficient number of enrollees. The MCO has indicated the results of a 2002 study, completed by Delmarva Foundation, are baseline; these results are not acceptable as baseline. The 2005 results provided by the MCO are being counted as baseline. In future project submissions, use the 2005 results as baseline. List numerators and denominators accurately. "Unknown" is not acceptable in a quantitative analysis. Provide a qualitative analysis.

Activity Name: Identification of Overweight/Obesity in the HSCSN Population

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

The American Academy of Pediatrics noted in its 2003 Committee on Nutrition Policy Statement on the Prevention of Pediatric Overweight and Obesity (OW/OB), that "The dramatic increase in the prevalence of childhood overweight and its resultant co-morbidities are associated with significant health and financial burdens warranting strong and comprehensive prevention efforts". The Delmarva Foundation Obesity Study in 2002 found that 36% of children sampled from 5 MCO's had BMI's in OW/OB range.

The HSCSN population is a prime population for Pediatric Overweight and Obesity due to pre-existing conditions. Issues requiring medications that predispose children to gain excessive weight, including physical mobility problems and mental health disorder and psychotropic medication use. In addition, the HSCSN membership is 97% an ethnic group disproportionately affected by obesity.

The financial impact is significant; 2003 - 2004 HSCSN spent $556,140 for the inpatient treatment of 3 members alone.

Early identification of excess weight by Primary Care Providers is vital to prevent obesity and to apply dietary and physical activity interventions. The most effective measure for early identification is calculation of Body Mass Index (BMI) for age and weight. BMI between 85th and 95th percentiles for age and sex is considered risk for overweight, a BMI over the 95th percentile is considered obese. The Obesity study performed by The Delmarva Foundation for the District of Columbia in CY 2002 looked at 342 Medicaid records ages six (6) years to 16years and over. The records were reviewed for 1. Documentation of ht/wt, which could be used to calculate BMI, 2. Members documented as overweight or obese, 3. Members who had diagnosis of overweight/obesity who also had documentation of education, intervention, follow-up.

In 2005, HSCSN looked at charts for inclusion of BMI and nutritional counseling to targeted population. This was not graded in their audits results. 11 PCP's records were reviewed total N= 51 charts - 49 charts had ht & wt documented; 26 charts had BMI documented with one chart documenting nutritional counseling for obesity. All providers visited received BMI calculator wheels during this measurement year.

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	**Members having height and weight documented in the medical record**
Numerator:	Children with HT/WT documented in record N=276 (81%)
Denominator:	Number of records reviewed N=342
First measurement period dates:	January 1, 2002 through December 31, 2002
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	**Members with BMI rates in the overweight/obese range**
Numerator:	Number of records PCP documented overweight/obese in record N = 24 (24%)
Denominator:	Number of children who were overweight/obese by BMI when calculated by the study N = 100
First measurement period dates:	January 1, 2002 through December 31, 2002
Benchmark:	None
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	**Members diagnosed with overweight or obesity having documentation of nutritional education, intervention or follow-up**
Numerator:	Members having PCP documentation of intervention, education, or follow-up N = 6 (22%)
Denominator:	Members with PCP documented diagnosis of overweight/obesity N = 24
First measurement period dates:	January 1, 2002 through December 31, 2002
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #4:	Members having BMI in overweight/obese range
Numerator:	Number of Medicaid MCO members BMI in overweight/obese range N = 107 (36%)

Denominator:	Total number of records with calculated BMI N = 276
First measurement period dates:	January 1, 2002 through December 31, 2002
Benchmark:	30.35% National Average
Source of benchmark:	Ogden, Flegal, Carroll & Johnson 2002
Baseline goal:	

C. Baseline Methodology.

A retrospective review of PCP medical records and District of Columbia MCO records for Medicaid children enrolled in the MCO between the ages of 6 and 19 years old who had at least one office visit with their PCP in CY 2002. a random sample of enrolled was selected. Four hundred and twenty (420) medical records was determined to meet the HEDIS criteria for sampling. The measurement items were based on the position statement on the prevention, diagnosis, and treatment of obesity from the American Association of Clinical Endocrinologists (AACE), the American College of Endocrinology (1998) as well as Barlow and Dietz Obesity Evaluation and Treatment Expert Committee Recommendations.

C.1 Data Sources.

[x] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

_____

_____

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:

[x] Medical/treatment record abstraction

If survey, check all that apply:

[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:

[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*
All Measures	500	All DC Medicaid MCO Children ages 6-19years	HEDIS Criteria (95% confidence level, 5% margin for error, including an over sampling of 20%	Random

C.4 Data Collection Cycle.	Data Analysis Cycle.
[X] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.5 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size and sampling method
- Any introduction of bias that could affect the results

_____None_____

_____

_____

_____

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/02 – 12/31/02	*Baseline:*	276	342	81%	None	None	
1/2005-12/2005	Remeasurement 1:	51	49	96%	None	None	
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/02 – 12/31/02	*Baseline:*	24	100	24%	None	None	
1/2005-12/2005	Remeasurement 1:	51	26	51%	None	None	
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/02 – 12/31/02	*Baseline:*	6	24	22%	None	None	
	Remeasurement 1:	Unknown	1	0.1%	None	None	
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

#4 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	
1/1/02 – 12/31/02	*Baseline:*	107	276	39%	30%		
	Remeasurement 1:	0	0	0	0		
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That the Analysis Covers.

Calendar year 2002

1. **Percentage of members having height and weight documented in the medical record**
2. **Percentage of members with BMI rates in the overweight/obese range**
3. **Percentage of members diagnosed with overweight or obesity having documentation of nutritional education, intervention or follow-up.**
4. **Percentage of members having BMI in overweight/obese range**

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1. For the quantitative analysis, include the analysis of the following:

- Comparison with the goal/benchmark
- Reasons for changes to goals
- If benchmarks changed since baseline, list source and date of changes
- Comparison with previous measurements
- Trends, increases or decreases in performance or changes in statistical significance (if used)
- Impact of any methodological changes that could impact the results
- For a survey, include the overall response rate and the implications of the survey response rate

The 2002 study analysis found that enrollees in the Medicaid Managed Care childhood population had an overweight/obesity rate of 39%, which is 9% higher than the national average. Primary Care Providers though collecting data that was needed to calculate BMI did so only 24% of the time. Only six records contained any documentation of education or intervention for overweight/obesity while the study found 107 children according to BMI calculations were overweight or obesity.

B.2. For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:

- Techniques and data (if used) in the analysis
- Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis
- Citations from literature identifying barriers (if any)
- Barriers/opportunities identified through the analysis
- Impact of interventions

The U.S. Department of Health and Human Services National Health Statistics found that in the U.S 15.8% of all children ages 6-19 years were overweight or obese in 2002. In 2003 the American Academy of Pediatrics found that the earlier an intervention to address overweight was initiated the better the outcome were.

Barriers found in the study:

- **Providers did not calculate BMI during routine exams leading to poor identification of overweight children**
- **Providers voiced reluctance to discuss overweight issues with children due to concern for hurting child/parents feelings**
- **Providers need increased resources to refer children for interventions and treatments**

HSCSN has not performed a second measurement of the data; the performance of the re-measurement will not change the original methodology, except that only HSCSN member records will be reviewed. The next re-measure will occur during 1st qtr 2006 following the implementation of interventions planned for 2nd qtr 2005.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
1/05	YES	Quality Coordinators started educating PCP on use of BMI to identify children who are overweight. Providers are not being scored at this time and the goal is to educate PCPs on best practices. In 2006 PCPs will be monitored to measure effectiveness of interventions.	PCP's had never been instructed to utilize BMI in the past.
6/2/05		A CME event will be held on obesity in the Medicaid Population for Medical Directors and Primary Care Providers. This forum will focus on identification, education, and interventions for members with obesity.	Primary Care Providers need education on strategies and interventions to address weight issues with their patients
6/2/05		Primary Care Providers will be supplied with an "Obesity Toolkit" that includes: BMI Wheel; Nutrition Education Handouts; Exercise Education Handouts; Stamp or Sticker for BMI/BMI %; Billing Codes for Overweight/Obesity; Posters (from Kaiser); Clinical Pathways for treatment	Primary Care Provider lack chart reminders to plot BMI, they lack BMI conversion tools that are easy to use; and need patient educational tools.
1st qtr 2006		Quality Coordinator will monitor medical records for documentation of BMI and provide training and support on how to use toolkit and how to access resources	Providers need re-enforcement to remember documentation as well as support to use the tools available to impact OW/OB issues with patients

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: Date of evaluation: 6/20/2006

Demographic Information	
MCO/PHP Name or ID:	Health Services for Children with Special Needs
Project Leader Name:	Nancy Doellgast
Telephone Number:	202-454-1254
Name of Quality Improvement Project:	Length of Stay in Residential Facilities
Dates in Study Period: 01/2005 to: 12/2005 Phase: Remeasurement 5	

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	The MCO's population is at high risk for members placed in psychiatric residential facilities due to the fact that more than one half of the membership are diagnosed with mental health disorders. Residential facility (ALOS) rates were provided and show an increase.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	The MCO addressed decreasing length of stay in residential treatment facilities by measuring ALOS and readmissions within 30 days.	QAPI RE2Q1QI A S1A2
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	The MCO included all eligible members in the study.	QAPI RE2Q1 QIA S1A2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	The MCO provided a clear rationale for the study. Many of their members have on-going chronic school problems, multiple acute psychiatric hospitalizations, and are resistant to or have failed outpatient services.	QIA S1A3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	The MCO's indicators indicators to address decreasing length of stay were objective, clearly defined, and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	The measures identified, ALOS and readmission rates, are valid proxies for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	The MCO specifies the population to which the study applies, all children discharged from residential treatment facilities and all readmissions within 30 days of discharge.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The MCO's data collection approach captured all enrollees to whom the study question applied.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	The MCO did not utilize a sampling methodology.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	N/A	The MCO did not utilize a sampling methodology.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:			
5.3 Did the sample contain a sufficient number of enrollees?	N/A	The MCO did not utilize a sampling methodology.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	The study design clearly specified the data to be collected, residential days and numbers of readmissions.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	Y	The study design clearly specified the sources of data to be used, medical/treatment records and administrative data.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	The MCO's study design specified using a hybrid methodology. Data was tracked manually and verified by claims data.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	The data collection methodology employed by the MCO provided for consistent, accurate data collection over the time periods studied.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	N/A	The study is in the remeasurement phase.	QAPI RE5Q1.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	There were multiple interventions addressing barriers that were described as ongoing since 2002. In late 2004, a behavioral health team was established. In 2005, delineation of ALOS for members with and without Pervasive Developmental Disorders was described as an intervention. This is not an intervention that addresses identified barriers. This is a measurement providing additional detail.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	**Y**	Numerical findings were presented accurately and clearly.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	**Y**	The analysis identified initial and repeat measurements. There were no defined factors influencing comparability of initial and repeat measurements or internal and external validity.	QAPI RE7Q2 QIA S1C4 QIA S2.1
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	**N**	The analysis did not include a thorough interpretation of the latest results, including planned follow-up activities addressing identified barriers.	QIA S2.2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: For the next submission, please provide a more focused qualitative analysis for the latest remeasurement year. Provide an interpretation based on the latest results discussing planned follow-up activities addressing identified barriers.			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	The MCO used the same methodology for the baseline measurement and all remeasurements. Remeasurement 5 included additional information.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	Y	The MCO was able to maintain a 0% readmission rate.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	Y	The MCO appears to have maintained a 0% readmission rate due to the interventions implemented.	QIA S3.2
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	N/A		QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**Y**	The MCO was able to sustain a 0% readmission rate.	QAPI RE2SQ3 QIA II, III
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: The MCO was able to maintain a 0% readmission rate.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): Utilization and care management of members with mental health issues were poorly managed.
4. Action taken by MCO (Barrier Analysis): In late 2004, the MCO established a behavioral health team to address utilization and care management.
5. Recommendations for the next submission: • For the next submission, please provide a more focused qualitative analysis for the latest remeasurement year. Provide an interpretation based on the latest results discussing planned follow-up activities addressing identified barriers.

Activity Name: To decrease the Average Length of Stay of HSCSN members in Residential Facilities

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

- The HSCSN population is at high risk for members placed in psychiatric residential facilities due to the fact that more than one half of the membership are diagnosed with mental health disorders. Many of the members are in special education services in the public school system. These members have on-going chronic school problems, multiple acute psychiatric hospitalizations, and are resistant to or have failed outpatient services.

  The financial impact is costly. It is important to provide intense utilization management to control the amount of time members' stay in residential facilities. Since 2002, the days per 1000 members has steadily decreased.

  The ALOS per month in residential increased in 2005 to 15.3 months from 11.8 in 2004. This increase was due to the identification of members with Pervasive Developmental Disorders who were either to difficult to treat or could not be treated due to their cognitive limitations, resulting in unlimited stays in Residential Treatment. In June 2005, the members with PDD ALOS ballooned to 28 months while Non-PDD members were 13.2 months. The combined ALOS in June 2005 was 17.5 months. Because of the substantial difference between members with PDD and Non-PDD, the Performance Outcome Improvement Committee made the decision to focus on the Non-PPD population. The Non-PDD is a more cognitively functional ambulatory population that could be managed through utilization review. The final ALOS for members with PDD in 2005 was 25.6 months and Non-PDD was 12.7. Nevertheless, the 12.3 months ALOS of Non-PDD members is still an increase above the combined 11.8 ALOS in 2004 and the organization's benchmark of 11.0 months. Later in this report a chart and graph will illustrate the comparative data of PDD members, Non-PDD members, and Combined members from 1998 through 2005. The average number of members in residential for 2005 was 40.9 which was a considerable decrease from 46.5 in 2004. The average since 1998 including 2005 is 38.6 members. The decrease in the average number of members in residential from 2004-2005 is apparently due to the Residential Review Committee's oversight by directing more members into utilizing outpatient services in the community.

- Recidivism within the HSCSN population is a primary concern. Members who spent time in residential treatment must come back to their original communities and family settings. The coping and behavioral management skills learned in residential treatment are not re-enforced in their homes. This creates a higher probability of HSCSN members relapsing and being re-admitted into residential treatment. HSCSN wrap-around services upon discharge are designed to curtail any potential problems and reduce recidivism. Having the ability to step down members to a least restrictive residential setting utilizing in-area group home placement prior to returning to their own homes maintains stability while readjusting to community life. Use of Intensive Outpatient Services for Mental Health clearly allowed HSCSN to have a recidivism rate of 0% less than 30 days of discharge.

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	Members Average Length of Stay in residential facilities by discharge.
Numerator:	Total number of RTC Days N- 9644 (13.2 ALOS/member)
Denominator:	All Children discharged from RTC - N=24 members
First measurement period dates:	January 1, 2001 through December 31, 2001
Baseline Benchmark:	10.4 months based on CY 2000 data
Source of benchmark:	HSCSN Internal Data
Baseline goal:	Maintain ALOS at or below 11.0 Months
Quantifiable Measure #2:	Readmission to RTC within 30days of Discharge.
Numerator:	Number of members readmitted to RTC within 30 days of discharge N-0 (0%)
Denominator:	All Children discharged from RTC - N = 24 members
First measurement period dates:	January 1, 2001 through December 31, 2001
Benchmark:	0% based on CY 2000 data
Source of benchmark:	HSCSN Internal Data
Baseline goal:	Zero
Quantifiable Measure #3:	
Numerator:	
Denominator:	

First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	

C. Baseline Methodology.

The Baseline methodology is determined by utilizing for the preceding calendar year ALOS measure against the current calendar year. There are no comparable credible national benchmark/baseline data available.

C.1 Data Sources.

[ ] Medical/treatment records
[ ] Administrative data:
[x] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[x] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[x] Other (list and describe):

The data is collected concurrently and annually.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:

[x] Medical/treatment record abstraction

If survey, check all that apply:

[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:

[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[x] Other (list and describe):

____The data is tracked manually and verified by claims data_____

_____

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.	Data Analysis Cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [x] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[ ] Once a year [ ] Once a season [x] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.5 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size and sampling method
- Any introduction of bias that could affect the results

_____

_____

_____

_____

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: Members Average Length of Stay in residential facilities by discharge.

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/01 – 12/31/01	Re-measurement 1:	9644 days	24 members	13.2 mos. (Increased 2.8 mo)	10.4 mos.-2000	11.0 months	
1/1/02 – 12/31/02	Re-measurement 2:	18864 days	56 members	11.1 mos. (decrease = 2.1 mo)	13.2 mos.-2001	11.0 months	
1/1/03 – 12/31/03	Re-measurement 3:	13222 days	38 members	11.5 mos. increase	11.1 mos.-2002	11.0 months	
1/1/04 – 12/31/04	Re-measurement 4:	11751 days	33 members	11.8 mos (0.3 mo. Increase)	11.5 mos.-2003	11.0 months	
1/1/05 – 12/31/05	Re-measurement 5:	16229 days (Combined 5455 days (PDD) 10774 days (Non-PDD)	35 members 7 members 28 members	15.3 mos. (14.5 increase) 25.6 mos 12.7 mos.	11.8 mos-2004	11.0 months	

#2 Quantifiable Measure: Members re-admitted to RTC within 30 days of discharge.

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/01 – 12/31/01	Re-measurement 2:	0 members	24 members	0%	0% - 2000	0%	
1/1/02 – 12/31/02	Re-measurement 2:	0 members	56 members	0%	0% - 2001	0%	
1/1/03 – 12/31/03	Re-measurement 3:	0 members	38 members	0%	0% - 2002	0%	
1/1/04 – 12/31/04	Re-measurement 4:	0 members	33 members	0%	0% - 2003	0%	
1/1/05 – 12/31/05	Re-measurement 5:	0 members	24 members	0%	0% - 2004	0%	

#3 Quantifiable Measure:.

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						
	Remeasurement 1:						
	Remeasurement 2:						
	Remeasurement 3:						

	Remeasurement 4:						
	Remeasurement 5:						

#4 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						
	Remeasurement 1:						
	Remeasurement 2:						
	Remeasurement 3:						
	Remeasurement 4:						
	Remeasurement 5:						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That the Analysis Covers.

2001 –2005

1. **Members Average Length of Stay in Residential Facilities by Discharge.**
2. **Member re-admitted to RTC within 30 days.**

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis, include the analysis of the following:

- Comparison with the goal/benchmark
- Reasons for changes to goals
- If benchmarks changed since baseline, list source and date of changes
- Comparison with previous measurements
- Trends, increases or decreases in performance or changes in statistical significance (if used)
- Impact of any methodological changes that could impact the results
- For a survey, include the overall response rate and the implications of the survey response rate

HSCSN is unique in the population it serves, there are no Medicaid Plans that manage specifically for Children with Special Needs also other Medicaid Plans do not cover RTC services after the 31st day of stay, HSCSN monitors and covers the entire member stay. Due to this there are no comparative benchmarks, HSCSN has utilized its own internal data and benchmarks from the previous year. However, after analyzing the ALOS from 2000 through 2003, the ALOS hovered at or around 11 months. As a result of the ALOS trend, initiated in 2004, HSCSN on-going internal benchmark goal is 11 months. Goals are identified through the analysis of the data and in conjunction with the Utilization Management Committee recommendations.

B.2 For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:

- Techniques and data (if used) in the analysis
- Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis
- Citations from literature identifying barriers (if any)
- Barriers/opportunities identified through the analysis
- Impact of interventions

The data used for this initiative was from actual member lengths of stay. Over time it was found that with prudent placement (e.g. the appropriate facility for member diagnosis and treatment needs, ALOS could be impacted with improved outcomes upon discharge. With the development of the RTC Committee recommending the right placement, assuring medical necessity for placement and the addition of utilization review to monitor need for continued stay or discharge readiness there was no recidivism for HSCSN members. MAA required measure for re-admission into an inpatient facility including RTC within 30 days of discharge. HSCSN has 0% re-admission rate to RTC within 30 days of discharge.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
1/2002	X	Contracted with a Consulting Psychiatrist	No clinical oversight of process
1/2002	X	Development of Quality and Utilization Management Position to monitor all members in RTC	There were no utilization review process, quality control, data collection and performance Improvement
3/2002	X	Approval of Mental Health Criteria to review medical necessity for treatment	Allow for clear guidelines to maintain members at the correct level of care
1/2004	X	Hiring a Psychiatrist as Director of Behavioral Health Program	There was no clinical oversight of entire behavioral health program.
4/2004	X	Quarterly meetings with referral agency (Child & Family Services) representatives to develop a stronger relationship	Members who are in the custodial care of CFSA have a longer ALOS on residential facilities than other referral agencies.
8/2004	X	Establishment of Behavioral Health Team	Utilization and care management of members with mental health issues were poorly managed thus increasing claims reimbursement.
1/2005	X	Delineation of ALOS for PPD member vs. Non-PDD members	This allows for a clearer picture of utilization of residential services as opposed to member who are receiving residential custodial services.

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

Average Length of Stay										
Variables	Pervasive Developmental Disability			Non-PDD			Total Population			Benchmark
Year	# of Members	Total Days	ALOS	# of Members	Total Days	ALOS	# of Members	Total Days	ALOS	ALOS
1997	0	0	0	1	30	1	1	30	0.987	11
1998	1	60	2	3	356	3.9	4	416	3.421	11
1999	6	1219	6.7	20	5675	9.3	26	6894	8.722	11
2000	11	3761	11.1	20	6040	10.5	31	9801	10.4	11
2001	9	5309	19.4	18	4335	7.9	27	9644	11.75	11
2002	10	5222	17.2	47	13643	9.1	57	18865	10.89	11
2003	10	4584	15.1	28	8638	10.2	38	13222	11.45	11
2004	7	4900	23	27	8308	10.1	34	13208	12.78	11
2005	7	5455	25.634	28	10774	12.66	35	16229	15.25	11
Total	61	30510	16.453	192	57799	9.903	253	88309	11.48	11

Chart

Average Length of Stay										
Variables	Pervasive Developmental Disability			Non-PDD			Total Population			Benchmark
Year	# of Members	Total Days	ALOS	# of Members	Total Days	ALOS	# of Members	Total Days	ALOS	ALOS
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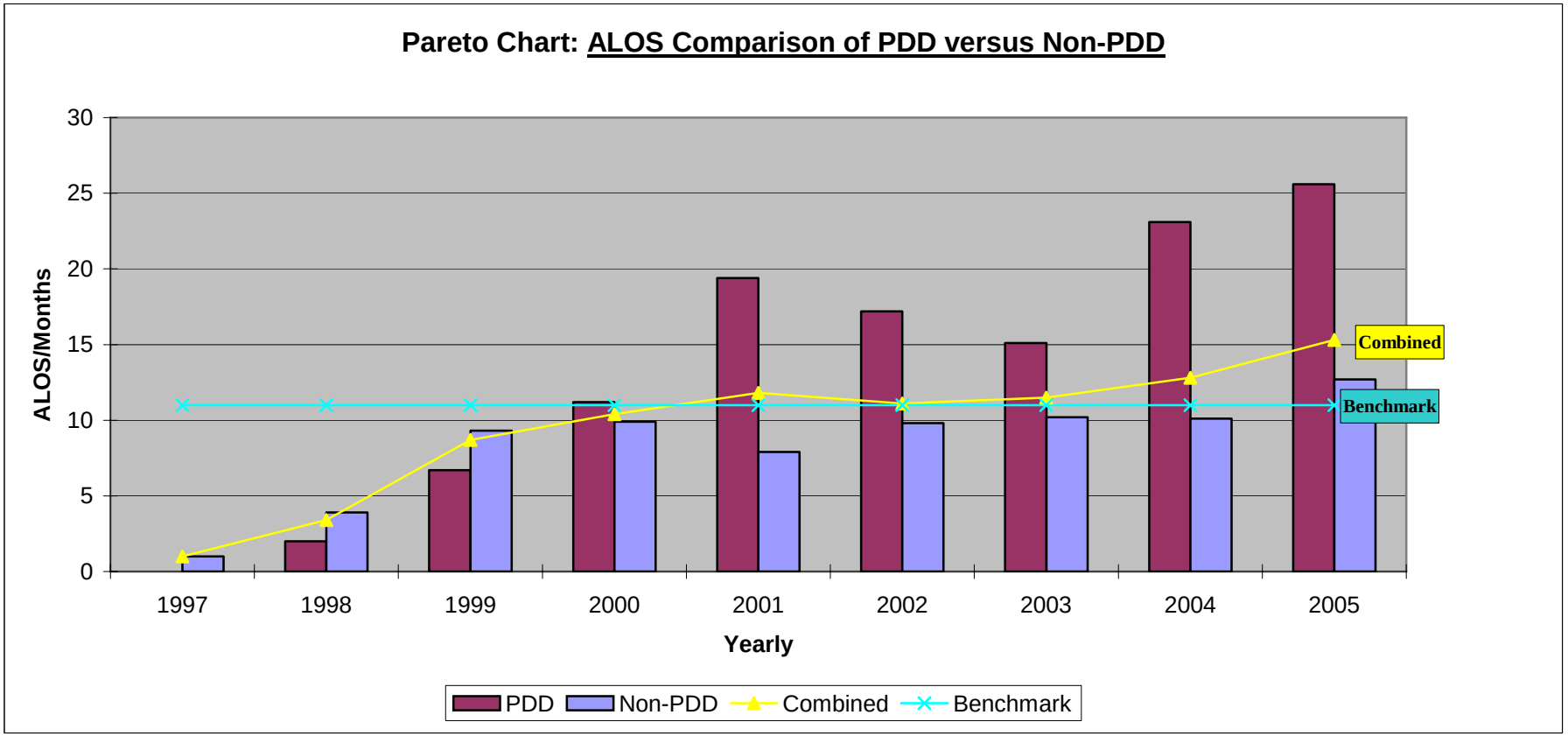
2003	10	4584	15.1	28	8638	10.2	38	13222	11.45	11
2004	7	4900	23	27	8308	10.1	34	13208	12.78	11
2005	7	5455	25.634	28	10774	12.66	35	16229	15.25	11
Total	61	30510	16.453	192	57799	9.903	253	88309	11.48	11

Graph


Pareto Chart: ALOS Comparison of PDD versus Non-PDD
ALOS/Months
30
25
20
15
10
5
0
1997
1998
1999
2000
2001
2002
2003
2004
2005
Yearly
Combined
Benchmark
PDD
Non-PDD
Combined
Benchmark