District of Columbia
Medical Assistance Administration

Medicaid Managed Care Organizations

External Quality Review Annual Report

Calendar Year 2005

DELMARVA FOUNDATION
District of Columbia

final report

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Medicaid Managed Care Annual Report

District of Columbia Medicaid Managed Care Overview

The District of Columbia's Medical Assistance Administration (DCMAA) funds a variety of medical services for approximately 95,000 of the District's most vulnerable children and adults. The DCMAA has a responsibility to ensure that Medicaid beneficiaries enrolled in contracted managed care plans receive services to which they are entitled, and to hold plans accountable for the quality of care provided.

During 2005, the following Medicaid Managed Care Organizations (MCOs) were providing health care services to the District's Medicaid beneficiaries:

- AMERIGROUP DC (AMG)
- DC Chartered Health Plan (CHP)
- Health Right, Inc. (HRI)
- Health Services for Children with Special Needs (HSCSN)

Introduction and Purpose

The intent of the District's 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, the DCMAA contracts with an External Quality Review Organization (EQRO) to conduct an evaluation of the services provided by the MCOs.

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 all Medicaid MCOs contracting with the DCMAA in calendar year 2005. The purpose of this review was to assess each 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, 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: External Quality Review," 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 DCMAA. The annual external quality review is a mandated activity in the MCOs' contract and the BBA External Quality Review regulations.

Although Delmarva's task to assess how well each MCO performs in the areas of quality, access, and timeliness from selected performance measures, performance improvement projects (PIPs), and 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 may also 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 DCMAA. Ascertaining whether health plans have met the intent of the BBA and the DCMAA requirements is a major goal of this report.

Data Sources

Delmarva Foundation has used the following data sources to evaluate each MCO's performance:

- Performance Systems Reviews (PSR).
- Performance Measures, includes nationally recognized Health Plan Employer Data and Information Set (HEDIS®) measures.
- Plan-conducted Performance Improvement Projects (PIPs).

Methodology

Delmarva performed an external independent review of all data from the above-listed sources, and has assessed quality, access, and timeliness across the three data disciplines. After discussion of this integrated review, Delmarva will provide an assessment to the DCMAA regarding how well the Medicaid MCOs are providing quality care and services to their beneficiaries.

Performance Systems Review

Delmarva reviewed the results of each MCO's performance systems review. For all health plans this review was conducted on-site at the MCO's corporate office. This review covered activities performed from January 1, 2005, through December 31, 2005. The purpose of the review was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program.

The review focused on standards and elements developed specifically to incorporate both the DCMAA 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.*

The results of this review will be summarized according to the three categories of quality, access, and timeliness. The specific data were obtained from documents, interviews, on-site observation, and a review of electronic systems provided by the MCOs at the request of Delmarva. The review was conducted in a manner consistent with the External Quality Review Protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

Delmarva requested pre-site documentation to conduct desk reviews prior to the on-site reviews. All MCOs provided the requested documentation for the pre-site desk reviews. Following the desk reviews, on-site reviews were conducted at the MCOs' offices in Washington, DC. At the time of the on-site reviews 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.)
- Reviews of complaint, grievance, and appeals case files
- Reviews of credentialing and recredentialing files
- Reviews of quality improvement committee meeting minutes and activities.

All MCOs underwent a complete review of all standards and elements. As Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "unmet." Each individual element received a compliance rate (100% for met, 50% for partially met, and 0% for unmet). The individual element compliance rates were rolled up to determine an overall compliance rate for each standard.

The PSR was conducted in three main areas consistent with the BBA requirements. The three main systems evaluated included:

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

The standards and corresponding elements can be found in Appendix A1. This report contains the overall results of MCOs' performance on the Performance Systems Review relative to quality, access, and timeliness.

Performance Measure Validation

This report includes MCO aggregate results of the HEDIS indicators that were required to be reported by the plans and submitted to DCMAA for services delivered in calendar year (CY) 2005 as they relate to quality, access, and timeliness of services provided to Medicaid beneficiciaries. The BBA requires that selected performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Each audit was conducted by Delmarva as prescribed by the National Committee on Quality Assurance's (NCQA) *HEDIS, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and is consistent with the validation method required by the EQRO protocols.

Since its introduction in 1993, HEDIS has become the gold standard in managed care performance measurement. Conceived as a way to streamline measurement efforts and promote accountability in managed care, HEDIS measures are now used by approximately 90% of all managed care organizations. The NCQA maintains and directs the HEDIS program.

The DCMAA's goal is that all contracting Medicaid MCOs will achieve national accreditation status and report accurate and reliable measures of the quality of care delivered to Medicaid beneficiaries. Current quality activities include requirements for plans to submit 41 HEDIS performance measures and achieve target performance goals set by the DCMAA. HEDIS rates are not adjusted for severity of illness or the general health status of a managed care plan's population.

This report contains MCO aggregate data results for HEDIS measures that we have categorized as being proxies for quality, access, and timeliness of services. The measures chosen are representative of care delivered to both child and adult members served by the MCOs. The results reported here are the weighted

DC MCO averages for the performance measure for services delivered in calendar year 2005 and are compared to the DCMAA target, the Medicaid national 25th percentile, Medicaid national mean, and the Medicaid national 90th percentile. Where available, rates are compared to the CY 2004 DC MCO aggregate.

The source document for national averages and percentiles is the most current version, at the time this report was prepared, of NCQA's *Quality Compass*. Currently, the national data are available from *HEDIS* 2005 which describe care delivered in calendar year 2005. Several of the performance measure results are better suited to tabular presentation. All aggregate results are presented in the appendix of this report.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are used to assess the health plan's focus on improving quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to issues of access or timeliness as major contributing factors that affect the attainment of the clinical quality goals.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. After developing a crosswalk between the QIA form and *Validating PIP Worksheet,* Delmarva staff developed review processes and worksheets using CMS' protocols as guidelines (2002). 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.

Each MCO submitted two PIPs for review as required. Delmarva reviewed the PIPs, assessed compliance with DCMAA contractual requirements, and validated the MCOs' methodologies in the following areas:

- Study Topics
- Study Questions
- Study Indicator(s)
- Identified Study Population
- Sampling Methods
- Data Collection Procedures
- Improvement Strategies
- Data Analysis and Interpretation of Study Results
- Likelihood that Reported Improvement is Real Improvement, and
- Whether the MCO has Sustained its Documented Improvement.

Each validation area received a determination of "met", "partially met", or "unmet". The overall MCOs' validation results are presented in this report as they pertain to the areas of quality, access, or timeliness.

Quality at a Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the DCMAA Medicaid Managed Care Program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medicaid enrollees. 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

The Performance Systems Review (PSR) included a review of three major systems. These include Enrollee Rights and Protections (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QAPI). The calendar year 2005 review was the first year that Delmarva assessed the MCOs against this set of standards. While many of these same standards were in place prior to 2005, this set of standards includes additional requirements required in the BBA regulations and the MCO contracts.

There are 11 ER standards, 28 GS, and 25 QAPI standards. Therefore, there are a total of 44 review determinations for ER (11 standards x 4 MCOs), 112 for GS (28 standards x 4 MCOs), and 100 for QAPI (25 standards x 4 MCOs). The aggregate PSR results are displayed in Table 1 below.

Table 1. Review Results by Performance Standard

Standard	Met	Partially Met	Unmet	Overall
Enrollee Right	36	8	0	44
Grievance Systems	69	28	15	112
Quality Assurance and Performance Improvement	78	22	0	100
Total	183	58	15	256

Overall, the MCOs performed well in the areas of ER and QAPI. The MCOs fully met the ER requirements for 36 of the 44 standards with the remaining 8 partially met. Seventy-eight of the 100 QAPI standards were fully met with the remaining 22 being partially met. The GS standards provided the area where most issues were identified with 69 of the 112 standards being fully met and 28 being partially met. Only 15 standards out of the entire PSR review were unmet and all fell into the GS standards category.

With these results, an overall MCO Weighted Average was calculated along with an MCO Weighted Average for each standard. These are included below.

Table 2. Aggregate PSR Results by Standard

Standard	MCO Weighted Average
Enrollee Rights	96.2%
Grievance Systems	74.5%
Quality Assurance and Performance Improvement	94.3%
Overall	87.7%

As noted above, while the set of standards used to assess the MCOs for CY 2005 is new, many of the requirements for ER and QAPI are the same as those evaluated in prior years. Additional standards were included in 2005 to be in accordance with the BBA regulations. It is, therefore, not surprising that the MCOs continue to perform well in these two areas.

While there were grievance systems standards in place prior to 2005, the CY 2005 set of standards includes additional requirements (extensions, expedited processes, notification requirements) that were not a part of prior EQRO reviews. Now that the MCOs have specific feedback on areas of improvement, it is anticipated that the MCOs will address these areas to improve results in the CY 2006 review.
In regards to the Grievance Systems standards, the MCO Weighted Average was a respectable 74.5%. Many of the issues identified in this review are specific to policy and procedural requirements that are not thoroughly documented in the MCO policies, although informal procedures may be in place. These outstanding issues are discussed in detail in the specific sections of this report focused on quality, access, and timeliness.

Overall, the MCO Weighted Average across all four MCOs is 87.7% for CY 2005. It is clear that all MCOs performed well in the areas enrollee rights and quality assessment and performance improvement. The MCOs did not perform as well in the Grievance Systems standards which had a major impact on the overall MCO Weighted Average. To improve the overall compliance rate (MCO Weighted Average) the MCOs should review the Grievance System standards and requirements, update their policies and procedures, and provide documentation of compliance in individual cases to meet the specific standards and requirements. If this occurs, it is anticipated that the overall compliance rate (MCO Weighted Average) for the Grievance Systems standards will improve at the time of the next review.

Enrollee Rights

All MCOs had an enrollee rights policy and procedure in place. The standard (ER2) requires that policies include all enrollee rights outlined in the regulations. All policies included all of the required enrollee rights, except for one: the right 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. The MCOs are aware of this and plan to include this enrollee right at the time of the next policy revision.

The Member Handbook and other beneficiary materials include the necessary information to describe the benefits and services available to beneficiaries under the DCMAA managed care program. All but one MCO's member materials contain an adequate description of the amount, scope, and duration of benefits.

All MCOs have policies and procedures that 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, the MCOs attempt to ensure that documents are written at the fifth grade reading level. The MCOs' contract with the DCMAA requires materials to be available in Spanish, Korean, Chinese, Vietnamese, and Amharic or Braille/audio format. In general, the MCOs refer beneficiaries to member/customer services staff to receive information in these other languages.

All MCOs have adequate enrollee/provider communications policies and procedures. These are communicated to the enrollees in the member handbook or related materials and to providers through provider orientation and/or the provider manual.

Grievance Systems

All MCOs have complaint, grievance, and appeals policies and procedures in place. The procedures provide beneficiary access to the District Fair Hearing process. All MCO's provide quarterly summary data to the DCMAA as a part of the MCO quarterly reports process. In general, information about the grievance and appeals system is reviewed with providers during provider orientation sessions, is contained in provider contracts, and is outlined in the provider manuals. 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.

All MCOs provide some sort of a notice of action (NOA) to the beneficiary and provider in cases of denials. The standards require the NOAs to contain several items including, but not limited to, the action the MCO has taken or intends to take, the reasons for the action, appeal rights, information about the expedited appeals

process, and the beneficiary's right to have benefits continue during the appeal process and how to request continuation of services.

All MCOs issue notices of action, but not all components are included in the NOAs. In general, the MCOs should ensure that the language level requirements explaining the reasons for the denial or the outcome of the appeal are written at the fifth grade reading level when possible. In addition, the right of beneficiaries to request continuation of benefits during an appeal should be included in the notices of action.

All MCOs' policies, procedures, and/or member information state that the MCO will provide beneficiaries assistance in completing forms for grievances and appeals and will acknowledge each grievance and appeal. All policies and procedures require 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.

Quality Assessment and Performance Improvement

In general, the MCOs demonstrated through documentation that they maintain and monitor a network of appropriate providers. The appropriate provider contracts are in place. In the current year, the MCOs monitored their networks anywhere from quarterly to annually. Only one MCO did not complete a provider network analysis in 2005.

The MCOs continue to have an established and well functioning credentialing and recredentialing program and process. The MCO credentialing and recredentialing policies and procedures do not allow the MCOs 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. In general, a review of credentialing and recredentialing files yielded favorable results with the majority of individual provider records meeting requirements. One MCO was moving toward a three year recredentialing cycle and therefore some records were out of compliance with expected timeframes of recredentialing every two years. One MCO did not did not complete medical record audits as part of the initial on-site review.

Cultural competency has been addressed by the MCOs and the DCMAA. MCOs use various methods, including beneficiary review of materials for appropriateness, staff training requirements, and hiring bilingual staff to accomplish cultural competency goals.

The MCOs have various policies and procedures in place to identify beneficiaries with special health care needs and place them into case management with an assigned case or care manager. The MCOs use electronic systems to manage and coordinate the care of those identified with special needs.

All MCOs have policies and procedures in place for the initial and continuing authorization of services, and timeliness for issuing referrals 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 consistent application of review criteria for decisions is ensured through the inter-rater reliability process as documented by three of the MCOs. One MCO will need to implement an inter-rater reliability process to meet requirements.

The authorization policies and procedures require consultation with the requesting provider when appropriate. The MCOs notify providers and beneficiaries 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. Three MCOs have policies and procedures in place 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. One will need to address this issue in its policies.

The MCOs have appropriate policies in place for delegation. The delegated provider agreements specify the delegate's and the MCO's responsibilities in the delegated relationship. Each MCO has a specific policy and procedures that describe the mechanisms in place to monitor the delegate, including regular reporting by the delegate and auditing of the delegate's performance of delegated duties. Contracts also include steps to be taken in case the delegate is not meeting the MCO's performance expectations (corrective actions). The MCOs were able to provide documentation of the monitoring process through committee meeting minutes and/or copies of reports from delegates.

The MCOs have 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. The MCOs review/update the clinical practice guidelines at least every two years and the CPGs are used for making decisions regarding utilization management (UM), beneficiary education, and coverage of services. CPGs are contained in the provider manuals. Some MCOs have them posted on their websites.

All MCOs have a written quality management/improvement program. These documented programs include goals, objectives, program and committee structures, and various other components. Each MCO also has a

work plan for the program that includes the objectives, timeframes, and responsible parties for specific tasks. As the MCOs have matured, there is a migration toward the use of dashboards, report cards, and/or balanced scorecards. In general, the MCOs appear to have become better at data collection, analysis and reporting. The use of such report cards and dashboards will assist the MCOs in their planning efforts.

Collectively, the MCOs met the majority of the health information systems standards. The systems in place assist the MCOs by providing information on utilization, grievances, and disenrollments. However, some MCOs need to demonstrate improvement in the systems' ability to integrate information for coordinating beneficiary care, and for use in quality improvement and utilization management activities. The MCOs have mechanisms in place to verify the accuracy and timeliness of data, and screen the data for completeness, logic and consistency. Information is collected in standard formats to the extent feasible and all data collected is made available to DCMAA and CMS.

Performance Measure Validation

The performance measures validated as a part of the CY 2005 review include several HEDIS measures. These measures focus on quality, access and timeliness of care, but the aspect of quality can also be measured in the process used by the MCOs to collect and report measures.

The NCQA HEDIS Compliance Audit procedures were used to validate the selected measures. This included a review of information systems capabilities and a medical record abstraction assessment for MCOs that used the hybrid methodology. The information systems capabilities assessment focused on evaluating aspects of the information systems (IS) that specifically impact the MCOs ability to accurately report the required performance measures. The medical record abstraction process assessment requires an assessment of the credentials, training, and oversight of medical record reviewers, as well as the training materials, abstraction and data entry tools, and the application of inter-rater reliability tests.

After the IS and medical record abstraction assessment, the selected measures received an outcome of "report" or "not report" for each measure. For the CY 2004 performance measure validation two of the four MCOs were unable to report all the required measures. For the CY 2005 performance measure validation, all MCOs were able to produce key documentation to support their ability to accurately and reliably produce the required performance measures. This resulted in all MCOs receiving audit designations of "report" for the required performance measures.

From a quality perspective, this indicates that the MCOs have the appropriate systems and quality standards in place to capture, process, and integrate data from both internal and external sources to monitor the healthcare services provided to the District's Medicaid beneficiaries.

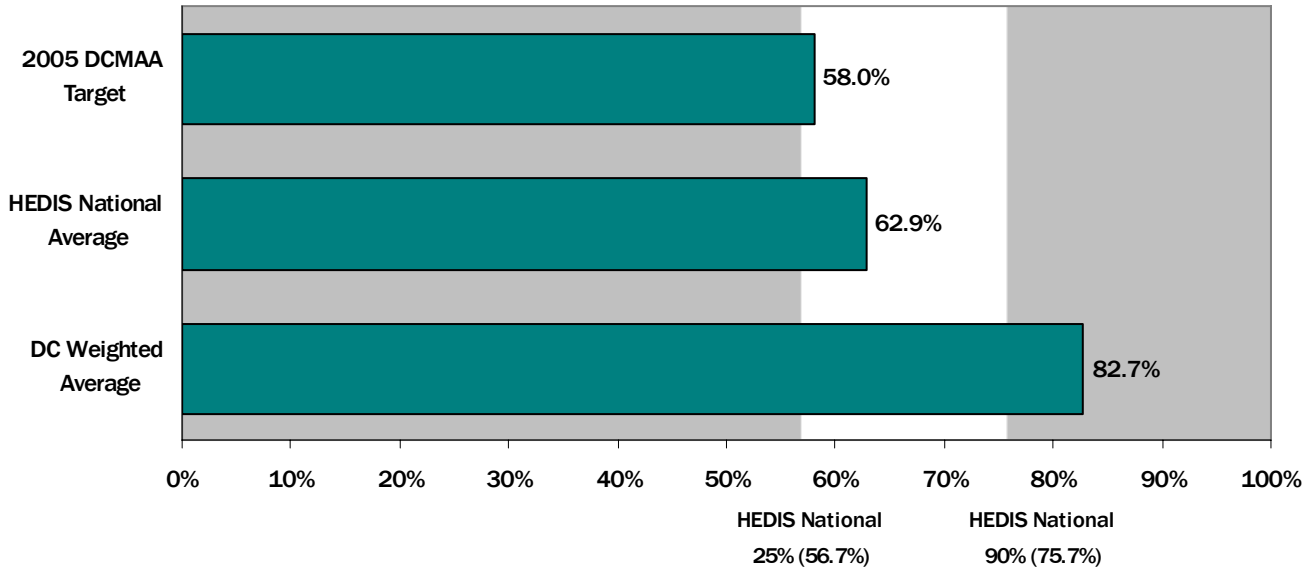
Delmarva has selected several performance measures reported by the MCOs as representative of health care quality. The measures were chosen because they encompassed the population characteristics and an array of preventive care services common to all DCMAA MCOs and beneficiaries.

The HEDIS measures chosen as being representative of quality of healthcare services included in this report are:

- Childhood Immunization Status (Combo 2)
- Adolescent Immunization Status (Combo 2)
- Use of Appropriate Medications for People with Asthma - Combined

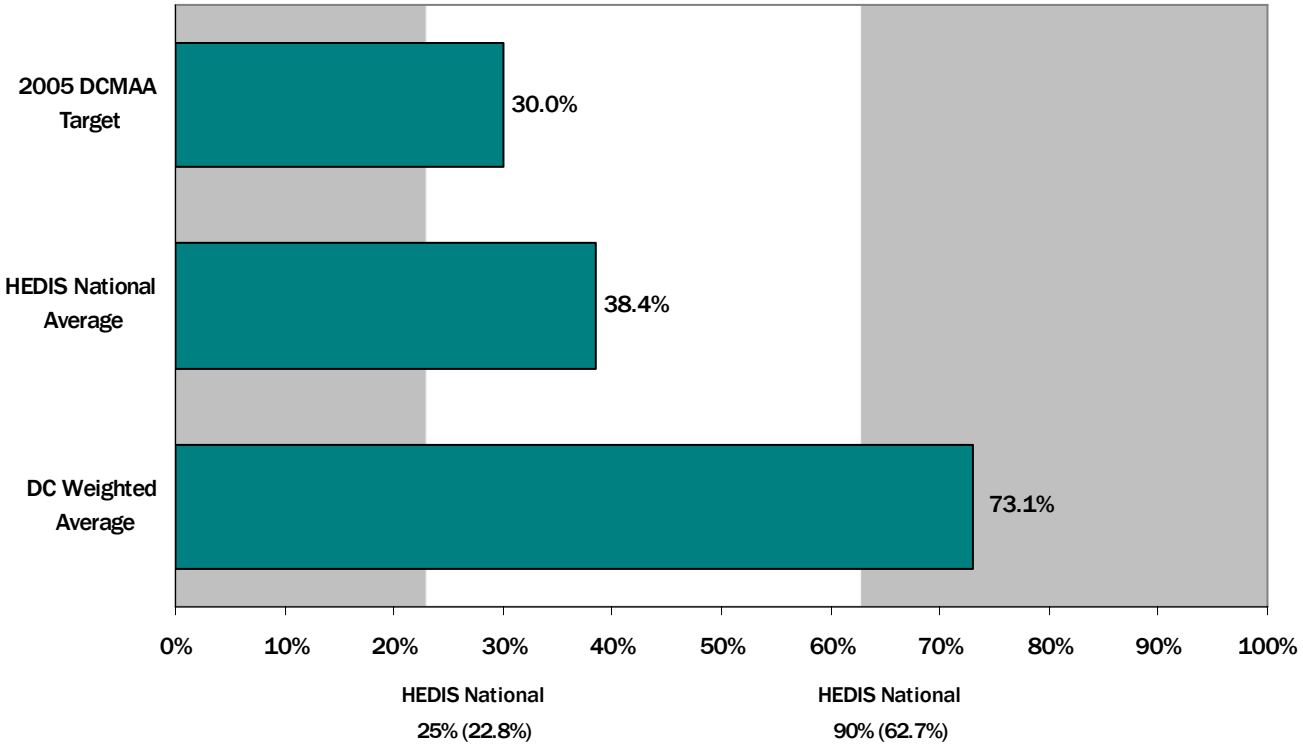
The Childhood Immunization Status – Combo 2 measure is the percentage of enrolled MCOs children 2 years of age during CY 2005 who had 4 Dtap/DT, 3 IPV, 1 VZV, and 4 PCV immunizations by their second birthday. Figure 1 presents the results for the Childhood Immunization Status-Combo 2 in CY 2005. Overall, the DCMAA plans scored above the HEDIS National 90th percentile of 75.7%.

Figure 1. Childhood Immunization Status
Combo 2



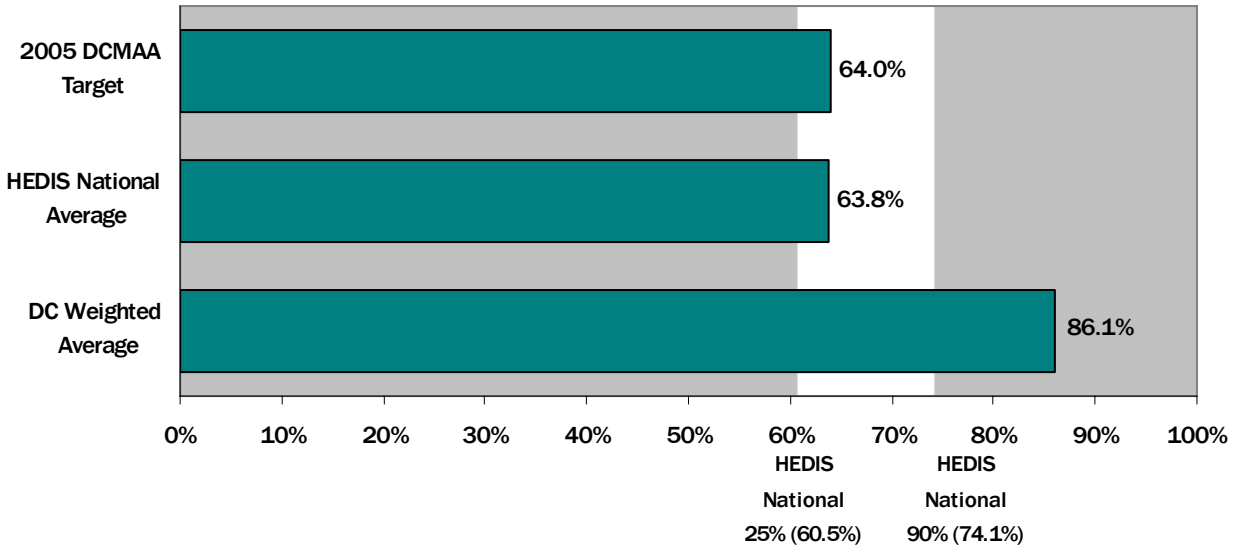
The Adolescent Immunization Status – Combo 2 measure is the percentage of enrolled MCOs adolescents 13 years of age who had a second dose of MMR, 3 HBV, and 1 VZV by their thirteenth birthday. Figure 2 presents the results for the Adolescent Immunization Status-Combo 2 in CY 2005. Overall, the DCMAA plans scored above the HEDIS 90th percentile of 62.7%.

Figure 2. Adolescent Immunization Status
Combo 2



Use of Appropriate Medications for People with Asthma represents the percentage of enrolled MCOs members 5-56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication. Figure 3 presents the results for the Use of Appropriate Medications for People with Asthma for CY 2005. The DCMAA plans exceeded the HEDIS National Average (63.8%), the DCMAA Target (64.0%), and the HEDIS National 90th Percentile (74.1%).

Figure 3. Use of Appropriate Medications for People with Asthma-Combined



Performance Improvement Projects

The MCOs were required to conduct two PIPs during CY 2005. In general, they were expected to study their MCO specific population characteristics, develop quality indicators, set goals and objectives, conduct root cause analysis, develop an analytic plan, conduct baseline measurement, and develop and implement interventions. MCOs were not required to use the same indicators or interventions.
Overall, the MCOs all developed indicators relevant to their population using MCO specific data. Data sources were fairly well defined and data collection methods were explained. The majority of indicators presented were defined and objective.

Identified areas for improvement included, in some cases, providing data collection tools for review, completing a more formal barrier analysis, developing a more defined data analysis plan, and providing the qualifications of data collection staff. Some MCOs need to develop more robust interventions to ensure that they better address the identified barriers. Additionally, as MCOs conduct remeasurement, it is important that statistical significance testing be performed.

Table 3 MCO overall results for the quality process steps for PIPs.

Activity Number	Activity Description	Aggregate Review Determination	Explanatory Note
1	Assess the Study Methodology	Met	
2	Review the Study Question(s)	Met	
3	Review the Selected Study Indicator(s)	Met	
4	Review the Identified Study Population	Met	
5	Review Sampling Methods	Partially Met	This indicator was not applicable to MCOs that used an entire population rather than a sample of the population. However, one MCO's sampling method required corrective action.
6	Review Data Collection Procedures	Partially Met	One MCO received a partially met and was required to provide documentation of data collection methods.
7	Assess Improvement Strategies	Met	
8	Review Data Analysis and Interpretation of Study Results	Partially Met	Several MCOs did not perform reliability and validity testing or did not provide adequate analytic plans.
9	Assess Whether Improvement is Real Improvement	Not Applicable	The plans have not reached the remeasurement phase for both projects.
10	Assess Sustained Improvement	Not Applicable	Projects that are in remeasurement, have not been in implementation phase long enough to assess whether improvement has been sustained.

All of the MCOs conducted PIPS in CY 2005 as directed by the DCMAA to address obesity. These PIPs were considered proxies for quality since the indicators, in most cases, pertained to the quality of services provided in the physician practice.

Prior to the development of plan specific PIPs addressing this topic, the MCOs participated in a District-wide collaborative effort focused on addressing overweight and obesity. The intent of the MCO developed Obesity PIPs was to build on the momentum gained through the efforts of the prior collaborative.

Among the indicators chosen by the MCOs for the Obesity PIPs were:

- Documentation of height and weight by the primary care practitioner

- Documentation of body mass index (BMI)
- Documentation of physical activity
- Referral for nutritional counseling/physical activity programs for members identified as overweight or at risk

Interventions for the Obesity PIPS included the development of a variety of educational programs targeting both providers and members and development of physical activity programs for members. For those MCOs in the remeasurement phase of this project, improvements in the indicators were noted. However, MCOs did not conduct statistical significance tests.

In addition to the obesity PIPs, three MCOs were directed by DCMAA to conduct PIPs in the area of prenatal care. More detail regarding the prenatal PIPs is provided in the timeliness section of this report.

Summary of Quality

The dimension of quality was assessed using three data sources. These included data from the performance systems review, performance improvement projects, and performance measure validation.

The MCOs have made major strides in the provision of information to enrollees, data collection, and reporting efforts. All MCOs provide the required quarterly reports that include key indicators which allow the DCMAA to monitor the MCOs. Beneficiary handbooks and other beneficiary materials include the necessary information to describe the benefits and services available to beneficiaries and how to access services. The policies and procedures also include steps beneficiaries can use to access interpreters free of charge 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, the MCOs attempt to ensure that documents are written at the fifth grade reading level. The MCOs also have provisions in place to allow open enrollee/provider communications.

All MCOs have quality management and utilization management programs in place. These programs include complaint, grievance and appeals procedures. Each year the MCOs appear to improve their processes in regards to collecting and monitoring data in regards to appropriateness and timeliness of review. Overall, the authorization, grievance and appeals procedures appear to be in place since the MCOs have made concerted efforts to update them to be consistent with the BBA requirements. There are, however, some policy areas that have been identified to target for improvement. These include the need to ensure that expedited appeals and authorizations can be requested by the beneficiaries and that extensions for decision making can be extended when requested by the MCO or beneficiary.

In general, the MCOs demonstrated through documentation that they maintain and monitor a network of appropriate providers. The appropriate provider contracts are in place. In the current year, the MCOs monitored their networks anywhere from quarterly to annually.

The MCOs continue to have an established and well functioning credentialing and recredentialing program and process. The MCO credentialing and recredentialing policies and procedures do not allow the MCOs 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. In general, a review of credentialing and recredentialing files yielded favorable results with the majority of individual provider records meeting requirements.

Cultural competency has been addressed by the MCOs and the DCMAA. MCOs use various methods, including beneficiary review of materials for appropriateness, staff training requirements, and hiring bilingual staff to accomplish cultural competency goals.

The four MCOs have appropriate policies in place for delegation. The delegated provider agreements specify the delegate's and the MCO's responsibilities in the delegated relationship. Each MCO has a specific policy and procedures that describe the mechanisms in place to monitor the delegate, including regular reporting by the delegate and auditing of the delegate's performance of delegated duties.

The MCOs have developed and/or implemented a variety of appropriate clinical practice guidelines (CPGs), based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field. Procedures are in place to adopt and modify CPGs on a routine basis

All four MCOs have a written quality management/improvement program. These documented programs include goals, objectives, program and committee structures, work plans and various other components. Collectively, the MCOs met the majority of the health information systems standards. The systems in place assist the MCOs by providing information on utilization, grievances, and disenrollments. The MCOs continue to identify new and innovative ways to use data in their quality improvement. For example, as the MCOs have matured, there is a migration toward the use of dashboards, report cards and/or balanced scorecards.

The performance measure validation process required Delmarva to conduct the information systems (IS) capabilities and medical record abstraction validation. The MCOs demonstrated that they had the automated systems, information management practices, and data control procedures to ensure that all information

required for reporting the indicators was adequately captured, translated, stored, analyzed and reported. This was not the case in CY 2004.

The overall results for the quality performance measures indicate that the MCOs have done well in ensuring that both children and adolescents receive age appropriate immunizations and that asthmatics receive appropriate medication treatment.

In regards to performance improvement projects, although the MCOs were able to use population based data to develop indicators and analytic plans, there are areas where improvement is needed. These areas include, in some cases, development of more robust study designs, interventions, and reliability and validity testing.

Although the MCOs received training by NCQA prior to beginning the PIPs, the MCOs would clearly benefit from on-going training and technical assistance in the quality improvement processes.

Access at a Glance

Access is an essential component of a quality-driven system of care. One of the key components to the Medicaid Managed Care program is assuring access for all enrollees to the services provided by the MCOs. The findings with regard to access are discussed in the following sections.

Performance Systems Review

Delmarva's operational systems review of the MCOs required a review of access standards in the areas of Enrollee Rights and Protections, Quality Assessment and Performance Improvement, and Grievance Systems as outlined in the BBA. The assessment of access as it relates to the performance systems review is summarized below by system.

Enrollee Rights

All MCOs have policies and procedures that 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 format. Beneficiary enrollment materials are provided in English and Spanish with other languages available on request by the beneficiary. The MCOs were also able to demonstrate concerted efforts to write enrollee materials at or below the fifth grade reading level. The MCOs' contract with the DCMAA requires materials to be available in Spanish, Korean, Chinese, Vietnamese, Amharic, or Braille/audio format.

The enrollment materials provided to enrollees by the MCOs contain provider directories. The directories include the appropriate information about network providers including names, locations, telephone numbers, non-English languages spoken by provider, and whether or not the provider is accepting new patients.

The beneficiary materials include information on how to access the MCO'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 provides information on how after-hours, urgent, and emergent care can be obtained. Preauthorization is not required for emergency services and beneficiaries can use any hospital or setting for emergency care. All MCO member materials include the specialty referral policy for care and explain other benefits that cannot be provided by the beneficiary's PCP.

All MCOs have advance directives policies and procedures in place, except for one MCO. However, all MCOs offer members information on advance directives, usually through the member handbook. This information includes the enrollee right to participate in decisions concerning their own health care and to have open communication with their PCP or other providers of care. The MCOs have provider agreements in place which state that providers are not prohibited or restricted from advising, or 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 from advising the beneficiary about the risks, benefits, or consequences of treatment or non-treatment.

Grievance Systems

All of the MCOs have authorization, grievance and appeals policies and procedures in place. In general, the timeframes for completion of authorizations, grievances and appeals are in accord with the requirements. All policies and procedures allow beneficiaries to file a grievance, and MCO level appeal and to request a District Fair Hearing at any time during the process. Providers are also ensured access to the complaint, appeals and grievances system and may file on behalf of him/herself or a beneficiary. Summary data for grievances and appeals are provided to DCMAA at least quarterly by the MCOs. A sample of grievance and appeals cases were requested and provided by each MCO. In most of the cases reviewed, the cases were resolved timely.

The Performance Systems Review resulted in a total of 15 review determinations of "unmet" in the three areas (enrollee rights, grievance systems, quality assessment); all 15 unmet review determinations were found in the Grievance Systems standards. Although the MCOs have the basic grievance and appeals policies and procedures in place, some of them need to be refined to meet some of the specific requirements. In general, the MCOs would benefit from reviewing the BBA regulations regarding MCO and enrollee requests for extensions of timeframes, the ability of enrollees to request expedited authorizations and appeals, and the requirements for notifying enrollees in both of these situations. These processes must be incorporated into the MCO policies and procedures to meet the full requirements of the BBA.

Quality Assessment and Performance Improvement

The BBA standards and the MCO contract require the MCOs to have specific access standards in place. These include the following requirements:

- Live access to Member Services 24/7
- Primary care providers must be available 24/7
- Access to emergency care immediately
- Urgent care appointments within 24 hours of request
- Psychiatric assessment and stabilization services 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
- An 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 at least one with 24/7 access
- Ability to select or have a primary care provider (PCP) assigned within 6 days of enrollment

All of the MCOs have the required access standards in place in internal policies. The MCOs also provide these standards to providers in the provider manual. Some of the methods used by the MCOs to monitor provider adherence to the standards using various means to include complaint monitoring, provider relations assessments, CAHPs surveys and geo-access reports.

In addition to the access standards required of providers, there are other standards the MCOs are required to have in place. Specifically, these include the following standards:

- Female enrollees must have direct access to a women's health specialist within the network for covered care necessary to provide routine and preventive health care services
- Enrollees must be allowed to seek a second opinion form a qualified health provider within the network or the MCO must arrange for the enrollee to obtain one outside of the network with no cost to the enrollee.

All four MCOs have internal policies and procedures in place to address these standards. The member handbook is often the source of information to enrollees to notify them of the availability of these services.

Performance Measure Validation

In light of the DCMAA's goal that every Medicaid beneficiary be connected to a medical home, the MCOs were all required to collect performance measures for CY 2005 pertaining to children and adults' access to primary care practitioners and preventive health care services. The following measures were chosen to represent access:

- Children and Adolescents' Access to Primary Care Practitioners-Ages 12-24 mos.
- Children and Adolescents' Access to Primary Care Practitioners-Ages 25 mos-6 yrs.
- Children and Adolescents' Access to Primary Care Practitioners- Ages7-11yrs.
- Children and Adolescents' Access to Primary Care Practitioners- Ages 12-19yrs.
- Adults' Access to Preventive/Ambulatory Health Services-Ages 20-44yrs.
- Adults' Access to Preventive/Ambulatory Health Services-Ages 45-64yrs.
- Annual Dental Visit – Total (ages 2-21)

These measures each provide the percentage of DC MCOs beneficiaries in a particular age range who had an ambulatory or preventive care visit during CY 2005. Two of these measures, adults' access to preventive/ambulatory health services for ages 20-44 and ages 45-64, were also collected for CY 2004.

Figures 4 through 7 provide the MCOs' results for children's access to primary care practitioners. For all measures, the aggregate MCO rates exceeded the DCMAA targets.

Figure 4. Children and Adolescents' Access to Primary Care Practitioners 12-24 months

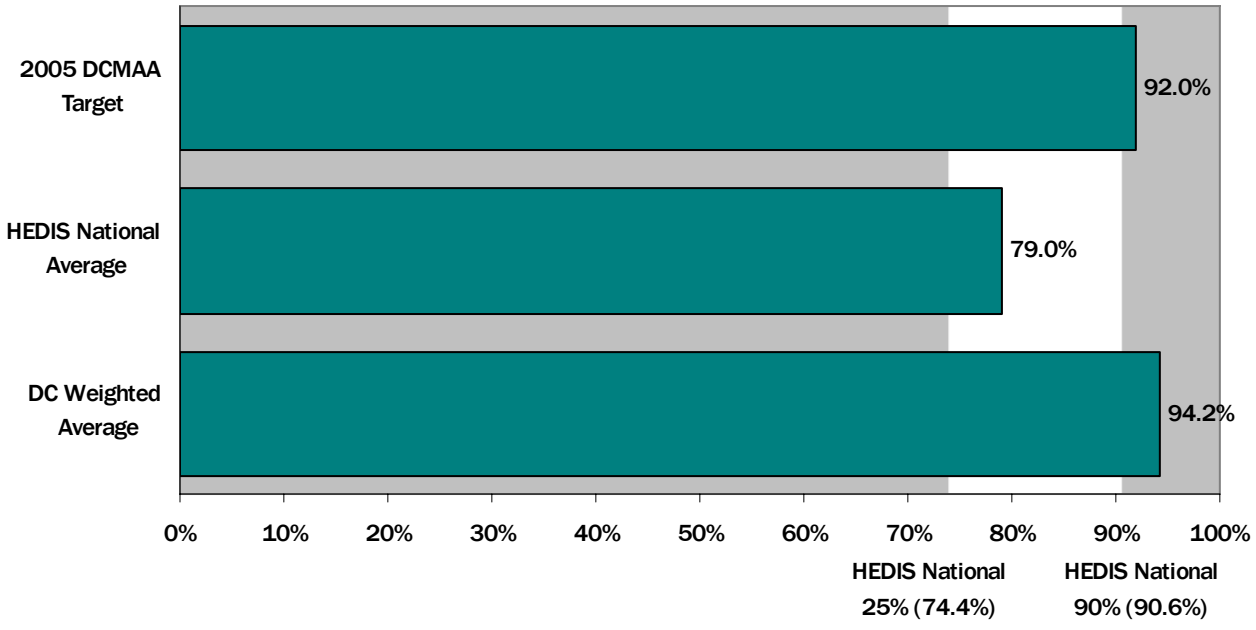


Figure 5. Children and Adolescents' Access to Primary Care Practitioners 25 months to 6 years

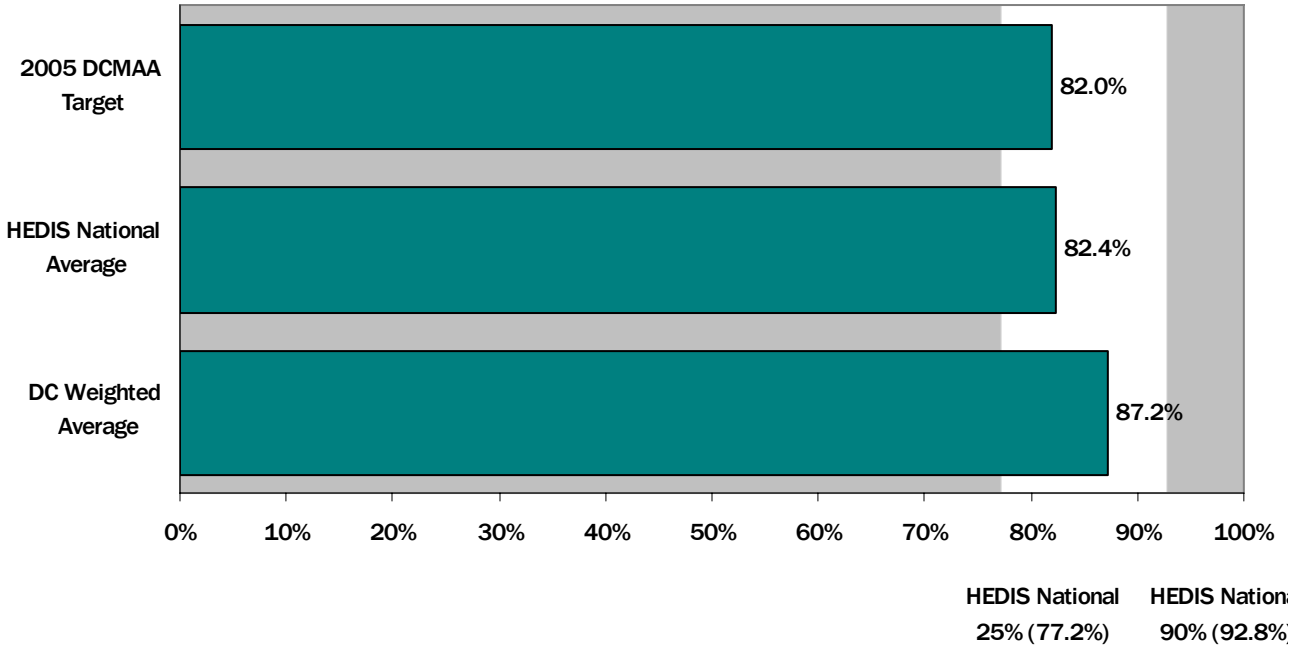


Figure 6. Children and Adolescents' Access to Primary Care Practitioners 7 to 11 years

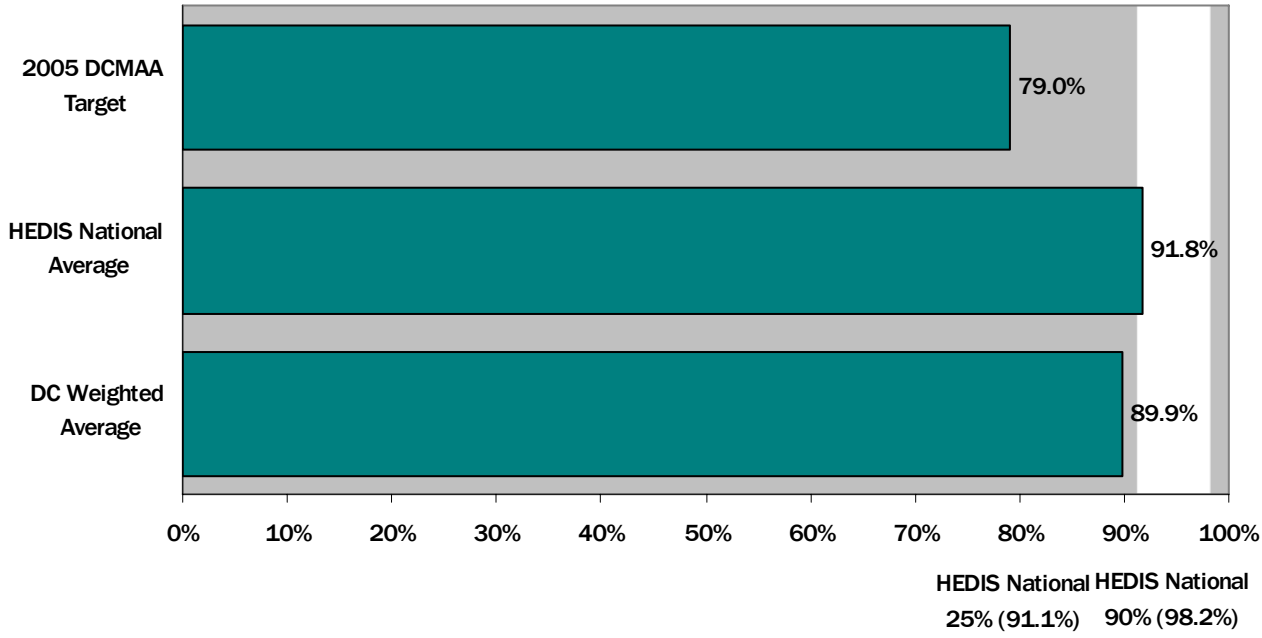


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Figure 7. Children and Adolescents' Access to Primary Care Practitioners 12 to 19 years

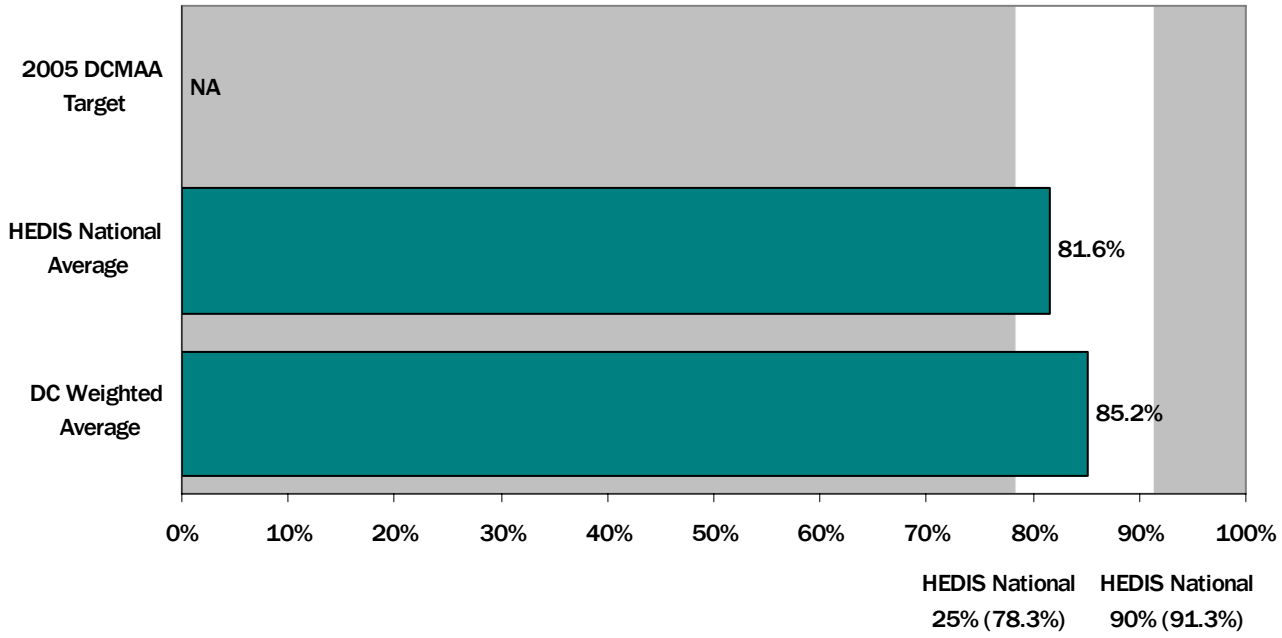


Figure 8 presents the results for the adult access to preventive ambulatory care services measure for ages 20 to 44 years for CY 2005. Overall, in CY 2004, the DCMAA plans scored 74.6% for this measure. In CY 2005, the MCOs remain slightly below the Medicaid National Average of 75.8% but exceed the DCMAA target of 74.0%.

Figure 8. Adults' Access to Preventive/Ambulatory Health Services - ages 20 - 44

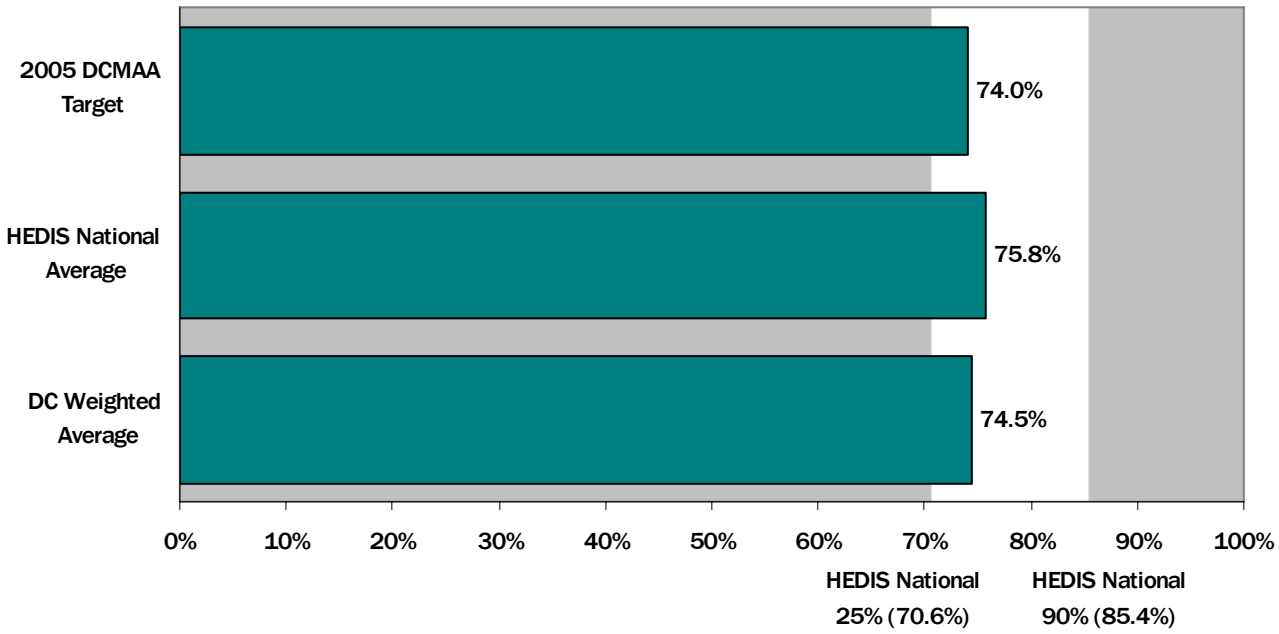


Figure 9 presents the results for the adult access to preventive ambulatory care services measure for ages 45 to 64 years for CY 2005. There was no change from the CY 2004 rate of 73.3% to the CY 2005 rate.

Figure 9. Adults' Access to Preventive/Ambulatory Health Services - ages 45-64

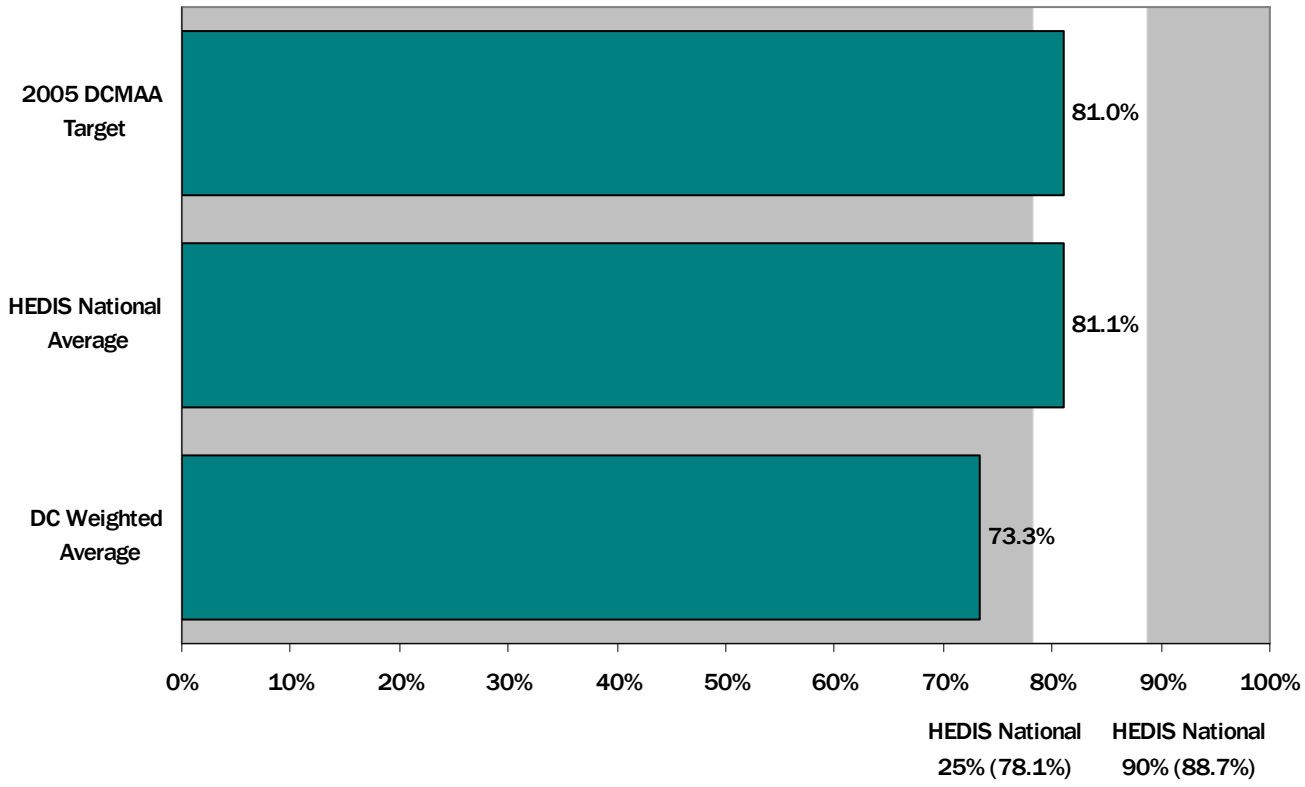
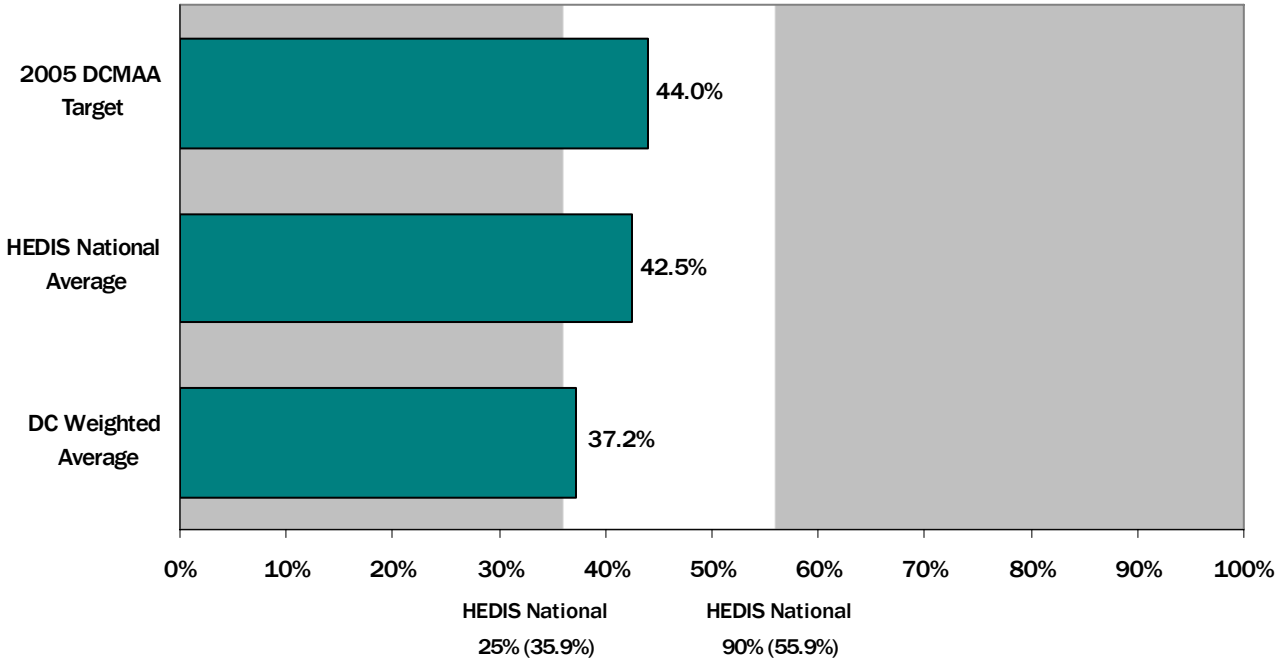


Figure 10 presents the results for the annual dental visit measure for children ages 2-21 years. Overall, the MCOs have exceeded the HEDIS 25th percentile of 35.9% but did not meet the DCMAA target goal of 44.0%.

Figure 10. Annual Dental Visits



Performance Improvement Projects

The CY 2005 PIPs conducted by the MCOs focused on indicators such as timeliness of prenatal and post partum care as well as documentation of body mass index, and identification of overweight or obese members, and the average length of stay in residential treatment. These projects do not address access, but barriers identified by the MCOs included access issues. Across the MCOs and projects, barriers identified included, but were not limited to:

- Member loss of eligibility
- Transportation issues
- MCO difficulty in communicating with the PCP office
- Lack of established practitioner-member relationship
- Follow-up systems that had not been established or implemented
- Member ability to change MCOs frequently
- Ability of members to choose and keep a non-participating OB
- Incorrect addresses and telephone numbers

Interventions utilized by the MCOs to address access issues have included special prenatal care and outreach programs, collaboration efforts with the Women, Infant, and Children (WIC) program, member incentives, and telephonic and mail appointment reminders.

Summary of Access

One primary focus of assessing beneficiary access is ensuring that beneficiaries are provided information on benefits, services, and providers of care, and grievance and appeals procedures so they understand what they are entitled to. In this area, all MCOs performed well. All MCOs have policies and procedures that 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 format. Beneficiary enrollment materials are provided in English and Spanish with other languages available on request by the beneficiary. The MCOs were also able to demonstrate concerted efforts to write enrollee materials at or below the fifth grade reading level. The MCOs have provider agreements in place which state that providers are not prohibited or restricted from advising, or advocating on behalf of a beneficiary's health status, medical care, or treatment options, including any alternative treatments.

All of the MCOs have authorization, grievance, and appeals policies and procedures in place that generally meet the basic requirements. An important part of the process, noted in all MCOs procedures, is the rights of beneficiaries to file a grievance, and MCO level appeal and to request a District Fair Hearing at any time during the process. Providers are also ensured access to the complaint, appeals and grievances system and may file on behalf of him/herself or a beneficiary. Summary data for grievances and appeals are provided to the DCMAA at least quarterly by the MCOs. A sample of grievance and appeals cases were requested and provided by each MCO. In most of the cases reviewed, the cases were resolved in a timely manner.

The Grievance Systems standards appear to be the one area where policies and procedures can be enhanced. Specifically, the MCOs would benefit from reviewing the BBA regulations regarding MCO and enrollee requests for extensions of timeframes, the ability of enrollees to request expedited authorizations and appeals, and the requirements for notifying enrollees in both of these situations. These processes must be incorporated into the MCO policies and procedures to meet the full requirements of the BBA. It was noted in the case review that while the policies and procedures may not have been exactly correct, the beneficiaries were given the opportunity to request extensions and expedited authorizations even though the process was not formalized in procedures.

All of the MCOs have the required access standards in place in internal policies. Standards related to quality of care include, but are not limited to access to a primary care provider, members services, and psychiatric assessment and stabilization twenty-four hours a day, seven days a week.

Performance measure validation activities in the access arena focused on children and adult access to primary care practitioners and ambulatory care for age groups 12 months through 64 years. In addition, dental visits for ages 2 -21 years were measured. The plans met the DCMAA targets for children and adults' access to primary care practitioner and ambulatory care for ages 12 months through 44 years. However, the plans did not meet the DCMAA access targets for adults ages 45-64 or for dental visits for those ages 2-21 years.

None of the PIPs used indicators that focused on access issues. Although most PIPs did identify some type of access issue through barrier analysis and develop interventions to address the identified access issues.

Timeliness at a Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medicaid enrollees. Equally important is the timely delivery of those services. The findings related to timeliness are revealed in the sections to follow.

Performance Systems Review

The annual performance systems review for included a review of standards that addressed the timeliness of services and benefits. Specific dimensions related to timeliness were assessed in the following areas. The Performance Systems Review included an assessment of timeliness in the areas of Enrollee Rights and Protections, Grievance Systems, and Quality Assessment and Performance Improvement.

Enrollee Rights

The MCOs address timeliness to care as a component of enrollee rights and responsibilities. Standards for timeliness to care include immediate access to emergency care without preauthorization. Urgent care appointment standards require that members are able to receive care within 24 hours of request. These standards are monitored for provider compliance through various avenues including access surveys, the Consumer Assessment of Health Plans Survey (CAHPS), on-site visits from provider relations staff at the time of initial credentialing, and complaints monitoring. The standards are included in the MCOs' policies and procedures, provider manuals, and member handbooks.

All MCOs have procedures for accessing the complaint, grievances and appeals systems included in their member handbooks and related materials. All health plans have materials that adequately address the timeframes for filing and resolution of grievances and appeals, except for one MCO. This MCO must enhance its member handbook to provide sufficient detail to explain complaints, grievances, and appeals, including the timeframes and process for each of these. In addition, its policies and procedures must note the enrollee right to request continuation of benefits. The timely resolution of appeals and grievances is

monitored by most of the MCOs through monthly reports. Some MCOs actually use the timeliness to completion rate as an indicator on their MCO internal report cards.

Grievance Systems

The standards stipulate for the standard disposition of a grievance requiring notice to the affected parties, the resolution time may not exceed 90 days from the day the MCO receives the grievance. The MCO policies and procedures met this timeframe. Some MCOs had a shorter resolution period, with one MCO having a 14 day time constraint on the resolution.

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. Three of the four MCOs' policies and procedures require a resolution within 45 days or less. The remaining MCO did not have clear timeframes for appeal resolution. This MCO recognized the issue and was in the process of revising its authorization, appeals, and grievance policies and procedures to meet the timeframe and processing requirements.

The expedited appeal requires the MCO to resolve the appeal within three working days after receiving the appeal request. All four MCOs policies and procedures note the resolution time is 72 hours from the date the plan receives all necessary information to complete appeal.

The four MCOs have policies and procedures documenting the process for 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.

All of the MCOs have a member and provider appeal policy. Two of the MCOs include the requirement for notifying beneficiaries as expeditiously as their health condition requires, but not to exceed 14 days. Only one MCO addresses the right of the beneficiary or the provider to extend this time frame up to 14 calendar days if requested. The MCOs that were not compliant with this standard are currently revising policies to include these specific requirements.

Quality Assessment and Performance Improvement

As noted in the Access section of this report, the MCOs have the appropriate access and availability standards that address the scheduling of appointments and appointment waiting times. The MCOs use various methods to monitor access including the CAHPS survey, complaints, provider relations visits, medical record reviews, and assessing appointment availability at the time the office site review is conducted for initial credentialing. Three MCOs were able to demonstrate routine monitoring of the standards during CY 2005. The fourth MCO was conducting this assessment in 2006 at the time of the on-site EQRO review.

Performance Measure Validation

The MCO population is comprised largely of pregnant women and children. Therefore, timeliness of services provided to these members is of importance, for two reasons:

- Initiation of early prenatal care provides an opportunity to identify and monitor conditions that have the potential to result in poor health outcomes for either the mother or child beginning early in the pregnancy.
- The provision of age appropriate early and periodic screening and preventive care has proven to be one of the most cost effective methods for early identification of developmental and/or chronic conditions in young children.

The following measures of timeliness were selected for CY 2005:

- Prenatal and Postpartum Care-Prenatal
- Prenatal and Postpartum Care-Postpartum
- Well-Child Visits in the First 15 Months of Life-6 or More Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits

Figure 11 presents the Prenatal and Postpartum – Prenatal Timeliness measure. This measure is the percentage of women, who had a live birth between November 6, 2004 and November 5, 2005, who received a prenatal care visit in the first trimester or within 42 days of enrollment in an MCO. The aggregate MCO rate did not meet the DCMAA target of 76.0%. However, the MCOs improved over the CY 2004 Weighted Average of 71.2%.

Figure 11. Prenatal and Postpartum Care
Timeliness Prenatal

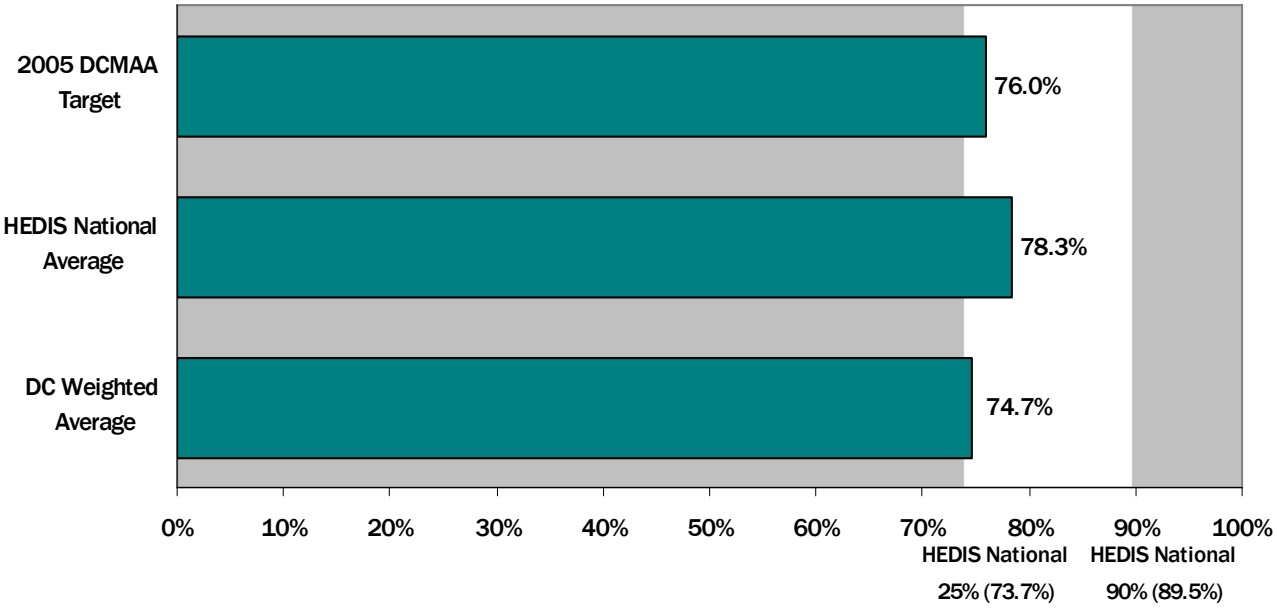


Figure 12 presents the aggregate plan rate for the Prenatal and Postpartum Care – Postpartum measure. This is the percentage of women, who had a delivery between November 6, 2004 and November 5, 2005, who had a postpartum visit on or between 21 and 56 days after delivery. The MCOs exceeded the DCMAA target of 55.0% and the HEDIS National Average of 55.9%.

Figure 12. Prenatal and Postpartum Care

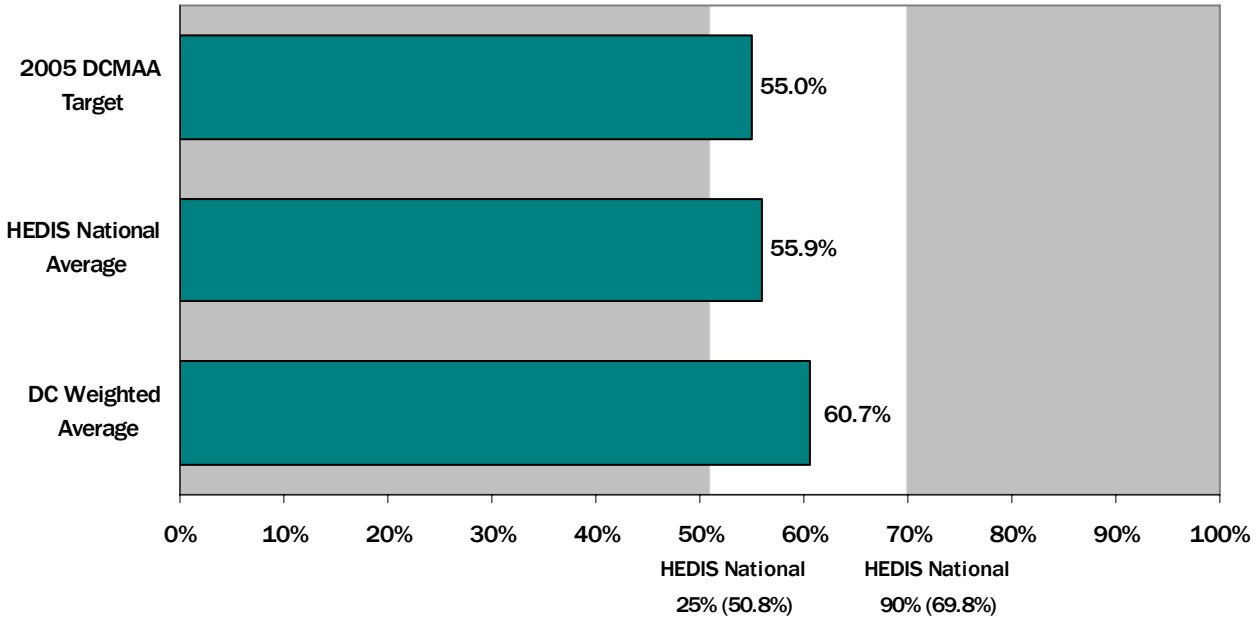


Figure 13 shows the MCO aggregate rate for those children who had six or more well-child visits by age 15 months. The MCOs exceeded the DCMAA target of 44.0% and the HEDIS National Average of 46.8%.

Figure 13. Well Child Visits First 15 Months
6 or More Visits

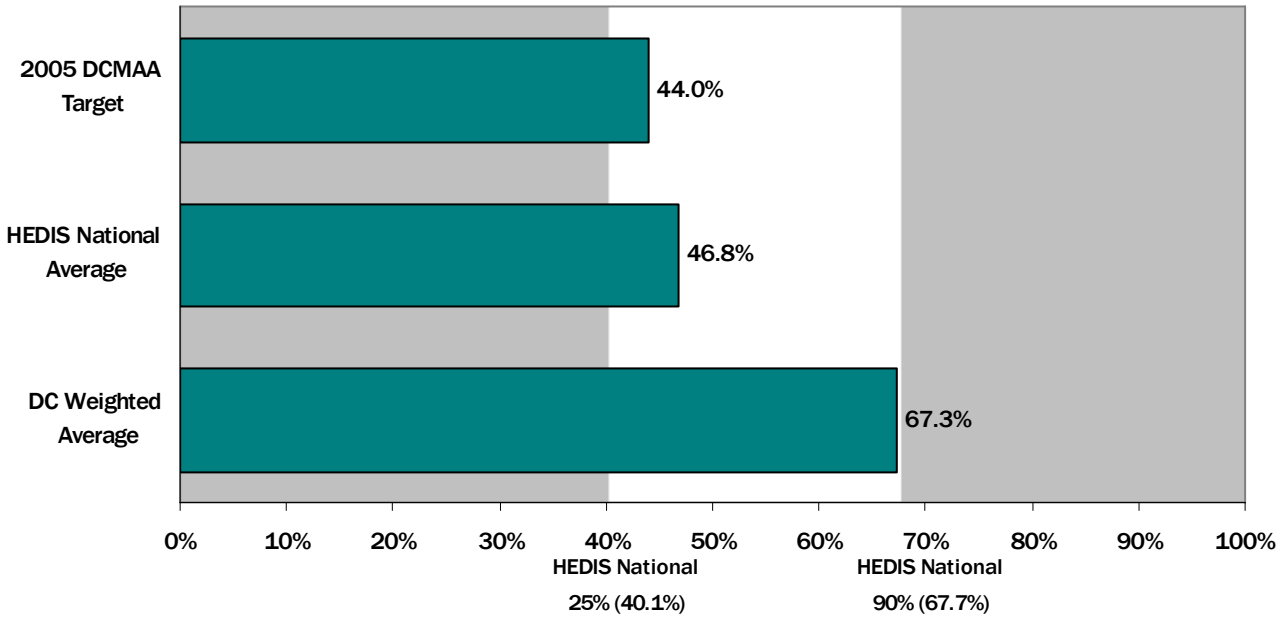


Figure 14 presents the MCO aggregate rate for those children who were three, four, five, or six years of age and had one or more well child visits with a primary care practitioner. The MCOs exceeded both the DCMAA target of 60.0% and the HEDIS 90th percentile of 77.5%.

Figure 14. Well Child Visits 3, 4, 5, 6 Year Olds

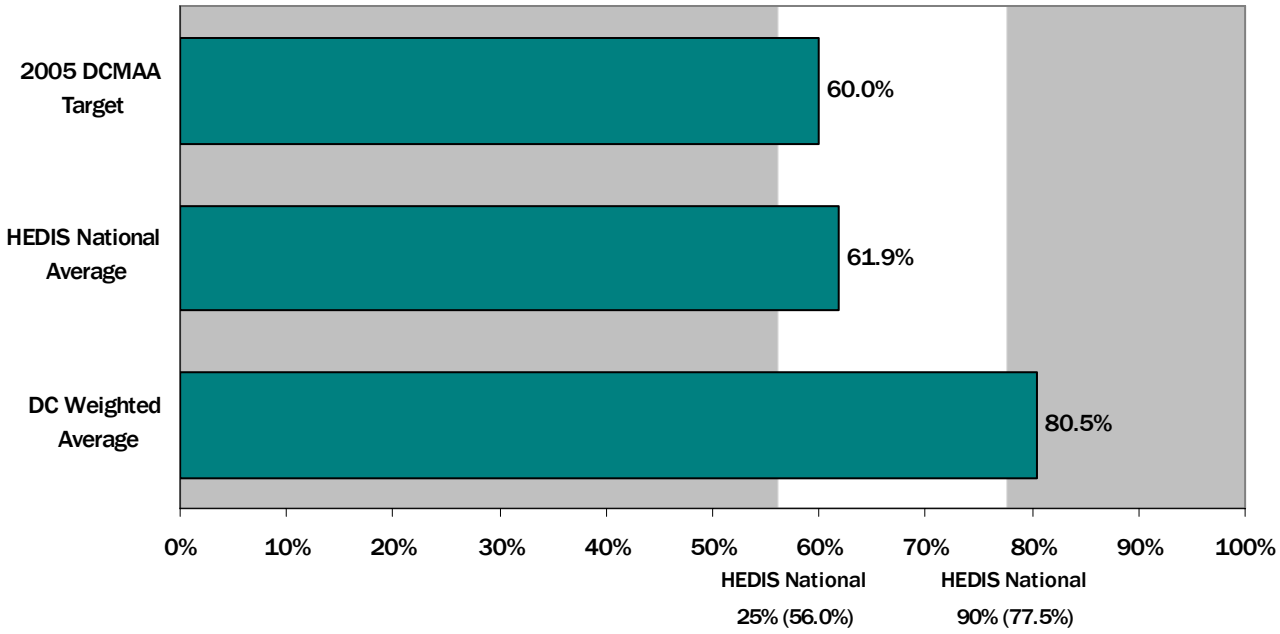
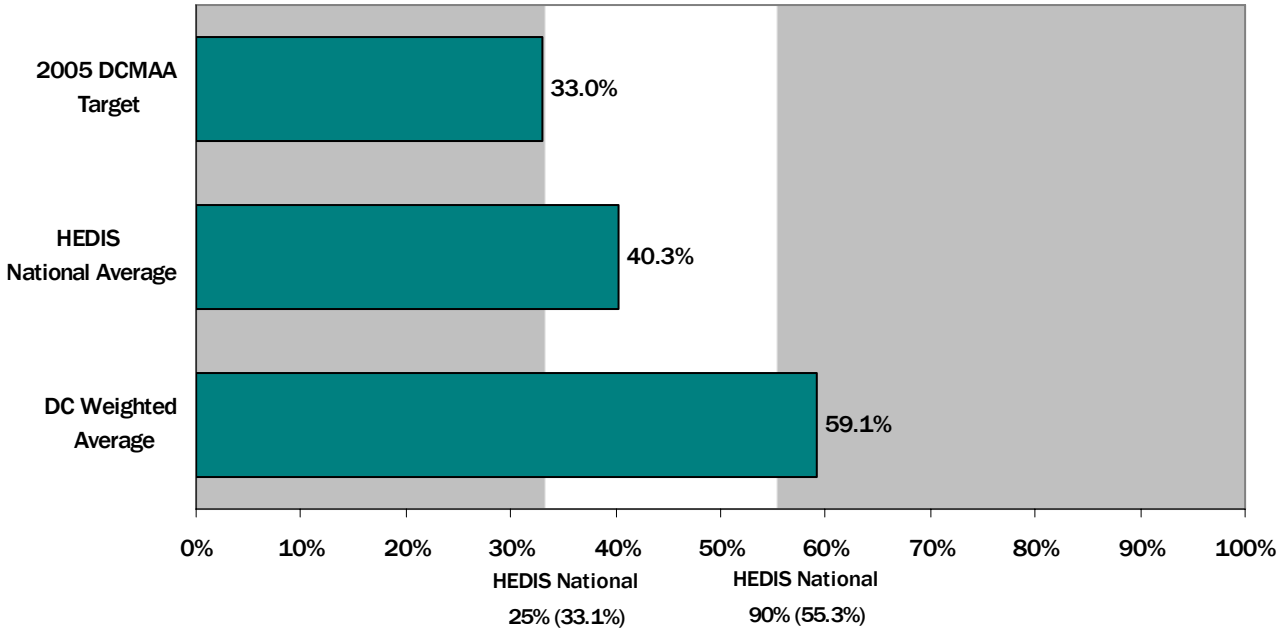


Figure 15 presents the aggregate MCO rate for adolescent well child visits. The MCOs exceed the DCMAA target of 33.0% and the HEDIS 90the percentile of 55.3%.

Figure 15. Adolescent Well Care Visits



Performance Improvement Projects

Prenatal PIPs were undertaken by three of the MCOs as mandated by the DCMAA. These projects included indicators focusing on timeliness of care. The measures included timeliness of prenatal care visit and receipt of a postpartum visit.

The MCOs collected baseline data during year one of their PIPs and performed remeasurement in year two of their PIPs. However, it must be noted that the data period used by an MCO for baseline or remeasurement may vary depending on the design of the MCO's PIP. For instance, one MCO may use a calendar year for the measurement period, while another may have chosen fiscal year. Therefore, PIP performance rates cannot be aggregated nor compared to the HEDIS rates presented in this report.

Overall, the MCOs made slight improvements in the indicator rates for timeliness for prenatal and postpartum care when evaluating the baseline and remeasurement results. However, as previously stated, the MCOs did not conduct statistical significance testing. It is recommended that MCOs conduct more robust analysis to include reliability and validity testing.

Summary for Timeliness

The MCOs address timeliness to care as a component of enrollee rights and responsibilities. Standards for timeliness to care include immediate access to emergency care without preauthorization. The MCOs have the required standards related to timeliness of care (urgent care, routine care, preventive care, emergent care etc.), waiting times, and appointment scheduling times. The MCOs use various methods to monitor provider adherence to standards such as CAHPS, on-site visits from provider relations staff at the time of initial credentialing, and complaints monitoring.

All MCOs have procedures for accessing the complaint, grievances and appeals systems included in their member handbooks and related materials. All MCOs have policies that require disposition of the grievances and appeals and notification to the affected parties within the timeframes specified by the BBA requirements. The timely resolution of appeals, grievances, and authorizations is monitored by most of the MCOs through internal MCO monthly reports (dashboards and score cards).

Performance measure included the HEDIS Prenatal and Postpartum Care timeliness measure. Although there was improvement in CY 2005 in the timeliness of prenatal care measure, both the prenatal and postpartum care measures are areas where the MCOs should continue to focus improvement efforts to reach established goals. In addition, although the MCOs have made strides in improving the timeliness of well child services, they should continue to work with providers and members to stress the importance of well-child care.

Prenatal PIPs were undertaken by three of the MCOs and included two indicators focusing on timeliness of care. Three of the MCOs selected the HEDIS measure for timeliness of prenatal care and two of the MCOs also selected the timeliness measure defined as "receipt of a post-partum visit on or before 21 and 56 days after delivery." It must be noted that the outcome measures for PIPs cannot be compared to the performance measures as noted previously for prenatal and postpartum care as the measurement cycles may vary for the PIPs.

The baseline rates reported by the MCOs for CY 2004 clearly indicated that this was an area that could benefit from improvement efforts and that reasonable interventions should be developed and implemented to address the critical barriers identified. The first CY 2005 remeasurement data submitted for review indicates that MCOs have, overall, made slight improvements in timeliness for prenatal and postpartum care.

Conclusions and Recommendations

Conclusions

In general, the MCOs have the appropriate quality processes in place to monitor the quality of, access to, and timeliness of, services provided to members. They have demonstrated that automated systems are in place for information management, data control, and measurement of quality indicators. Both accessibility and timeliness of health services is monitored by the MCOs and identified issues are acted upon, as appropriate. Further, the MCOs have shown some slight improvement in PIP indicators relative to timeliness.

The data and analysis presented in this report can assist the DCMAA to further develop a performance metric as it moves toward its goal of implementing a value based purchasing strategy that focuses both on cost effectiveness and quality of care. This section provides insight on the performance of the program, highlighting MCO strengths and challenges followed by suggestions on areas where DCMAA may want to focus future quality improvement efforts.

MCO Strengths

Performance Systems Review

The Performance Systems Review provided a comprehensive assessment of the MCOs systems related to meeting the provisions of the BBA and MCO contractual requirements. Through this assessment, the following strengths were identified:

- The required access and availability standards are in place
- Improved and enhanced methods for data collection, reporting and analysis for quality management/improvement, specifically the development and implementation of internal dashboards, score cards and report cards
- Credentialing and recredentialing processes are standardized and meet requirements with no major problems identified in individual provider files reviewed
- Concerted efforts to provide beneficiary information in alternative formats (Braille, large print, audio etc), other languages, and at a fifth grade reading level to meet the varying needs of beneficiaries
- Methodologies to identify beneficiaries with special needs and place them in appropriate programs such as case and disease management
- Delegation contracts are in place with expectations designated and routine monitoring by the MCO
- Clinical practice guidelines are in place, appropriate, and are updated/revised at least every two years or sooner if necessary
- Overall, monitoring processes have been enhanced with the MCO using their many available data sources such as CAHPS results, complaint, grievance and appeals data, over and under-utilization data, quality improvement project data and access and availability data

Performance Measure Validation

Validation activity findings for the DCMAA managed care plans indicate that there were minimal impacts on measure reporting due to information systems issues.

Strengths were related to the following categories:

- Data capture
- General information systems
- Use of registries
- Centralized processing of data
- Provider data
- Data sharing
- Eligibility programming

All plans are contracting with NCQA certified HEDIS software vendors to manage and maintain the source code for the measures. As the managed care plans gain experience in the requirements of measure production and the rigors of a validation process, the processes used to manage and monitor measure production are improving.

Performance Improvement Projects

In conducting performance improvement projects the MCOs' strengths were noted to be:

- Identifying population characteristics
- Indicator development

MCO Challenges

Performance Systems Review

Through an evaluation of each MCO's compliance with the Performance Systems Review (PSR) standards, opportunities were identified for improvement efforts. The majority of issues identified include the need for enhancing existing policies and procedures to meet the precise intent of the BBA requirements.

The PSR review identified the following opportunities for improvement:

- The enrollee rights and responsibilities policies must be updated to include the right of the beneficiary to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the regulations
- Notices of action (NOAs) must be enhanced to include all requirements. Specifically, the NOAs must include the reason for denial in language that is easily understood by the enrollee and the right to request that benefits can continue during an appeal when requested by the enrollee

- The policies and procedures for appeals must allow for the legal representative of a deceased enrollee's estate to be included as a party to the appeal
- The appeals policies and procedures must provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing unless the enrollee or provider requests expedited resolution
- The appeals policies and procedures must include a process to transfer a denied request for expedited resolution to the standard appeals process and to notify the beneficiary in such cases

Performance Measure Validation

Plans did experience some challenges related to information systems. These challenges did not influence rate calculations for most plans because they were overcome during the data collection phase of measure reporting.

Primarily, issues identified as challenges surrounded:

- Data completeness or submission.
- Use of global billing and coding arrangements.

Performance Improvement Projects

MCOs experienced some challenges in conducting PIPs. Some of these challenges have the potential to limit the successfulness and/or validity of the PIP outcomes.

Primarily, issues identified as challenges included:

- Root Cause Analysis
- Development of robust interventions
- Development of an analytic plan
- Sample size
- Reliability and validity testing

Recommendations

Maintaining forward momentum is important in continuing the successes of the DCMAA quality assessment and improvement strategy. Most plans have developed appropriate structural and operational policies and procedures, quality improvement processes, information systems, reporting methodologies, medical record review processes, and measure calculation strategies that have stabilized. But improving care is much more difficult than developing the methodologies for improving data capture.

Performance measures provide a picture of care delivered at a point in time, and as a measurement tool, the purpose of the measures is to provide an assessment of managed care plan performance. Plans should review

and interpret the results of their performance measure reports and identify how performance compares to other benchmarks. Plans should determine where possible improvement efforts are needed and will have the greatest impact on the members that they serve. Interventions that address issues at the system level are most likely to yield sustainable improvements.

One of the limitations in using HEDIS-based performance for quality improvement efforts is that the timeframe in which the results are available is not conducive to rapid indicator changes. Because the measurement cycle measures care delivered in the previous calendar year using a methodology that takes approximately 6 months to complete, results are not available to DCMAA managed care plans until June of the year after the measurement year. The identification of root causes and development and implementation of interventions could take several months, limiting the impact of the intervention on the next report. It is more reasonable to expect indicators to lag behind practice and demonstrate improvement every other year.

Achieving improvement in performance will require the cooperation of DCMAA and the DCMAA managed care plans, and the application of quality improvement methodologies aimed at increasing the delivery and effectiveness of services by providers to DCMAA managed care enrollees.

Using a framework similar to that developed by the Institute of Medicine in *Crossing the Quality Chasm*, DCMAA can influence the delivery of care. DCMAA can develop strategies to address care delivery at the patient, microsystem (single care team), organization (DCMAA managed care plans), and environmental (DCMAA managed care program) levels. The efforts of DCMAA at the environmental level will have an effect on the DCMAA managed care plans. A partnership approach utilized by DCMAA and the DCMAA plans to engage providers will have an impact on care delivered to DCMAA members.
DCMAA is in a strong position to use its significant influence to foster innovation in care delivery and collaboration, creating pull for quality improvement while realizing the need for maintaining quality assurance with the DCMAA managed care plans.

- DCMAA can make recommendations based on the data in this or other reports regarding what performance measures plans should focus on in their required PIPs (under the BBA, the district can mandate PIPs on specific topics).
- All DCMAA managed care plans should continue to participate in opportunities that promote sharing of best practices and interventions that have been successful in measurement, data capture, and care delivery settings.

Breakthrough improvements in care delivery may be most effectively driven from the position held by DCMAA. System-wide improvements can be used to accelerate health plan improvement. Leadership and culture change, although more philosophical in nature, have been identified as effective motivators of change

in complex systems such as the DCMAA managed care system. Leadership plays an important role in quality improvement, and DCMAA has the opportunity to lead the way in quality improvement and engage DCMAA plan CEOs in a discussion on the impact that leadership can have in improving health care quality. As the leaders of the plans, when CEOs are engaged in the concept of improving quality, the plans and DCMAA can set specific goals that improve care to enrollees. A unified partnership of DCMAA and DCMAA managed care plans approaching providers with a single voice, protocol, goal, or improvement has a greater chance of success than would a "shot gun approach" with many plans with many ideas coming to providers separately.

Culture plays an important role in the success of quality improvement programs. If a regulatory culture exists, plans may inadvertently determine a level of performance that is acceptable for regulatory purposes and perform to that level rather than striving to achieve the best care possible. DCMAA can suggest that quality improvement skills be developed in addition to the quality measurement skills that currently exist.

Approaching improvement opportunities directly with providers can yield longer lasting results than focusing on improving measures of DCMAA managed care plan system performance. Working with the provider community and focusing efforts on the culture and operation of the provider offices may be successful.

In summary, the reporting methodologies and systems in place at DCMAA managed care plans appear to be sufficient to accurately and reliably supply performance measures. DCMAA and the plans are in a position to maintain the reporting system while improving the delivery and outcomes of care. By focusing on culture, leadership, and a unified approach with a single voice, a partnership between DCMAA, DCMAA managed care plans, and providers could result in sustainable system-wide improvements and better outcomes for DCMAA enrollees.

- DCMAA managed care plans should be encouraged to continue efforts to increase data completeness. If global billing codes for maternity care must be used by the plans, alternative methodologies for identifying individual dates of service (e.g. dates of first prenatal visits) must be developed. If administrative data systems (claims, encounter, electronic registry, disease management, etc.) are more complete, reliance on medical record review will be decreased. This will reduce both the administrative and financial burden on DCMAA managed care plans.
- Continued use of existing registries or development of District-wide registries capturing data in singular repositories may also be a possible option for DCMAA and DCMAA plans. The support or development of registries would not only benefit DCMAA plans, but would benefit public health efforts and reinforce the use of administrative data for measurement activities.
- Teamwork, communication, and continued HEDIS skill development are again recommended. Attending NCQA-sponsored conferences focusing on HEDIS updates and best practices are a very good way for

plans to obtain methodologies that are deemed to be best practices by NCQA. General quality improvement and teamwork training is also suggested as the strategies and concepts in these general topic areas will likely lead to efficiencies in performance measure reporting and knowledge in quality improvement methods. In addition, improving documentation of processes and methodologies to assist during MCO staff changes would be beneficial.

- Specific training in root cause analysis, intervention development, and rapid cycle quality improvement methods would benefit the plans PIP efforts. It is important to recognize that in developing interventions that promote sustained improvement, stakeholder involvement and system change is generally necessary.

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Appendix 1

438.100 (a) (1-2)

The MCO must have written policies regarding enrollee rights.

438.100(b)(2)(ii)-(vi)

The enrollee rights and responsibilities policy and procedure must include the enrollee right to:

Element 1.1 – Be treated with respect and with due consideration for his or her dignity and privacy.

Element 1.2 – Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

Element 1.3 – Participate in decisions regarding his or her health care, including the right to refuse treatment.

Element 1.4 – 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.

Element 1.5 – Request and receive his or her medical records and request that they be amended of corrected.

Element 1.6 – Formulate advance directives. (417.436(d)(1)(i)(A).

Element 1.7 – Make decisions regarding health care including the right to accept or refuse medical treatment (417.436(d)(1)(i)(A).

Element 1.8 – The right to file grievances and appeals (438.10(g)(ii).

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.

438.10(c)(3):

The MCO must make its written information available in the prevalent, non-English languages in its particular service area.3.

438.10(c)(4)-(5)

The MCO must make language services [i.e., oral interpretation services] available to its enrollees:

Element 2.1 – These services must be free of charge to each enrollee.

Element 2.2 – The MCO must notify its enrollees that oral interpretation is available for any language.

Element 2.3 – The MCO must notify its enrollees that written information is available in prevalent languages.

Element 2.4 – The MCO must notify its enrollees how to access free interpretation services.

438.10(d)(1)(ii) and (d)(2)

Written material must be available in alternative formats.

Element 3.1 – 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.

Element 3.2 – All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

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.

Element 4.1 – 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.

Element 4.2 – Any restriction on the enrollee's freedom of choice among network providers.

Element 4.3 – Enrollee rights and responsibilities.

Element 4.4 – Information on grievance and fair hearing procedures,

Element 4.5 – 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.

Element 4.6 – Procedures for obtaining benefits, including authorization requirements.

Element 4.7 – The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

Element 4.8 – 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 (with reference to the definitions in 438.114).

Element 4.9 – The fact that pre-authorization is not required for emergency services.

Element 4.10 – The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.

Element 4.11 – 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.

Element 4.12 – The fact that enrollees have the right to use any hospital or other setting for emergency care.

Element 4.13 – The MCOs policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

Element 4.14 – Cost sharing, if any.

Element 4.15 – How and where to access any benefits that are available under the State plan, but are not covered under the current contract.

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:

Element 5.1 – Grievances, appeal, and fair hearing procedures.

Element 5.2 – 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.

Element 5.3 – The right to file grievances and appeals.

Element 5.4 – The requirements and timeframes for filing a grievance or appeal.

Element 5.5 – The availability of assistance in the filing process.

Element 5.6 – The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.

Element 5.7 – 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;

Element 5.8 – 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.

Element 5.9 – Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

438.114 Emergency and Post-Stabilization Services

438.10(g)(2)

The MCO must address advance directives. The MCO must:

Element 6.1 – Have written policies and procedures concerning advance directives. (417.436(d)).

Element 6.2 – Provide all adult enrollees with written information on advance directives policies, and include a brief description of applicable State law. (438.6(i)(2).

Element 6.3 – 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.

Element 6.4 – Provide its written policies respecting the implementation of the right to make decisions regarding care and the right to formulate an advance directive.

Element 6.5 – Provide for the education of staff concerning its policies and procedures on advance directives.

438.10(g)(3) and 438.

Information must provided to all enrollees, upon request, regarding

Element 7.1 – The structure and operation of the MCO**.**

Element 7.2 – Physician incentive plans (as set forth in § 438.6(h)).

Element 7.3 – To the extent available, quality and performance indicators, including, but not limited to disenrollment rates and enrollee satisfaction.

438.106 (a) –(c)

The MCO must provide that is Medicaid enrollees are not held liable for any of the following:

Element 8.1 – The MCO's debts in the case of the entity's insolvency.

Element 8.2 – 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.

Element 8.3 – 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.

438.102 Provider-Enrollee Communications Need to see Policy

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:

Element 9.1 – The enrollee's health status, medical care or treatment options including any alternative treatment that may be self-administered.

Element 9.2 – Any information the enrollee needs in order to decide among all relevant treatment options.

Element 9.3 – The risks, benefits, and consequences of treatment or non-treatment.

Element 9.4 – 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.

438.100(d)

Each MCO complies with any other applicable Federal or State laws (such as: the Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.)

Quality Assessment and Performance Improvement

438.206(b)(1)

The MCO, consistent with its scope of contracted services, meets the following requirements:

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.

Element 1.2 – In establishing and maintaining the network, the MCO must evaluate the specific provider access requirements in its contract with the DCMAA.

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.)

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.

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:

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.

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.

Element 2.3 – 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:

Element 2.4 – Demonstrates that its providers are credentialed as required by § 438.214.

438.206(c)(1)

The MCO must assure access and timeliness of services. The MCO must:

Element 3.1 – 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;

Element 3.2 – 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.

Element 3.3 – Makes services available 24 hours a day, 7 days a week when medically necessary.

Element 3.4 – Establish mechanisms to ensure compliance.

Element 3.5 – Monitor providers regularly to determine compliance.

Element 3.6 – Take corrective action if there is a failure to comply.

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.

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:

Element 4.1 – 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.

Element 4.2 – Coordinate the services the MCO or PIHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.

Element 4.3 – 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.

Element 4.4 – 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.

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.

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.

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:

Element 5.1 – (i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

Element 5.2 – (ii) Approved by the MCO or PIHP in a timely manner, if this approval is required by the MCO or PIHP; and

Element 5.3 – (iii) In accord with any applicable State quality assurance and utilization review standards.

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.

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:

Element 6.1 – Procedures for the processing of requests for initial and continuing authorizations of services.

Element 6.2 – 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.

438.210(b)(2) Authorization of services

The MCO must have mechanisms in place to:

Element 7.1 – Ensure consistent application of review criteria for authorization decisions; and

Element 7.2 – Consult with the requesting provider when appropriate.

438.210 (c) Coverage and authorization of services

(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.

438.210 (d) Authorization of Services

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.

438.210(d)(2) Expedited authorization decisions.

The MCO must have an expedited authorization policy and procedure. This policy and procedure must allow:

Element 8.1 – 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 or PIHP must make an expedited authorization decision and 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.

Element 8.2 – The MCO or PIHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO or PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

438.210(e)

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.

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

Element 9.1 – Must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO or the PIHP.

Element 9.2 – 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.

Element 9.3 – 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.

Element 9.4 – 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.

438.56 Disenrollment:

The MCO must have disenrollment policies and procedures in place. These policies and procedures must:

Element 10.1 – Specify the reasons for which the MCO may request disenrollment of an enrollee.

Element 10.2 – 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.

Element 10.3 – Specify the methods by which the MCO assures the agency that is does not request disenrollment for reasons other than those permitted under the contract.

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:

Element 11.1 – For cause, at any time.

Element 11.2 – 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.

Element 11.3 – Without cause, at least once every 12 months thereafter.

Element 11.4 – 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.

Element 11.5 – When the State imposes the intermediate sanction specified in §438.702(a)(3).

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.

438.56(d)(2)

Policies and procedures for disenrollment must specify the following conditions for disenrollment with cause.

Element 12.1 – The enrollee moves out of the MCO's, PIHP's… service area.

Element 12.2 – The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

Element 12.3 – 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.

Element 12.4 – 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.

438.56(d)(3)

Policies and procedures for MCO action on disenrollment requests must provide that:

Element 13.1 – The MCO may either approve a request for disenrollment or refer the request to the State.

Element 13.2 – 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.

438.56(e)(1)-(2)

Disenrollment timeframes. Disenrollment policies and procedures must note that:

Element 14.1 – 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.

Element 14.2 – If the MCO or the State agency (whichever is responsible) fails to make the determination within the timeframes specified above, the disenrollment is considered approved.

438.230(a)(1)-(b)(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.

438.230(b)(2)

There is a written agreement that-

Element 15.1 – Specifies the activities and report responsibilities delegated to the subcontractor; and

Element 15.2 – Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

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.

438.230(b)(4)

If any MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.

438.236(b)(1)-(b)(4) Practice Guidelines

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

Element 16.1 – Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

Element 16.2 – Consider the needs of the MCO's or PIHP's enrollees.

Element 16.3 – Are adopted in consultation with contracting health care professionals.

Element 16.4 – Are reviewed and updated periodically as appropriate.

438.236(c) Practice Guidelines

The MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

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.

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.

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:

Element 17.1 – Measurement of performance using objective quality indicators.

Element 17.2 – Implementation of system interventions to achieve improvement in quality.

Element 17.3 – Evaluation of the effectiveness of the interventions.

Element 17.4 – Planning and initiation of activities for increasing or sustaining improvement.

Element 17.5 – Reporting the status and results of each project to the State as requested.

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.

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:

Element 18.1 – Measure and report to the State its performance, using standard measures required by the State. including those that incorporate the requirements of 438.204© and 438.240(a)(2)[Note: 438.204(c) and 438.240(a0(2) are included below.]

Element 18.2 – 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.

438.240(b)(3)

The MCO must have in effect mechanisms to detect both underutilization and overutilization of services.

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.

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.

438.242(a) Health Information Systems

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.

438.242(b) Health Information Systems

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.

438.242(b) Health Information Systems

The MCO's health information systems must be able to ensure that data received from providers is accurate and complete by

Element 19.1 – Verifying the accuracy and timeliness of reported data;

Element 19.2 – Screening the data for completeness, logic, and consistency; and

Element 19.3 – Collecting service information in standardized formats to the extent feasible and appropriate.

Element 19.4 – Making all collected data available to the State and to CMS,

438.402(a)

Each MCO and PIHP 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.

438.402(b)(1)

The policies and procedures must allow for:

Element 1.1 – An enrollee to file a grievance, file an MCO level appeal, and may request a State fair hearing.

Element 1.2 – A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.

Element 1.3 – 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.

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 or PIHP's notice of action. Within that timeframe--

Element 2.1 – The enrollee or the provider may file an appeal; and

Element 2.2 – In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.

438.402(b)(3)

The MCO procedures for filing must state that the enrollee:

Element 3.1 – May file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO.

Element 3.2 – 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.

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.

438.404(b) Content of the Notice of Action (NOA)

The notice must explain the following:

Element 4.1 – The action the MCO or its contractor has taken or intends to take.

Element 4.2 – The reasons for the action.

Element 4.3 – The enrollee's or the provider's right to file an MCO or PIHP appeal.

Element 4.4 – 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.

Element 4.5 – The procedures for exercising the rights specified in this paragraph.

Element 4.6 – The circumstances under which expedited resolution is available and how to request it.

Element 4.7 – 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.

438.404(c)(1)and (2) and 431.211Timing of the NOA

Element 5.1 – For termination, suspension, or reduction of previously authorized Medicaid-covered service, the State or local agency must mail a notice at least 10 days before the date of action.

Element 5.2 – For denial of payment, the MCO must mail the notice at the time of any action affecting the claim.

431.213 Exceptions from Advance Notice

The State or local agency must mail a notice at least 10 days before the date of action, except in the circumstances below. Policies and procedures should state that the agency may mail a notice no later than the date of action if:

Element 6.1 – The agency has factual information confirming the death of a recipient;

Element 6.2 – The agency receives a clear written statement signed by the recipient that he no longer wishes services; or

Element 6.3 – Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

Element 6.4 – The recipient has been admitted to an institution where he is ineligible under the plan for further services;

Element 6.5 – The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address.

Element 6.6 – The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

Element 6.7 – A change in the level of medical care is prescribed by the recipient's physician;

Element 6.8 – The notice involves an adverse determination made with regard to the preadmission screening requirements (of section 1919(e)(r) of the Act)or

Element 6.9 – The date of action will occur in less than 10 days.

§431.214 NOA in the case of probable fraud.

The policies and procedures allow the MCO to shorten the period of advance notice to 5 days before the date of action if:

Element 7.1 – (a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

Element 7.2 – (b) The facts have been verified, if possible, through secondary sources.

§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:

Element 8.1 – 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.

Element 8.2 – Possible extensions of the 14 calendar day timeframe are allowed if the enrollee, or the provider, requests extension; or

Element 8.3 – 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.

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.

Element 9.1 – The MCO must have an expedited authorization process policy and procedures in place.

Element 9.2 – 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.

Element 9.3 – 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.

Element 9.4 – 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

Element 9.5 – 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.

438.406.(a)(1)-(3) Handling of Grievances and Appeals

In handling grievances and appeals, the MCO must:

Element 10.1 – Give enrollees any reasonable assistance in completing forms and taking other procedural steps.

Element 10.2 – Acknowledge receipt of each grievance and appeal.

Element 10.3 – 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.

Element 10.4 – 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.

438.406 (b) (1)-(4)

The policies and procedures for appeals must:

Element 11.1 – 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.

Element 11.2 – Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

Element 11.3 – 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.

Element 11.4 – Include, as parties to the appeal, the enrollee and his or her representative, or the legal representative of a deceased enrollee's estate.

§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.

Element 12.1 – 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 or PIHP receives the grievance.

Element 12.2 – 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 or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

Element 12.3 – 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.

438.408(c)(1)

The MCO policies and procedures can allow for the extension of timeframes. The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:

Element 13.1 – The enrollee requests the extension; or

Element 13.2 – The MCO or PIHP 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.

438.408(c)(2)

Requirements following extension. If the MCO or PIHP extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

438.408(d)(1)

(d) Format of notice-Grievance Resolution

The MCO will notify the enrollee of the disposition of the grievance.

438.408(d)(2) (2) Notification of the Outcome of Appeals.

Enrollees must be notified of the outcome of appeals.

Element 14.1 – For all appeals, the MCO or PIHP must provide written notice of disposition.

Element 14.2 – For notice of expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

438.408(e)(1) Content of notice of appeal resolution.

The written notice of the resolution must include the following:

Element 14.1 – The results of the resolution process.

Element 14.2 – The date it was completed.

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.

Element 15.1 – The right to request a State fair hearing, and how to do so,

Element 15.2 – The right to request to receive benefits while the hearing is pending, and how to make the request; and

Element 15.3 – That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

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.

438.410(b) Punitive Action.

The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

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

Element 16.1 – Transfer of the appeal to the timeframe for standard resolution.

Element 16.2 – Prompt oral notice to the enrollee of the denial, and follow up within 2 calendar days with a written notice.

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.

438.416 Recordkeeping and reporting requirements.

The MCOs must maintain records of grievances and appeals and provide reports to the State.

438.420(b) Continuation of Benefits

The MCO must continue the enrollee's benefits if:

Element 17.1 – The enrollee or the provider files the appeal timely.

Element 17.2 – The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

Element 17.3 – The services were ordered by an authorized provider.

Element 17.4 – The original period covered by the original authorization has not expired.

Element 17.5 – The enrollee requests and extension of benefits.

438.420(c) Duration of continued or reinstated benefits.

Element 18.1 – If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

Element 18.2 – The enrollee withdraws the appeal.

Element 18.3 – Ten days pass after the MCO or PIHP 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.

Element 18.4 – A State fair hearing Office issues a hearing decision adverse to the enrollee.

Element 18.5 – The time period or service limits of a previously authorized service has been met.

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.

§438.424(a).Services not furnished while appeal is pending.

If the MCO or PIHP, 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.

§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.

Fraud and Abuse Detection (from DC contract MCO Contract)

H8.3.1.1 through 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:

Element 19.1 – The MCO shall ensure that all officers, directors, managers and employees know and understand the provisions of the fraud and abuse compliance plan.

Element 19.2 – 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.

Element 19.3 – 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).

Element 19.4 – The plan shall contain provisions for the investigation and follow-up of any compliance plan reports.

Element 19.5 – The fraud and abuse compliance plan shall ensure that the identities of individuals reporting violations of the plan are protected.

Element 19.6 – 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.

Element 19.7 – The compliance plan shall require that confirmed violations be reported to MAA within 24 hours of being confirmed.

Element 19.8 – 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.

Element 19.9 – The written plan shall ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

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.

Appendix 2

Table A-1: DCMAA Measurement Year 2005 Performance Measure Results

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Effectiveness of Care					
Childhood Immunization Status–DTP	88.4%	72.0%	72.0%	75.6%	85.8%
Childhood Immunization Status–IPV	91.7%	83.0%	81.5%	84.8%	92.8%
Childhood Immunization Status–MMR	92.9%	87.0%	85.2%	88.1%	94.1%
Childhood Immunization Status–HIB	90.2%	77.0%	75.2%	78.9%	88.3%
Childhood Immunization Status–Hep B	93.8%	79.0%	78.6%	81.9%	91.2%
Childhood Immunization Status–VZV	92.7%	81.0%	81.0%	84.7%	92.2%
Childhood Immunization Status-pneumococcal conjugate	58.2%	NA	NA	NA	NA
Childhood Immunization Status–Combo 1	Measure Retired	Measure Retired	Measure Retired	Measure Retired	Measure Retired
Childhood Immunization Status–Combo 2	82.7%	58.0%	56.7%	62.9%	75.7%
Childhood Immunization Status–Combo 3	55.6%	NA	NA	NA	NA
Adolescent Immunization Status-MMR	84.5%	68.0%	61.2%	71.6%	90.2%
Adolescent Immunization Status-Hep B	82.7%	51.0%	49.2%	61.0%	80.8%
Adolescent Immunization Status-VZV	74.6%	41.0%	32.5%	47.4%	71.8%
Adolescent Immunization Status-Combo 1	Measure Retired	Measure Retired	Measure Retired	Measure Retired	Measure Retired
Adolescent Immunization Status-Combo 2	73.1%	30.0%	22.8%	38.4%	62.7%
Appropriate Treatment for Children with Upper Respiratory Infection	89.5%	NA	76.9%	80.0%	89.0%
Appropriate Treatment for Children with Pharyngitis	40.4%	NA	44.6%	54.6%	77.0%
Breast Cancer Screening	52.2%	54.0%	48.0%	54.0%	67.8%
Cervical Cancer Screening	67.1%	63.0%	58.9%	64.5%	76.6%
Chlamydia Screening in Women 16-20	62.7%	42.0%	37.3%	45.2%	63.6%

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Chlamydia Screening in Women 21-25	68.3%	46.0%	38.7%	48.2%	64.5%
Chlamydia Screening in Women Total	65.8%	45.0%	38.2%	46.4%	63.5%
Controlling High Blood Pressure	60.9%	58.0%	55.8%	61.5%	71.1%
Beta-Blocker Treatment after a Heart Attack	NA	83.0%	79.2%	85.0%	96.9%
Persistence of Beta-Blocker Treatment after a Heart Attack	NA	NA	NA	NA	NA
Cholesterol Management for Patients with Cardiovascular Conditions-Screening	68.6%	57.0%	51.4%	59.8%	78.1%
Cholesterol Management for Patients with Cardiovascular Conditions-LDL-C <130	55.3%	34.0%	25.8%	39.8%	59.0%
Cholesterol Management for Patients with Cardiovascular Conditions-LDL-C <100	31.4%	NA	14.9%	27.7%	42.9%
Comprehensive Diabetes Care-HbA1C Testing	75.7%	75.0%	70.0%	75.0%	88.8%
Comprehensive Diabetes Care-Poor HbA1C Control (>9.0)	46.2%	41.0%	57.6%	49.4%	31.1%
Comprehensive Diabetes Care-Eye Exam	46.2%	42.0%	35.3%	44.1%	60.9%
Comprehensive Diabetes Care-LDL-C Screening performed	81.5%	76.0%	74.0%	78.6%	91.6%
Comprehensive Diabetes Care-LDL-C controlled <130	58.6%	48.0%	45.0%	50.2%	65.0%
Comprehensive Diabetes Care–LDL-C controlled <100	35.2%	NA	24.2%	30.3%	41.6%
Comprehensive Diabetes Care-kidney disease monitored	59.5%	38.0%	37.9%	45.8%	63.0%
Use of Appropriate Medications for People with Asthma- ages 5-9	86.6%	62.0%	58.1%	62.8%	76.4%
Use of Appropriate Medications for People with Asthma- ages 10-17	87.0%	62.0%	58.7%	61.8%	72.7%
Use of Appropriate Medications for People with Asthma- ages 18-56	84.6%	63.0%	58.6%	64.4%	75.3%
Use of Appropriate Medications for People with Asthma- Combined	86.1%	64.0%	60.5%	63.8%	74.1%
Follow-up After Hospitalization for Mental Illness-within 7 days	6.9%	36.0%	23.3%	37.5%	62.5%
Follow-up After Hospitalization for Mental Illness-within 30 days	14.0%	56.0%	44.1%	54.3%	81.3%
Antidepressant Medication Management-Contacts	3.9%	18.0%	12.1%	19.0%	31.6%

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Antidepressant Medication Management-Acute Phase	20.8%	46.0%	41.6%	46.4%	55.1%
Antidepressant Medication Management-Continuation Phase	12.3%	29.0%	23.3%	30.4%	38.6%
Access and Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services-Ages 20-44	74.5%	74.0%	70.6%	75.8%	85.4%
Adults' Access to Preventive/Ambulatory Health Services-Ages 45-64	73.3%	81.0%	78.1%	81.1%	88.7%
Adults' Access to Preventive/Ambulatory Health Services-Ages 65+	67.6%	79.0%	74.0%	79.8%	91.5%
Children and Adolescents' Access to Primary Care Practitioners-12-24 mos	94.2%	92.0%	91.1%	91.8%	98.2%
Children and Adolescents' Access to Primary Care Practitioners–25 mos-6 yrs	87.2%	82.0%	78.3%	81.6%	91.3%
Children and Adolescents' Access to Primary Care Practitioners – 7-11 yrs	89.9%	79.0%	77.2%	82.4%	92.8%
Children and Adolescents' Access to Primary Care Practitioners – 12-19yrs	85.2%	NA	74.4%	79.0%	90.6%
Prenatal and Postpartum Care-Prenatal	74.7%	76.0%	73.7%	78.3%	89.5%
Prenatal and Postpartum Care-Postpartum	60.7%	55.0%	50.8%	55.9%	69.8%
Annual Dental Visit-2-3 yrs	23.2%	NA	NA	NA	NA
Annual Dental Visit-4-6 yrs	47.8%	44.0%	39.0%	46.4%	64.4%
Annual Dental Visit-7-10 yrs	43.7%	44.0%	40.9%	47.9%	62.3%
Annual Dental Visit-11-14 yrs	38.8%	44.0%	37.7%	43.4%	57.2%
Annual Dental Visit-15-18 yrs	31.2%	44.0%	30.7%	37.3%	50.7%
Annual Dental Visit-19-21 yrs	21.5%	44.0%	17.3%	28.7%	43.3%
Annual Dental Visit-Total	37.2%	44.0%	35.9%	42.5%	55.9%
Satisfaction with the Experience of Care					
CAHPS 30.H Adult-Advising Smokers to Quit	65.0%	66.0%	63.3	67.0	74.3
CAHPS 30.H Adult-Courteous and Helpful Office Staff	82.9%	87.0%	86.6%	88.6%	92.9%

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
CAHPS 30.H Adult-Customer Service	75.3%	69.0%	66.0%	69.7%	78.8%
CAHPS 30.H Adult-Getting Care Quickly	63.5%	71.0%	69.3%	73.0%	80.9%
CAHPS 30.H Adult-Getting Needed Care	68.6%	72.0%	69.4%	74.3%	82.7%
CAHPS 30.H Adult-How Well Doctors Communicate	84.4%	85.0%	84.6%	86.6%	91.1%
CAHPS 30.H Adult-Rating of All Health Care	71.9%	72.0%	69.6%	73.0%	80.6%
CAHPS 30.H Adult-Rating of Health Plan	70.7%	69.0%	67.1%	71.6%	81.3%
CAHPS 30.H Adult-Rating of Personal Doctor	78.7%	77.0%	74.7%	77.4%	84.0%
CAHPS 30.H Adult-Rating of Specialist Seen Most Often	74.0%	75.0%	72.6%	76.0%	81.8%
CAHPS 30.H Child-Courteous and Helpful Office Staff	90.8%	NA	NA	NA	NA
CAHPS 30.H Child-Customer Service	80.2%	NA	NA	NA	NA
CAHPS 30.H Child-Getting Care Quickly	72.3%	NA	NA	NA	NA
CAHPS 30.H Child-Getting Needed Care	77.2%	NA	NA	NA	NA
CAHPS 30.H Child-How Well Doctors Communicate	91.3%	NA	NA	NA	NA
CAHPS 30.H Child-Rating of All Health Care	81.4%	NA	NA	NA	NA
CAHPS 30.H Child-Rating of Health Plan	80.9%	NA	NA	NA	NA
CAHPS 30.H Child-Rating of Personal Doctor	88.7%	NA	NA	NA	NA
CAHPS 30.H Child-Rating of Specialist Seen Most Often	77.1%	NA	NA	NA	NA
Health Plan Stability					
Practitioner Turnover-PCP	10.1%	NA	5.2%	7.9%	13.0%
Practitioner Turnover-Non-PCP	30.3%	NA	5.5%	12.9%	25.8%
Practitioner Turnover-OB/GYN	8.4%	NA	3.8%	7.7%	14.0%
Practitioner Turnover-Chemical Dependency Providers	6.8%	NA	.5%	10.2%	31.0%
Practitioner Turnover-Mental Health Providers	6.6%	NA	3.5%	11.2%	25.6%

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Practitioner Turnover-Dentists	7.5%	NA	.5%	7.5%	17.7%
Frequency of Ongoing Prenatal Care-<21%	8.2%	NA	4.2%	19.3%	50.9%
Frequency of Ongoing Prenatal Care-21-40%	9.8%	NA	3.0%	6.6%	13.4%
Frequency of Ongoing Prenatal Care-41-60%	12.0%	NA	4.6%	7.8%	13.4%
Frequency of Ongoing Prenatal Care-61-80%	16.2%	NA	10.0%	13.8%	21.4%
Frequency of Ongoing Prenatal Care-81%+	53.9%	NA	34.5%	50.9%	80.0%
Well-Child Visits in the First 15 Months of Life-0 Visits	2.6%	NA	1.0%	6.0%	11.6%
Well-Child Visits in the First 15 Months of Life-1 Visits	1.9%	NA	1.2%	4.1%	8.1%
Well-Child Visits in the First 15 Months of Life-2 Visits	2.7%	NA	2.5%	4.9%	10.0%
Well-Child Visits in the First 15 Months of Life-3 Visits	3.5%	NA	5.3%	7.5%	11.3%
Well-Child Visits in the First 15 Months of Life-4 Visits	7.3%	NA	10.1%	12.3%	17.3%
Well-Child Visits in the First 15 Months of Life-5 Visits	14.0%	NA	15.7%	18.3%	25.3%
Well-Child Visits in the First 15 Months of Life-6 or More Visits	67.3%	44.0%	40.1%	46.8%	67.7%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.5%	60.0%	56.0%	61.9%	77.5%
Adolescent Well-Care Visits	59.1%	33.0%	33.1%	40.3%	55.3%
Frequency of Selected Procedures-Myringotomy MF 0-4	0.8	NA	.5	1.9	4.0
Frequency of Selected Procedures-Myringotomy MF 5-19	0.1	NA	.1	.4	.7
Frequency of Selected Procedures-Tonsillectomy MF 0-9	0.3	NA	.3	.6	.9
Frequency of Selected Procedures-Tonsillectomy MF 10-19	0.1	NA	.2	.3	.5
Frequency of Selected Procedures-Non-Obs D and C F 15-44	0.2	NA	.2	.3	.6
Frequency of Selected Procedures-Non-Obs D and C F 45-64	0.2	NA	.2	.4	.8
Frequency of Selected Procedures-Hysterectomy -Abdominal F 15-44	0.2	NA	.2	.3	.4
Frequency of Selected Procedures-Hysterectomy -Abdominal F 45-64	0.4	NA	.4	.6	.9

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Frequency of Selected Procedures-Hysterectomy - Vaginal F 15-44	0.1	NA	.1	.1	.3
Frequency of Selected Procedures-Hysterectomy - Vaginal F 45-64	0.2	NA	.1	.2	.4
Frequency of Selected Procedures-Cholecystectomy opn M 30-64	0.0	NA	0.0	.1	.1
Frequency of Selected Procedures-Cholecystectomy opn F 15-44	0.0	NA	0.0	0.0	.1
Frequency of Selected Procedures-Cholecystectomy opn F 45-64	0.1	NA	0.0	.1	.2
Frequency of Selected Procedures-Cholecystectomy cld M 30-64	0.2	NA	.1	.2	.4
Frequency of Selected Procedures-Cholecystectomy cld F 15-44	0.3	NA	.4	.6	.9
Frequency of Selected Procedures-Cholecystectomy cld F 45-64	0.3	NA	.4	.6	1.1
Inpatient Utilization - General Hospital/Acute Care-Total Discharges/1000	10.5	NA	5.8	7.6	11.0
Inpatient Utilization - General Hospital/Acute Care-Total Days/1000	62.2	NA	19.1	26.9	39.7
Inpatient Utilization - General Hospital/Acute Care-Total Average Length of Stay	4.9	NA	3.1	3.5	4.4
Inpatient Utilization - General Hospital/Acute Care-Medicine Discharges/1000	7.0	NA	2.0	3.3	5.5
Inpatient Utilization - General Hospital/Acute Care-Medicine Average Length of Stay	5.0	NA	3.2	3.5	4.3
Inpatient Utilization - General Hospital/Acute Care-Surgery Discharges/1000	0.9	NA	.7	1.1	2.0
Inpatient Utilization - General Hospital/Acute Care-Surgery Average Length of Stay	6.7	NA	4.7	5.4	6.8
Inpatient Utilization - General Hospital/Acute Care-Maternity Discharges/1000	4.3	NA	3.1	5.7	9.8
Inpatient Utilization - General Hospital/Acute Care-Maternity Average Length of Stay	3.0	NA	2.5	2.6	3.0
Inpatient Utilization - General Hospital/Acute Care-Medicine Days/1000	48.9	NA	6.5	12.3	22.0
Inpatient Utilization - General Hospital/Acute Care-Surgery Days/1000	5.2	NA	3.6	6.2	11.3
Inpatient Utilization - General Hospital/Acute Care-	13.2	NA	7.9	14.8	24.7

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Maternity Days/1000					
Ambulatory Care-Outpatient Visits/1000	271.2	NA	231.5	283.2	375.9
Ambulatory Care-Emergency Room Visits/1000	48.6	NA	39.0	49.0	66.8
Ambulatory Care-Ambulatory Surgery Procedures/1000	3.2	NA	2.5	4.5	8.6
Ambulatory Care-Observation Room Stays/1000	1.7	NA	.3	1.5	3.3
Inpatient Utilization-Non-acute Care-Discharges/1000	0.2	NA	0.0	.2	.4
Inpatient Utilization-Non-acute Care-Days/1000	1.0	NA	.6	2.7	5.3
Inpatient Utilization-Non-acute Care-Average Length of Stay	11.8	NA	11.4	14.4	21.4
Discharges and Average Length of Stay Maternity Care-Discharges/1000	5.5	NA	4.3	8.0	13.6
Discharges and Average Length of Stay Maternity Care-Days/1000	17.1	NA	11.7	21.0	31.1
Discharges and Average Length of Stay Maternity Care-Average Length of Stay	3.1	NA	2.5	2.7	3.2
Discharges and Average Length of Stay Maternity Care-Vaginal Discharges/1000	4.0	NA	3.2	5.9	9.7
Discharges and Average Length of Stay Maternity Care-Vaginal Average Length of Stay	2.7	NA	2.1	2.3	2.6
Discharges and Average Length of Stay Maternity Care-C-Section Discharges/1000	1.5	NA	1.2	2.2	3.5
Discharges and Average Length of Stay Maternity Care-C-Section Average Length of Stay	4.3	NA	3.4	3.8	4.4
Discharges and Average Length of Stay Maternity Care-Vaginal Days/1000	10.8	NA	6.9	13.0	21.4
Discharges and Average Length of Stay Maternity Care-C-Section Days/1000	6.3	NA	4.7	7.9	13.1
Cesarean Section Rate	Measure Retired	Measure Retired	Measure Retired	Measure Retired	Measure Retired
VBAC Rate	Measure Retired	Measure Retired	Measure Retired	Measure Retired	Measure Retired
Births and Average Length of Stay - Newborn Discharges/1000	2.2	NA	1.7	2.8	4.5
Births and Average Length of Stay - Newborn Days/1000	8.5	NA	5.3	9.1	16.1
Births and Average Length of Stay - Newborn Average Length of Stay	3.9	NA	2.8	3.2	3.9

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Births and Average Length of Stay - Newborn Discharges/1000 F 10-49	4.6	NA	4.8	8.3	13.8
Births and Average Length of Stay - Well Newborn Discharges/1000	1.9	NA	1.5	2.6	4.1
Births and Average Length of Stay - Well Newborn Average Length of Stay	2.5	NA	2.0	2.1	2.4
Births and Average Length of Stay - Complex Newborn Discharges/1000	0.4	NA	.1	.2	.4
Births and Average Length of Stay - Complex Newborn Average Length of Stay	10.2	NA	11.0	14.7	20.0
Births and Average Length of Stay - Well Newborn Days/1000	4.6	NA	3.3	5.5	9.2
Births and Average Length of Stay - Complex Newborn Days/1000	3.9	NA	1.7	3.7	7.9
Births and Average Length of Stay - Well Newborn Discharges/1000 Female 10-49	4.0	NA	4.4	7.6	12.3
Births and Average Length of Stay - Complex Newborn Discharges/1000 Female 10-49	0.6	NA	.3	.7	1.2
Mental Health Utilization Inpatient– Discharges/1000	3.0	NA	.3	.8	1.2
Mental Health Utilization Inpatient- Average Length of Stay	7.2	NA	5.0	7.3	9.9
Mental Health Utilization-Percent of Members Receiving Care- Any	4.6%	NA	2.5%	6.3%	12.1%
Mental Health Utilization-Percent of Members Receiving Care- Inpatient	1.5%	NA	.3%	.5%	.9%
Mental Health Utilization-Percent of Members Receiving Care- Intermediate	0.0%	NA	0.0%	.1%	.2%
Mental Health Utilization-Percent of Members Receiving Care- Ambulatory	5.2%	NA	3.0%	6.3%	11.9%
Chemical Dependency Utilization Inpatient– Discharges/1000	0.1	NA	.1	.3	.6
Chemical Dependency Utilization – Inpatient Days	127.0	NA	NA	NA	NA
Chemical Dependency Utilization Inpatient- Average length of Stay	5.1	NA	3.3	5.5	7.9
Identification of Alcohol and Other Drug Services – Any Services	1.2	NA	.6	1.5	2.8
Identification of Alcohol and Other Drug Services – Inpatient Services	0.6	NA	.3	.6	1.0
Identification of Alcohol and Other Drug Services – Intermediate Services	NA	NA	0.0	0.0	.1

Measure	DCMAA Average*	DCMAA Target	HEDIS 25th Percentile+	HEDIS Mean	HEDIS 90th Percentile
Identification of Alcohol and Other Drug Services – Ambulatory Services	0.7	NA	.5	1.2	2.3
Outpatient Drug Utilization-Average Cost of Prescriptions	$41.29	NA	$22.29	$37.17	$68.94
Outpatient Drug Utilization-Average Number of Prescriptions PMPM	7.5	NA	7.9	11.0	19.1
Health Plan Descriptive Information					
Board Certification-PCP	71.5%	NA	76.7%	82.8%	92.0%
Board Certification-OB/GYN	69.3%	NA	76.1%	80.3%	88.9%
Board Certification-Pediatrician	75.0%	NA	72.8%	78.7%	92.6%
Board Certification-Geriatricians	64.0%	NA	68.8%	77.9%	100.0%
Board Certification-Other Specialists	67.7%	NA	76.8%	81.0%	90.0%
Enrollment by Product Line-Total Male (MM)	106,430	NA	165,505	453,263	1,158,212
Enrollment by Product Line-Total Female (MM)	171,360	NA	231,059	583,777	1,443,550
Enrollment by Product Line-Total (MM)	277,790	NA	394,575	1,037,040	2,601,762

NA – Not Applicable
NR – Not Reported

3) _____

* District average is a weighted average.

+ HEDIS percentile and mean scores are from NCQA *Quality Compass* 2005