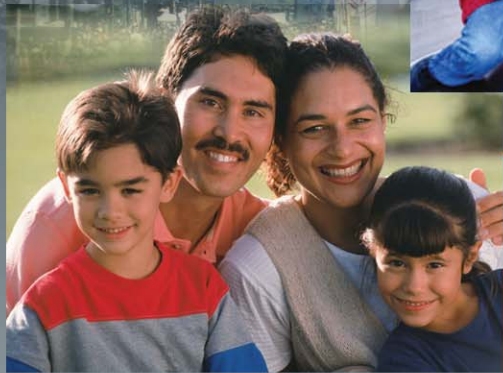


District of Columbia
Department of Health Care Finance



Calendar Year 2010 Operational Standards Reviews (OSR) Results

Health Services for Children With Special Needs

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Section I

Annual Review of Access, Structure and Operations

Program Overview

As the External Quality Review Organization (EQRO) for the District of Columbia's (District), Department of Health Care Finance (DHCF) the Delmarva Foundation (Delmarva) performs an annual review of Access, Structure and Operations (42 CFR 438.358 (3)). The purpose of this review was to conduct an analysis and evaluation on quality, timeliness, and access to health care services provided by your organization. The focus of this review was on coordination and continuity of care, case management, and the resolution of concerns identified in prior reviews.

Introduction

The Access, Structure and Operations Review is conducted at the managed care organization's (MCO's) office and is performed by a team of health professionals. The team that performs the annual review consists of health professionals with experience in managed care and quality improvement systems. The team completes its review and provides feedback to DHCF and each MCO with the goal of improving the care provided to Medicaid enrollees. Prior to the onsite review, each MCO is required to submit a presite survey form and supply documentation for various processes such as quality management and enrollee rights. Delmarva staff reviews these documents prior to the MCO visit.

The onsite review provides the MCO with an opportunity to demonstrate the efficacy of their health care system. Policies, committee minutes, work plans, reports, and other written procedures are presented to the reviewers that demonstrate the continuous quality improvement efforts undertaken by the MCO. Key staff interfaces with the team to further define their organization's operational protocols. In addition, the team evaluates the effectiveness of any corrective action plans (CAPs) initiated as a result of the prior year's review.

Information gained from interviews with MCO staff is compared to the policies, procedures, standards, guidelines, and other information submitted by the MCO. This comparison assists Delmarva in ascertaining if there is an understanding and practice among MCO staff of the published policies and procedures.

Findings for this review were based on the review of documents submitted by the MCO and interviews with MCO management. This review did not include interviews with beneficiaries, providers, or families of beneficiaries, nor did it include reviews of case files, visits to service provision locations, or observation of actual service provision.

The performance standards used to assess the MCO's operational systems are developed from the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care", Code of Federal Regulations, and Departmental requirements. DHCF leadership approved the MCO performance standards used in the CY 2010 review before application.

Methodology

For CY 2010, the following performance standards were included in the review cycle:

- Enrollee Rights
- Care Coordination
- Treatment Plan
- Managing Enrollees with Special Health Care Needs
- Practice Guidelines
- Over and Underutilization
- Quality and Appropriateness of Care
- Access and Availability
- Quality Program Oversight

For CY 2010, the MCO is expected to meet the compliance rate of 100% for all standards. The MCO is required to submit a CAP for any standard that does not meet the minimum compliance rate.

In March 2010, Delmarva provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2010 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva and DHCF staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2010 Review Timeline
- External Quality Review Contact Persons
- Presite Visit Overview and Survey
- Presite OSR Document List
- Operational Systems Review Standards and Guidelines

Prior to the onsite review, the MCO was required to submit a completed presite survey form and provide documentation for various processes such as quality, enrollee rights, and continuity of care, policies. The documents provided were reviewed by Delmarva staff prior to the one day onsite visit.

During the onsite review, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion of the onsite review, an exit conference was held with the MCO. The purpose of this conference was to provide the MCO with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conference that the MCO would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCO was given 10 business days from receipt of the follow-up letter to submit any additional information to Delmarva; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the onsite review, Delmarva documented its findings for each standard by element and component. The level of compliance for each element and component was rated with a review determination of met, partially met, or unmet as follows:

Met	100%
Partially Met	50%
Not met	0%

Each element or component of a standard is of equal weight. A CAP is required for each performance standard that did not meet the 100% minimum required compliance rate, as defined for the CY 2010 review. Preliminary results of the OSR are compiled and submitted to the DHCF for review. Upon the Department’s approval, the MCO received a report containing its individual review findings. After receiving the preliminary report, the MCO is given 45 calendar days to respond to Delmarva with any required CAPs. The MCO may also respond to any other issues contained in the report at its discretion within this same time frame, and/or request a consultation with DHCF and Delmarva to clarify issues or ask for assistance in preparing a CAP. The content of all CAPs is evaluated and a determination is made as to its adequacy in collaboration with the Department. A CAP is determined to be adequate only if it addresses all required elements and components (time lines, action steps, etc.). Delmarva reviews any additional materials submitted by the MCO, makes appropriate revisions to the MCO’s final report, and submits the report to the DHCF for review and approval. The Final MCO Annual Quality of Care Report is posted to the MCO-specific portal. This concludes the annual Access, Structure and Operations review process.

Results

In addition to the review standards, the 2010 also included a review of the MCO's Quality Improvement Collaborative activities. As a part of a multi-year initiative to evaluate health care outcomes across the MCOs, DHCF launched the Quality Improvement Collaborative (Collaborative). The Collaborative was designed to direct MCO resources to the most pressing health issues facing the District: perinatal outcomes; infant mortality, and adverse outcomes for chronic conditions (asthma, diabetes, hypertension and congestive heart failure). The quality outcomes data will be used to gauge improvements in the care and service to these populations over time with the ultimate goal of improving health services delivery to these enrollees.

Improving performance on the prenatal and postpartum care HEDIS measures as well as improving the adverse birth outcomes in the District were identified as opportunities for improvement and were the impetus for the creation of the DC DHCF Quality Improvement Collaborative. In preparation for this initiative, HSCSN began enhancements to their care management system, CaseTrakker. The Case Trakker perinatal module was modeled to mirror HEDIS specifications particularly for the prenatal and postpartum performance measures. These additional system capabilities are designed to monitor and track timelines for both contractual requirements and the 2009 indicator measures in the adverse birth outcome measures.

HSCSN reported an increase of 23 percentage points in the timeliness rate of prenatal care in the first trimester component in a 3 year period from 2006 to 2009. Although a significant improvement in performance, HSCSN's rate of 71% is lower than the NCQA Medicaid 90th percentile of 92%. The postpartum rate remained constant (60-59%) since 2007 and below the NCQA Medicaid 90th percentile of 73%. The rate for adverse perinatal outcomes is a baseline measurement and HSCSN's internal goal is set at zero.

Enrollee Rights and Protections (ER 3)

The 42 CFR § 438 Subpart C, Enrollee Rights and Protections, details requirements to ensure that managed care enrollees have the right to receive information about the availability health care services, how to access services, policies and procedures relative to obtaining services, and the right to make health care decisions. HSCSN fully met each standard, and no corrective action plans are required.

Quality Assessment and Performance Improvement (QA 2, 5-8, 24, 27 & 28)

The 42 CFR § 438 Subpart D, Quality Assessment and Performance Improvement, sets forth specifications for quality strategies that states must implement to ensure the delivery of quality health care by its contracted MCOs. HSCSN fully met each standard, and no corrective action plans are required.

HCQIS Quality Plan Standards

The Centers for Medicare & Medicaid Services (at the time known as the Health Care Financing Administration) developed health care quality improvement standards to encourage the delivery of quality health care in 1993. These standards continue to be considered important in assessing quality for MCOs. Delmarva's 2010 Quality Review includes the following Health Care Quality Improvement System (HCQIS) review standards: I.B, III.A-III.E, and XI. HSCSN fully met each standard, and no corrective action plans are required.

Conclusions and Recommendations

HSCSN's quality and performance improvement program continues to evolve and improve. Staff presented evidence of a system wide process to continuously monitor designated performance indicators across the organization. Overall program goals are aligned with DC DHCF's Collaborative to Improve Perinatal and Chronic Disease Outcomes and incorporated into HSCSN's quality improvement program.

HSCSN implemented enhancements to the care management software system, Case Trakker, to assist assigned care managers with the requisite tools to support and manage the prenatal population. Both the Perinatal and Chronic Care performance measures will also be monitored as indicators in the Performance Improvement Project (PIP). These approaches are consistent with the District's Collaborative efforts to improve outcomes for at risk enrollees.

For the first time in 2009, HSCSN membership expanded to include enrollees with special needs from the District Department of Youth Rehabilitation Services (DYRS). This has presented new challenges and required creative approaches to address the socio-economic issues affecting enrollees' abilities to receive

necessary health care services. HSCSN enrollees with special needs in the Child and Family Services Agency (CFSA) also presented challenges.

HSCSN's policies, processes, and quality improvement plans presented during the review were comprehensive, well crafted, and easy to follow. HSCSN offers a unique model for providing services to children with special needs.

Section II

Findings

Enrollee Rights and Protections (42 CFR § 438.10, 100)

Select Enrollee Rights and Protections Standards were exempted from the 2010 review. The following standard was included in the 2010 review.

(42 CFR § 438.10.f.iii) (42 CFR § 438.100.b.2.ii, iii, iv) The MCO must provide to enrollees information on enrollee rights and responsibilities.

This element is met.

a) The MCO must uphold each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

This component is met.

The Enrollee Rights and Responsibilities Policy stipulates the right of each enrollee and their family to be treated in a caring, respectful, culturally-sensitive and professional manner by HSCSN staff with recognition of their dignity and right to privacy. These rights are also contained in the Enrollee Handbook.

b) The MCO must uphold each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

This component is met.

HSCSN's Enrollee Rights and Responsibilities Policy stipulates the enrollee and his/her family's right to receive information about the enrollee's treatment in a language that allows understanding in order to make decisions about appropriate or medically necessary treatment options, regardless of cost or benefit coverage. This information is also contained in the Enrollee Handbook.

c) The MCO must uphold each enrollee's' right to participate in decisions regarding his or her health care, including the right to refuse treatment.

This component is met.

HSCSN's Enrollee Rights and Responsibilities Policy stipulates the enrollee and his/her family's right to receive information about the enrollee's treatment in a language that allows understanding in order to make decisions. The enrollee and his/her family can be involved in developing the plan of treatment along with the right to say yes or no to treatment before it is given to the enrollee. Enrollees have the right to seek a second opinion and/or to refuse proposed treatment. The Enrollee Handbook also contains these rights.

Grievance System (42 CFR § 438.400)

All Grievance System Standards were exempted from the 2010 review.

Quality Assessment and Performance Improvement (42 CFR § 438.200)

Selected Quality Assessment and Performance Improvement System Standards were exempted from the 2010 review. The following standards were selected for review for all plans in the 2010 review.

HSCSN met the selected 2010 quality standards.

Additional standards were derived from federal regulations, the Health Care Quality Improvement System (HCQIS) and the District of Columbia's managed care contract.

(42 CFR § 438.206.b.5) Each MCO, consistent with the scope of the contracted services, must meet the following requirements:

d) The MCO must coordinate with the out-of-network provider with respect to payment and ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

This component is met.

HSCSN's Care Management Program is designed to ensure that appropriate health care services are provided through an integrated delivery system. All HSCSN members are individuals with special health care needs and each is assigned a Care Manager responsible for the coordination of these enrollees.

Although HSCSN maintains a network of participating providers, there may be instances when needed services are not available. All requests for out-of-network providers are referred to the Medical Director for review and determination. When determined to be appropriate, the Single Case

Agreement Policy provides details on how such services may be obtained. The Authorization of Out-of-Network Services Policy stipulates that all out-of-network services are provided at no cost or co-payment to the enrollee. Staff also provided sample language for an individually negotiated agreement that would be used in such circumstances.

The initial copy of the Single Case Agreement Policy presented to the review team onsite had a stamped signature rather than the Medical Director's signature. It is recommended HSCSN institute a policy to control the use of a stamp signature or eliminate its use. It is also recommended that HSCSN have strong and clearly delineated security and monitoring provisions related to signature authority as they transition to an electronic approval process.

(42 CFR § 438.208.b, b.1, 2, 3, 4) The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet state requirements and must do the following:

This element is met.

a) The MCO must ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

This component is met.

The Primary Care Physician Selection and Change Policy requires the assignment of a primary care provider (PCP) by a Care Manager within 30 days of enrollment for all members who do not select their own PCP. An enrollee may select a specialist as the PCP if he/she is willing and has the capacity to accept the enrollee in this capacity.

The Care Manager arranges for covered primary care and Early Periodic Screening Diagnosis and Treatment (EPSDT) services with a participating PCP or with a clinic for enrollees whose PCP is a specialist or sub-specialist not providing the full range of services to the enrollee. The Care Management Program Policy also outlined the role of the Care Managers and their responsibilities in coordinating health care services for enrollees within a multi-disciplinary treatment team with primary, specialty, and other community providers.

b) The MCO must coordinate the services that enrollees receive from the MCO with the services that the enrollee receives from any other MCO, PIHP, or PAHP.

This component is met.

The Care Management Program Policy outlines the Care Managers roles and responsibilities in facilitating cooperative relationships and coordinating enrollee services received from other MCOs, prepaid inpatient health plans (PIHPs) or prepaid ambulatory health plans (PAHPs). HSCSN's Transition to Adult Level Care and Services Policy requires Care Managers to be responsible for coordinating and transitioning enrollees receiving services in a variety of settings. These include transitioning from early intervention stages, in or out of acute care facilities, long term care (LTC), psychiatric residential treatment facilities (PRTC), or other institutional care. Also enrollees transitioning in or out of HSCSN or enrollees entering or exiting the custody of specific community agencies will be assisted by Care Managers in coordinating their continuing health care services.

c) The MCO must share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

This component is met.

The Care Management Program Policy outlines the Care Managers roles and responsibilities in facilitating coordination and cooperation between all health care providers and others providing services to the enrollee. The policy defines this collaboration to include the enrollee's caregiver, other providers, social service agencies, the Court system, and other MCOs, PIHPs, or PAHPs. The primary program goal is to facilitate the identification of health issues requiring services and to coordinate access to the appropriate level of care without duplication. Achieving and maintaining the enrollee's optimal health status requires a comprehensive approach to the integration of effective services. This policy also contains an extensive listing of community programs and agencies that are utilized to coordinate the care of HSCSN enrollees.

d) The MCO must ensure that, in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 42 CFR, Parts 160 and 164, Subparts A and E, to the extent that they are applicable.

This component is met.

The Confidentiality of Medical Records Policy stipulates how the privacy rights of enrollees are to be protected and are consistent with federal requirements. HSCSN's HIPAA Workforce Training Requirements Policy requires appropriate training for all employees to assure that they understand the HIPAA patient privacy and security requirements established under state and federal law. The HSC HIPAA Privacy and Security Officer has the ultimate responsibility for training and ensuring compliance with these requirements.

(42 CFR § 438.208.c.1, 2, 3) The MCO must coordinate services for enrollees with special health care needs:

This element is met.

a) The State must implement mechanisms to identify persons with special health care needs to MCOs as those persons are defined by the State.

This component is met.

HSCSN's contract with DC DHCF defines eligible enrollees as individuals with one or more physical, mental, or developmental conditions that meet certain requirements. The eligibility categories include individuals up to 26 years of age who receive Supplemental Security Income (SSI) benefits or have an SSI-related diagnosis or are under the custody of the Department of Youth Rehabilitation Services (DYRS) or the Child and Family Services Agency (CFSA). All HSCSN enrollees are individuals with special health care needs as defined by contractual requirements.

b) The MCO must implement mechanisms to assess each Medicaid enrollee identified by the State and identified to the MCO by the State 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.

This component is met.

All HSCSN's enrollees have special health care needs and each is assigned a Care Manager. The Care Management Program Policy specifies that each enrollee have an initial medical, psychosocial assessment, and an interim Care Coordination Plan (CCP) developed within five days of enrollment and the initial CCP completed within 45 days of enrollment. Ongoing comprehensive assessments are conducted twice a year for each enrollee. Face-to-face visits are also performed based upon the assigned acuity/severity level or other enrollee risk factors. New and periodic enrollee assessments may also require additional interventions and may include face-to-face visits, referrals for outreach services or to external community resources for specialized services.

c) The MCO's assessment mechanisms must use the appropriate health care professionals.

This component is met.

The Care Management Program Policy indicates assessment mechanisms are in place for use by the appropriate health care professionals and describes the qualifications for the staff and their supervisors. Care Managers are assigned to specific enrollees based on diagnoses and levels of special services needed, with those enrollees requiring the most support being managed by registered

nurses (RNs) or licensed clinical social workers (LCSWs). Additional tools are used for enrollees with certain diagnoses such as asthma and diabetes and the management of these patients is with disease specific assessments, protocols, and clinical guidelines.

(42 CFR § 438.208.c.3.i, ii, iii) The MCOs must develop a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.

This element is met.

a) The treatment plan must be developed by the enrollee's primary care provider with enrollee participation.

This component is met.

The Interim, Initial, and Subsequent Care Coordination Plan Policy outlines the PCP role in the development of the treatment plan. Although initiated by the HSCSN Care Manager, the CCP is further developed by the enrollee's PCP and with input from the enrollee and/or caretaker or guardian when appropriate.

b) The treatment plan must be developed in consultation with any specialists caring for the enrollee.

This component is met.

The Interim, Initial, and Subsequent Care Coordination Plan Policy specifies the Care Manager's responsibility to include specialists and other relevant providers and agencies in the development of the enrollee's CCP following parental or enrollee consent. The Care Management Program Policy states a multi-disciplinary approach is used to periodically reassess enrollee health care needs. This evaluation includes input from PCPs, specialists, the Individualized Education Program (IEP), the Individual Family Service Plan (IFSP) and Individuals with Disabilities Education Act (IDEA). The care planning and coordination with other specialists and agencies was also described during interviews with HSCSN staff.

c) The treatment plan must be approved by the MCO in a timely manner, if this approval is required by the MCO.

This component is met.

The Interim, Initial, and Subsequent Care Coordination Plan Policy requires every enrollee to have an interim CCP completed by the Care Manager within five days of enrollment. The initial CCP must be completed within 45 days with comprehensive assessments at least twice a year for subsequent

updates. The timelines for CCP development, completion, and updating are systematically monitored by the Performance Outcomes and Improvement Committee (POIC).

d) The treatment plan must be in accord with any applicable state quality assurance and utilization review standards.

This component is met.

The Interim, Initial, and Subsequent Care Coordination Plan Policy contains requirements from the HSCSN CASSIP contract and the incorporation of utilization management procedures. HSCSN's multi-disciplinary team approach includes evaluation and periodic assessments, planning of treatment, care coordination, case management, health education, and assistance in obtaining all preventive and therapeutic health care services. Preventive services include clinical practice guidelines for EPSDT services.

(42 CFR § 438.208.c.4) The MCO must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist.

This element is met.

The Enrollee Handbook outlines the specific circumstances enrollees do not need a referral to access specialty services. The Care Management Program Policy clearly documents enrollees do not require prior authorization to access primary care, OB/GYN, family planning, treatment for sexually transmitted diseases, vision care (under 21 years of age), dental, immunizations, or emergency services. The Enrollee Handbook informs enrollees how to obtain medically necessary specialty care services. After a referral from the PCP the Care Manager assists the enrollee in making an appointment with a HSCSN specialty care provider. PCPs must follow the HSCSN referral and authorization process for specialty services that are not specified in their CCP.

(42 CFR § 438.236.a, b.1, 2, 3, 4, c, d) The MCO must maintain practice guidelines. The adopted practice guidelines must address the following requirements:

This element is met.

a) The MCO's adopted practice guidelines must be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.

This component is met.

The Clinical Practice Guidelines Policy clearly defines how the guidelines are based on valid and reliable evidence and how they are adopted for use by HSCSN. Quality Council Committee (QCC)

meeting minutes confirmed the presentation, review, and approval process. In 2009 the QCC approved clinical practice guidelines for Diabetes, Type 2 Diabetes in Children and Adolescence, Attention-Deficit/Hyperactivity Disorder (Child and School-Aged), Prevention of Pediatric Overweight and Obesity, and the Immunization Schedule (ages 7-18 years). HSCSN made the clinical guidelines readily available on the plan's website and presented examples of materials explaining guidelines for both members and providers

b) The MCO's adopted practice guidelines must consider the needs of the MCO's enrollees.

This component is met.

The Clinical Practice Guidelines Policy requires the development of clinical guidelines to address the clinical issues important to the treatment of special needs and high-risk children and adolescents. The minutes of multiple QCC meetings demonstrated the review and adoption of clinical guidelines and provided evidence of the process for updating them.

c) The MCO's practice guidelines must be adopted in consultation with contracting health care professionals.

This component is met.

The Clinical Practice Guidelines Policy requires the guidelines be reviewed and approved by the HSCSN QCC. The QCC meeting minutes documented evidence of HSCSN following their process and consulting with contracting health care professionals for review and input in the adoption of clinical guidelines.

d) The MCO's practice guidelines must be reviewed and updated periodically, as appropriate.

This component is met.

The Clinical Practice Guidelines Policy indicates all practice guidelines must be reviewed at least every two years or as changes occur in professional and/or industry standards. This activity is substantiated in the QCC meeting minutes.

e) The MCO must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

This component is met.

The Clinical Practice Guidelines Policy indicates providers have access to all adopted guidelines on the HSCSN website and are notified of new guidelines via the Provider Newsletter and other

provider directed communications. Enrollees are provided specific guidelines relevant to the risk/targeted population. Clinical practice guidelines are readily available on the plan's website for both providers and enrollees.

f) The MCO must apply the clinical practice guidelines when making decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

This component is met.

HSCSN's Clinical Practice Guidelines Policy confirms the use of a multi-disciplinary approach in developing and reassessing the appropriateness of clinical practice guidelines and works to integrate these guidelines with utilization management criteria, information for enrollee education, and benefit decisions. Ongoing feedback was presented to the QCC on new or updated criteria as a component of the continued monitoring of this oversight function.

In addition to the review of clinical practice guidelines, the QCC meeting minutes document the review of the specific utilization management criteria. InterQual criteria was adopted in 2009 with input from provider QCC members. In response to providing services to enrollees in the Department of Youth Rehabilitation Services (DYRS), Child and Adolescent Inpatient Subacute Criteria was presented to the QCC for provider review, input, and adoption. Guidelines were used to create enrollee educational information that was distributed to both generalized and targeted populations, as appropriate. The topics for specific risk populations include diabetes, asthma, attention-deficit disorder, sickle cell anemia, autism, and teen pregnancy.

(42 CFR § 438.240.b.4) The MCO must have in effect mechanisms to detect both under- and over-utilization of services.

This element is met.

HSCSN has multiple mechanisms in place to detect both under- and over-utilization of services. , it's the 2009 Utilization Management Evaluation presented a list of goals and benchmarks as well as a comprehensive evaluation on the extent to which goals were met. The Benefits and Utilization Management Committee (BUMC) monthly meeting minutes reflect efforts to manage under- and over-utilization with further oversight provided by the Performance Outcomes and Improvement Committee.

(42 CFR § 438.240.b.4) The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

This element is met.

HSCSN was operationally designed to identify and coordinate the unique needs of children and adolescents with special health care needs. This specialized focus is clear in its supporting documentation as well as staff interviews. HSCSN's Quality and Performance Improvement Program documents the evaluation of priority categories to assess their enrollees' availability and access to appropriate health care services within established timelines. Each enrollee's assigned Care Manager has the responsibility to assist in collaborating with all health providers and coordinating care as required in the individualized CCP.

Utilization management is an integral component in the care management continuum of care. HSCSN implemented enhancements to the care management software system, Case Trakker, to assist care managers assigned to manage the prenatal population. The perinatal module was revised to include timeframes in the perinatal HEDIS specifications and indicators as defined in the adverse birth outcome measure. Additionally, the team model and guidelines for care managers were revised to provide assignments based upon assessment of acuity and level of care needs for each enrollee.

Clinical guidelines are the basis for formulating treatment plans, health education, disease management, measurement of health outcomes, and the identification of opportunities for improvement. HSCSN adopted and incorporated asthma and diabetes disease management guidelines into their care management system in support of the DC DHCF chronic care collaborative initiative.

(HCQIS III.C) The governing body routinely receives written reports on the quality program that describe actions taken, progress in meeting quality program objectives, improvements made and an evaluation of the effectiveness of the improvements.

This element is met.

The HSCSN Board of Directors (BOD) has final authority, responsibility and accountability for resources and decisions concerning the utilization and quality of health care outcomes, including care coordination of services for plan enrollees. On an annual basis, the BOD must review and approve the Quality and Performance Improvement Program, the evaluation and the work plan. This was documented in the annual BOD meeting in 2009. Responsibility, authority, and accountability is delegated to the Chief Operating Officer (COO), Chief Medical Officer(s), and the POIC. All written reports submitted to the BOD effectively described HSCSN's quality program, the annual evaluation and the work plan.

(HCQIS III.B) The governing body has formally designated an accountable entity or entities within the organization to provide oversight of the quality program, or has formally decided to provide oversight as a committee.

This element is met.

The Quality and Performance Improvement Program Policy stipulates that the Board of Directors (BOD) holds final authority for the allocation of resources and decisions related to quality. This policy further specifies that the program is evaluated on an annual basis and a report is submitted to both the BOD and DC DHCF for approval 90 days after the end of each calendar year. Evidence of this process was provided in the form of BOD meeting minutes.

The HSCSN's BOD membership does not include an enrollee representative; however, regular enrollee input is solicited from members through both the Community Services Advisory Committee (CSAC) and the Parents Advocacy Leaders Group (PALS). The HSCSN Enrollee Handbook also invites any enrollees, parents/caregivers, network providers, advocacy and community groups and relevant District agencies to join their committees or support groups.

(HCQIS I.B) The Quality Plan incorporates written guidelines for evaluation of the continuity and effectiveness of the quality program.

- a) The MCO conducts regular and periodic examination of the scope and content of the quality program to ensure that it covers services in all settings
- b) There is evidence that quality activities have contributed to improvements in the care and services delivered to enrollees.

This element is met.

HSCSN maintains an active Quality and Performance Improvement Program for the purposes of oversight and assessment of the health plan enrollees, focusing on the performance of organization-wide functions that significantly affect enrollee health outcomes. The quality plan defines the categories aligned with DC DHCF's Collaborative to Improve Perinatal and Chronic Disease Outcomes which is incorporated in the HSCSN's Quality and Performance Improvement Program. The priority categories of evaluation are:

- Availability & access
- Collaboration & coordination of care
- Staff education & training
- Utilization management
- Quality/performance assessment, measurement and improvement

- Enrollee & provider satisfaction
- Certification & regulatory compliance

The annual evaluation details a comprehensive assessment using comparative performance indicators compared with national benchmarks. The specific analyses compared the current and trended results with the overall program goals and describe the interventions implemented during 2009. When the goal was not met, additional evaluations identified and explained the performance gaps.

(HCQIS III.A, D, E) A comprehensive annual written report on the quality program is completed, reviewed, and approved by the MCO's governing body. The annual report on the quality program must include:

- a) Quality studies and other activities completed (Perinatal and Chronic Care Collaboratives)
- b) Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results
- c) Demonstrated improvements in quality.
- d) Areas of deficiency
- e) Recommendations for Corrective Action Plans (CAPs)
- f) An evaluation of the overall effectiveness of the quality program including next steps and lessons learned. Additionally an evaluation of the impact to stakeholders/members must be included.

This element is met.

As required by the Quality and Performance Improvement Program Policy, the BOD meeting minutes documented the review and approval of the Quality and Performance Improvement Program Evaluation for CY 2009. This comprehensive evaluation includes information about organizational performance improvement efforts, assessment of results, identification of areas requiring further improvement, and changes in interventions targeted to meet the defined goals in 2010.

The quality plan defines the categories evaluated by HSCSN's Quality and Performance Improvement Program. The categories are:

- Access/availability
- Coordination/continuity of care
- Practice guidelines
- Utilization management
- Cultural competency
- Satisfaction (enrollee, family, staff, and providers)

- Regulatory compliance
- Quality and performance improvement

The quality process encompasses the organization in the identification of performance indicators to be periodically monitored and compared with benchmarks or threshold within reporting timeframes. Performance indicators are detailed, specific and tied to overall performance goals. Rates for services, operational indicators, and health care outcome performance results are in a priority-based Report Card format.

Key quality studies were completed in conjunction with HSCSN's participation in the Perinatal and Chronic Care Collaboratives. The identified indicator rates, established by the Perinatal Collaborative, are included for reporting in HSCSN's Report Card monitoring as well as in the Performance Improvement Project (PIP) as required by DC DHCF. The Chronic Care performance measures will also be monitored in both this format and as indicators in the PIP as required by DC DHCF.

(HCQIS XI) The MCO has established standards for access. Performance on these dimensions of access is assessed against the standards.

This element is met.

HSCSN's network of participating providers are regularly evaluated to ensure an adequate number of provider types, an appropriate mix of practitioners, and an adequate geographical distribution to meet access and cultural competency requirements. This network is evaluated on a periodic basis to ensure consistent availability to serve their population. Included among network specialists are designated early intervention provider and pediatric specialty services, at both Children's National Medical Center and Georgetown.

The Access to Covered Services Policy defines the responsibility of HSCSN's Care Management /Utilization Management Department (CM/UM) as ensuring access to required medical services are provided on a timely basis according to the individual needs of the enrollee. Based upon feedback from CM/UM and the Customer Care departments, specific gaps in the network were identified. Recruitment of providers to close these service gaps is a planned targeted effort for CY 2010.

GEO Access was used to analyze and to evaluate compliance with specific contract access requirements. The Accessibility and Availability Survey documented that 100% of enrollees in the District have access to a provider within the standard for the provider type. Access to a PCP, specialist, and mental health provider was evaluated and trended results for the three-year period from 2007 to 2009 showed improvement in all provider access categories.

HSCSN's membership expansion included enrollees with special needs from the District Department of Youth Rehabilitation Services (DYRS). Recruitment of mental health providers to serve a pediatric special needs population remains a challenge in the District. Feedback and surveys identified specific enhancement needs for services and access and these were incorporated into the recommendations targeted for improvement in 2010.