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2016 EXTERNAL QUALITY REVIEW:
Medicaid Managed Care Organization Performance Report
STATE OF DELAWARE, DIVISION OF MEDICAID & MEDICAL ASSISTANCE

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Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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Introduction

Purpose of Report

The Delaware Division of Medicaid & Medical Assistance (DMMA) contracted with Mercer Government Human Services Consulting (Mercer) to conduct an external quality review (EQR) of the managed care organizations (MCOs), Highmark Health Options (HHO) and United Healthcare Community Plan (UHCP) participating in the State of Delaware's Medicaid health care service programs. This document presents a summary evaluation of the MCOs' performance based on data collected through as part of the annual EQR. This report aims to assess MCO performance in accordance with goals identified in DMMA's current Quality Management Strategy (QMS)[1]:

- **Goal 1:** Improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment.
- **Goal 2:** Improve quality of care and services provided to Diamond State Health Plan (DSHP), DSHP Plus and Children's Health Insurance Program (CHIP) members.
- **Goal 3:** Control the growth of health care expenditures.
- **Goal 4:** Assure member satisfaction with services.

In addition to evaluating MCO performance with respect to DMMA's QMS goals, this report offers a summary of the comprehensive compliance review based on the Centers for Medicare and Medicaid Services (CMS) EQR requirements under 42 CFR 438.358. Based on findings of the descriptive and comparative analyses, Mercer identified MCO strengths and opportunities for improved performance in the delivery of health care services for enrollees in Delaware's managed Medicaid programs.

EQR

CMS mandates a state-level Quality of Care EQR for participating MCOs.[2] Federal regulations under 42 CFR Part 438, subpart E set forth parameters the State must follow when conducting EQRs of a contracted MCO. The EQR is a systematic analysis and evaluation by a qualified External Quality Review Organization (EQRO). The evaluation requires aggregated information about the quality, timeliness and access to health care services that an MCO or its contractors provide under contract for Medicaid recipients.

[1] Division of Medicaid & Medical Services. (2014, April). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services.

[2] Medicaid & Medical Services. (2014, April). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services

Part of the EQR service includes validation of information furnished to complete the analysis. This includes a review of descriptive information and a review of data and procedures used to determine the extent to which they are accurate, reliable and free from bias, in accord with national standards for data collection and analysis.

Quality, as it pertains to the EQR, refers to the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structure and operations. Quality also accounts for how this is accomplished through the provision of health services that are consistent with current professional knowledge and widely-established best practices.[3]

Recent changes by CMS to EQR protocols address significant changes in national healthcare policy, which offer new opportunities for measuring and improving quality of health care delivery. This includes changes effected by the Children's Health Insurance Program Reauthorization Act of 2009, the American Recovery and Reinvestment Act, and the Affordable Care Act.

Methodology

Primary data sources for analysis in this report include the Consumer Assessment of Healthcare Providers and Systems survey (CAHPS), the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) and the 2016 Delaware comprehensive EQR. The performance improvement projects (PIPs) and performance measures (PMs) DMMA selected for validation were based on DMMA's QMS goals noted above.

Results for the two Delaware Medicaid MCOs have been de-identified, and respective scores for HEDIS and CAHPS performance measures are reported in comparison to national percentiles from NCQA's Quality Compass.[4] Results are grouped into a rating system of five stars (90th percentile), three stars (50th–89th percentile) or two stars (below 50th percentile). The EQRO evaluated MCO compliance with Medicaid and the CHIP managed care regulations and is presenting them in four domains: enrollee rights and protections, quality assessment and performance improvement, grievances and appeals, certification and program integrity. A similar star scoring approach was used to present results of the validation of performance measures and PIPs. See Tables 1–3, below to interpret star ratings throughout the remainder of the report.

Table 1. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	« « « « «
50th–89th percentile	« « «
Lower than 50th percentile	« «

[3] National Quality Strategy. Content last reviewed April 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/key3.html; (iv) U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Quality Indicators. Available at http://www.qualityindicators.ahrq.gov/

[4] Quality Compass provides a database of national averages among organizations submitting data to NCQA. Benchmark data comes from accredited and non-accredited organizations and consists of publicly and privately reported performance metrics. Available at www.qualitycompass.org.

Table 2. EQR Compliance Score Scale	
Compliance Points Earned	**EQR Report Score**
90% + of possible points	« « « « «
75%–89% of possible points	« « «
< 75% of possible points	« «

Table 3. PM and PIP Validation Score Scale	
PIP/Validation Evaluation	**EQR Report Score**
Fully compliant	« « « « «
Substantially compliant	« « «
Not compliant	« «

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CAHPS

Member Perception of Healthcare Services

One of the goals described in the Delaware Medicaid QMS is to "Assure member satisfaction with services." The State understands the importance of perception of service experience of Medicaid enrollees. Enrollees who exhibit confidence in services delivered to them will engage those services more effectively and more often, increasing the likelihood of a healthier membership. CAHPS surveys (adult and pediatric) target enrollees' viewpoint and evaluation of their own experiences with health care delivery. The survey covers topics important to enrollees and focuses on aspects of quality they are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The following results and subsequent ratings are based on the CAHPS composite scores developed by combining individual survey questions into broader topics. A star rating was assigned to each composite measure according to the following scale.

Table 4. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	« « « « «
50th–89th percentile	« « «
Lower than 50th percentile	« «

CAHPS Performance Evaluation

CAHPS performance varied across domain and by population within each MCO. A side-by-side comparison of both MCOs shows differences in performance as well.

Table 5. 2016 MCO CAHPS Compliance Ratings — Adult

Measure Description	MCO A	MCO B
Rating of personal doctor	« «	« « «
Rating of specialist	« «	« «
Rating of all health care	« «	« « «
Rating of health plan	« « «	« « «
Getting needed care	« « «	« « «
Getting care quickly	« « «	« « «
How well doctors communicate	« « «	« « « « «

Table 6. 2016 MCO CAHPS Compliance Ratings — Child		
Measure Description	**MCO A**	**MCO B**
Rating of personal doctor	« « « « «	« « «
Rating of specialist	« « « « «	« « «
Rating of all health care	« « « « «	« « «
Rating of health plan	« « «	« « «
Getting needed care	« « « « «	« «
Getting care quickly	« « « « «	« « «
How well doctors communicate	« « « « «	« « « « «

Overall Member Experience with Care

Member ratings of the entire care delivery experience for children were strong at MCO A and moderate at MCO B. Both MCO A and B had moderate results when members rated their health plans — a key indicator of a member's experience with the MCO.

While MCO A performed poorly on the adult CAHPS survey, results from the pediatric survey demonstrated strong and consistent performance delivering care to children. MCO A performed at or above the benchmark for the 90th percentile for CAHPS metrics nationwide for pediatric composite measures with the exception of the health plan rating that scored in the 75th national percentile. While there were positive results within the child CAHPS survey, the adult survey results for MCO A highlight opportunities for significant improvement. Plan members who completed the CAHPS survey scored four adult metrics as moderate (rating of health plan, getting needed care, getting care quickly and how well doctors communicate). However, respondents gave the lowest score when rating personal doctors, specialists and when asked to rate all health care. (Tables 2 and 3)

Members rated MCO B's performance at or above the 90th percentile benchmark when asked how well doctors communicate for both the adult and child CAHPS. Areas in need of improvement include ratings for adult specialists (< 10th percentile) and for getting needed care for children (25th percentile). All other metrics reveal moderate performance between the 50th and 90th percentiles for MCO B.

Comparing MCO A to MCO B suggests significant opportunities for improvement at both MCOs. Primary concerns for MCO A revealed by this year's reporting include the rating of adult personal doctors, adult specialists and all health care delivered to adults. This focus should consider the MCO's strong performance in the pediatric arena — this is a strength for the MCO in terms of CAHPS results. Primary concerns for MCO B include the adult composite score for rating of specialist and the pediatric composite score for getting needed care.

3

HEDIS Results

This section provides an overview of two critical domains for evaluation: Access to Care and Quality of Care. Analysis using HEDIS for performance evaluation is industry standard for external reporting in the managed care industry. HEDIS is developed and maintained by NCQA. Data used for calculating HEDIS results include information from medical charts and provider claims (i.e., encounter data from electronic health records, claims data from billing systems, etc.) within Delaware's Medicaid managed care network. NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans, as well as national and regional benchmarks. A star rating was assigned as follows for each composite measure:

Table 7. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	« « « « «
50th–89th percentile	« « «
Lower than 50th percentile	« «

Evaluation of Effectiveness and Access to Health Care

The Delaware QMS prioritizes improvement of timely access to appropriate care and services for adults and children, with an emphasis on primary preventive care and remaining in a safe and least-restrictive environment. Providing timely access to preventive and primary care services promotes the goal of a comprehensive health care delivery system for Delaware Medicaid.

Timely Access to Primary and Preventive Services

Medicaid enrollees who utilize primary and preventive services have been found to be better equipped to manage acute and chronic medical conditions, versus those who do not have access to these services. Patients with adequate access to primary care are more likely to have preventive care, as well as consistent care for chronic conditions. Both have been shown to reduce unnecessary emergency department visits and inpatient hospital admissions. MCO A was at or above the 50th percentile on five of the seven Timely Access to Primary and Preventive Services measures. The MCO was below the 50th percentile in older adult access to preventive services. Ratings of MCO B indicate room for performance improvement in providing access to its care and services for both adults and children across all measures.

Table 8. Timely Access to Primary and Preventive Services		
HEDIS Performance Measure Description	**MCO A**	**MCO B**
Children's access to primary care physician (PCP) (Ages 12 months–24 months)	« « «	« «
Children's access to PCP (Ages 25 months–6 years)	« « «	« «
Children's access to PCP (Ages 7 years–11 years)	« « «	« «
Adolescent's access to PCP (Ages 12 years–19 years)	*	« «
Adult's access to preventive/ambulatory health services (Ages 20 years–44 years)	« « «	« «
Adult's access to preventive/ambulatory health services (Ages 45 years–64 years)	« « «	« «
Adult's access to preventive/ambulatory health services (Ages 65+ years)	« «	« «

*Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Access to Maternal and Pregnancy Services

Early and consistent access to quality prenatal care services can improve chances of delivering healthy babies. Providing access to comprehensive maternal and prenatal services impacts MCO service delivery significantly, and constitutes effective means of preventing lifelong disability via healthy deliveries. Both MCOs performed above the 90th percentile for timeliness of prenatal but below the 50th percentile for postpartum care during the 2015 reporting period.

Table 9. Access to Maternal and Pregnancy Services		
HEDIS Performance Measure Description	**MCO A**	**MCO B**
Prenatal and postpartum care — timeliness of prenatal care	« « «	« « «
Prenatal and postpartum care — postpartum care	« «	« «

Overall Access Performance

HEDIS results provide a litmus test for evaluating patient access to care. The comparisons of reportable-HEDIS data between MCOs and against the national benchmarks, above, indicate both MCOs need to focus quality improvement strategies for accessing preventive and maternity care.

Evaluation of Quality of Care

The Delaware Medicaid QMS includes goals of improving quality of care and services provided to DSHP, DSHP Plus and CHIP members. Quality-related performance measures describe attributes of health services provided to members. These PMs provide an overview of the effectiveness of a health care delivery system by looking at service utilization, patients' health outcomes and comprehensiveness of disease management services for common causes of morbidity and mortality.

Evaluation of Neonatal Services

Effective preventive care begins early in life. Healthier children will be more likely to remain healthier as adults. High-quality health care in early stages of life promotes a healthier membership pool. As shown in the following table, both MCOs perform above the 50th percentile for quality of early life services for the following performance measures.

Table 10. Quality of Early Life Services

HEDIS Performance Measure Description	MCO A	MCO B
Childhood immunization status (Combination 2)	« « «	« « «
Sufficient (6+) well-child visits in first 16 months of life	*	« « «
Well-child visits in years 3–6	« « «	« « «

*Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Evaluation of Early Detection Services

Routine screenings and early detection services allow providers to identify and address health concerns at an early stage, often preventing costly and invasive interventions associated with later detection. As shown below, MCO B is below the 50th percentile for both breast cancer screening and cervical cancer screening, and MCO A is below the 50th percentile for cervical cancer screening.

Table 11. Early Detection Service Quality

HEDIS Performance Measure Description	MCO A	MCO B
Breast cancer screenings	*	« «
Cervical cancer screenings	« «	« «

*Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Quality of Diabetes Management Services

Diabetes mellitus has a strong association with morbidity and mortality in the United States. Often associated with inadequate diabetes management, comorbidities such as hypercholesterolemia (high cholesterol), hypertension (high blood pressure), and other chronic conditions merit attention. Comprehensive care for this disease includes a variety of monitoring services. HEDIS scores indicate need for improvement in diabetes care.

Table 12. Quality of Diabetes Management

HEDIS Performance Measure Description	MCO A	MCO B
Comprehensive diabetes care — HbA1c testing	« «	« «
Comprehensive diabetes care — dilated retinal eye exam	« «	« « «

Weight and Nutrition Management Quality

Also associated with morbidity and mortality in the United States is obesity and its related health conditions. Expenditures attributed to these conditions are also on the rise. When initiated early in life, proper nutrition, physical activity and weight assessment and control effectively prevent obesity and the associated disease burden. Nutrition counseling is an important means of educating individuals in order to help them lead healthier, more productive lives. Both MCOs are above the 50th percentile for counseling for nutrition and physical activity among children. MCO B is below the 50th percentile for adult Body Mass Index (BMI) assessment; due to a small denominator this measure was not reportable for MCO A.

Table 13. Clinical Quality of Weight and Nutrition Management

HEDIS Performance Measure Description	MCO A	MCO B
Adult BMI Assessment	*	« «
Counseling for nutrition	« « «	« « «
Counseling for physical activity	« « «	« « «

*Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Overall Quality Performance

Strengths and Opportunities

Both MCOs have operated at or above the 50th percentile for each of the child/adolescent quality of care measures reported. These services to the young and vulnerable population are key to improving the health outcomes of the Delaware Medicaid population.

Both MCOs scored low to moderate for overall performance on measures pertaining to quality of care. Both MCO's have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. This topic has been an ongoing theme targeted by DMMA's Quality Improvement Initiative task force and MCO quality committees. Improved performance in these areas could dramatically improve the quality of life, morbidity, and mortality of Delaware Medicaid enrollees.

4

EQR: Compliance

Compliance Scoring

As required by CMS under federal regulation, Mercer, acting as the EQRO, completed a comprehensive compliance review using the CMS protocol "Assessment of Compliance with Medicaid Managed Care Regulations." The review has been grouped into the follow compliance areas below:

- Enrollee rights & protections
- Quality assessment & performance improvement
- Grievances and appeals
- Certifications and program integrity

The EQRO compliance evaluation assigns the MCO a score for each metric that makes up these four review areas. The assessment of "Met", "Partially Met" and "Not Met" is given a score, and an equal weighting was assigned to each of the four standards. Regulation mandates MCOs develop a required corrective action plan for all metrics resulting in a "Partially Met" or "Not Met" rating. All corrective action plans are reviewed and approved for implementation by DMMA prior to integration. A star rating was assigned to each MCO based on their overall compliance score according to the rating scale below:

Table 14. 2016 EQR Compliance Scoring Scale

Compliance Points Earned	EQR Report Score
90% + of possible points	« « « « «
75%–89% of possible points	« « «
< 75% of possible points	« «

Compliance Evaluation

MCO A scored above 90% on all four content areas of the compliance review. MCO B scored above 90% in the areas of grievances and appeals and certifications and program integrity. The two areas in need of the most improvement for MCO B are enrollee rights and protections and quality assessment and performance improvement. (Table 15)

Table 15. 2016 MCO Overall Compliance Ratings						
	MCO A			MCO B		
Content Area	**Possible Points**	**Points Scored**	**Percent**	**Possible Points**	**Points Scored**	**Percent**
Enrollee Rights and Protections	25	23.36	93.4%	25	22.37	89.5%
Quality Assessment and Performance Improvement	25	23.26	93.1%	25	20.83	83.3%
Grievances and Appeals	25	24.24	97.0%	25	22.73	90.9%
Certifications and Program Integrity	25	22.77	91.1%	25	24.55	98.2%
Total	***100***	***93.63***	***93.6%***	***100***	***90.48***	***90.5%***
Total Compliance Rating	« « « « «			« « « « «		

Overall Compliance Performance

Strengths and Opportunities

Both of Delaware's Medicaid MCOs performed well overall in 2016, scoring in the highest compliance-rating tier. While MCO A attained greater than 90% of possible points in all four areas, MCO B earned greater than 90% of the points possible in two areas: Grievances and Appeals and Certifications and Program Integrity. MCO B also obtained a third rating, for Enrollee Rights and Protections, less than one percent below this threshold. These results indicate that both MCOs are compliant with the majority of federal regulations and state contract expectations.

Findings of the compliance review indicate room for improvement at MCO B for Quality Assessment and Performance Improvement metrics. Identifying which parts of a healthcare system need priority attention requires a robust Quality Assessment and Performance Improvement framework — a precursor to quality improvement integration in complex healthcare delivery systems.

Both MCOs achieved more than 90% of possible points for Grievances and Appeals. While this result is acceptable, it represents a composite score. Neither MCO performed well for training of contractors and other general requirements — both received non-compliant ratings for those subcategories of grievances and appeals. Many of these federally-defined regulations facilitate removal of bias within the grievance and appeal process. Meeting these criteria ensures appropriate outcomes for members and MCOs when opinions diverge. Both MCOs have been required to develop a corrective action plan and to target and improve performance in these areas.

5

Performance Measurement

Validation of Performance Measures

Performance measurement uses robust tools and methodologies to collect information about large complex health care delivery systems. The objective of the performance measure validation in the compliance process is to validate accuracy of Medicaid, CHIP and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The review process includes application of the CMS protocol entitled "Validating Performance Measures," which is aimed at assessing compliance with specifications for each performance measure.

The measures reviewed for 2016 were mandated by the State and used technical specifications developed as part of the Quality Care Management Monitoring Report and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual compliance review and Information Systems Capabilities Assessment Request for Information (RFI) responses with supporting documentation. During onsite meetings, Mercer facilitated discussions about data management processes, report generation, data validation and data submission. After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review. The following table summarizes the scale used to evaluate performance measure compliance.

Table 16. Performance Measure Validation Scoring Scale

PIP/Validation Evaluation	EQR Report Score
Fully compliant	« « « « «
Substantially compliant	« « «
Not compliant	« «

The following table shows a breakdown of PMs that were validated for 2016:

Table 17. Performance Measures Validated

Measure	Reporting Frequency	Reporting Format
Antidepressant medication management	Annual	CMS Core Measure
Childhood and adolescent immunization rate(s)	Annual	CMS Core Measure
Live births weighing less than 2,500 grams	Annual	CMS Core Measure
Health risk assessments	Monthly	Quality and Care Management Measurement Reporting Templates (QCMMR)
Number of home- and community-based services (HCBS) critical incidents	Monthly	QCMMR

Table 17. Performance Measures Validated		
Measure	**Reporting Frequency**	**Reporting Format**
Percent of DSHP Plus members receiving behavioral health (BH) services	Monthly	QCMMR

Validation of Performance Measure Findings

The validation process reveals that MCO A's reported performance measurement was fully compliant for all but one performance measure: the number of HCBS critical incidents. The PM validation review also indicates MCO B as fully compliant in all but two scores: live births weighing less than 2,500 grams and health risk assessment services. The following table shows a side-by-side comparison of the results for both MCOs:

Table 18. Performance Measure Validation Ratings		
Measure Description	**MCO A**	**MCO B**
Antidepressant medication management	« « « « «	« « « « «
Childhood and adolescent immunization rate(s)	« « « « «	« « « « «
Live births weighing less than 2,500 grams	« « « « «	« «
Health risk assessments	« « « « «	« « «
Number of HCBS critical incidents	« « «	« « « « «
Percent of DSHP Plus members receiving BH services	« « « « «	« « « « «

Assessment for MCO A

MCO A has a business partner that is responsible for generating PMs on behalf of MCO A. The partner uses a NCQA certified HEDIS software for calculating all HEDIS performance measures and this source code is considered fully compliant. The sampling process, tools and inter-rater reliability testing for generating hybrid measure results appear appropriate. At the time of the review, the final calendar year 2015 HEDIS results were not available. Source code for generating the QCMMR report of health risk assessments completed and percentage of DSHP Plus members receiving BH services was provided and appears valid. Although a process flow for managing HCBS critical incidents was provided, no source code was provided for generating the report to complete the QCMMR, as it is not an automated process. Consideration should be given for automating this report to ensure consistency and accuracy in reporting.

DMMA experienced some challenges gathering complete, accurate and timely QCMMR results from MCO A in the early part of 2015, which was to be expected after the go-live of January 1, 2015. As the QCMMR is one of the primary means of ongoing oversight and monitoring for DMMA and it is a tool used for reporting to CMS, this is a critical component of MCO performance. In 2016, as the QCMMR undergoes revision and enhancement, guaranteeing the appropriate subject matter experts and programming staff participate in discussion will be critical to ensuring MCO A's success in accurately generating and submitting the information,

Opportunities for improvement in validation of performance measures at MCO A include measurement validation of the number of HCBS critical incidents. Although a written description of the data-analytic process was provided, and considered sufficient and complete, MCO A did not provide access to source code used for data processing and analysis. MCO A should submit this source code as requested as part of the annual EQR RFI. For measures generated by a manual process, the MCO should provide additional descriptive detail of how the measure is calculated and results validated. The MCO must collaboratively develop appropriate and complete measurement plans and statistical-programming specifications/scripts that completely consider and describe data sources, programming logic and code for statistical analysis platforms used to compile results from raw data.

Assessment for MCO B

MCO B also utilizes NCQA-certified HEDIS quality metrics for reporting. The MCO uses a fully compliant data-analytic process to analyze these data. The EQRO compliance review has deemed sampling, review tools and inter-rater reliability testing for generating hybrid measure results by MCO B as appropriate.

DMMA experienced significant challenges gathering complete, accurate and timely QCMMR results from MCO B throughout 2015's reporting cycle. One concern highlights a lack of engagement by the data analysis and information technology liaisons early in the process of measure development. Early engagement most often leads to clearer mutual understanding of the purpose behind each metric. Without data-analytic scripting code — used by the MCO for generating reporting results from raw data, this part of the process could not be properly evaluated nor validated. Other reports in 2016's reporting cycle and the onsite discussions have indicated that the subject matter expert reviews and attests to the accuracy of the data with limited collaborative review from other team members involved in the technical process of managing and analyzing the data. Leadership at MCO B mandates thorough evaluation of data and reporting of variance from expected or normative results. The QCMMR comprises primary means of ongoing oversight and monitoring by DMMA for its Medicaid MCOs. Since it functions as a tool used for evaluation and reporting to CMS, the QCMMR serves as a foundational component of MCO performance evaluation by the State. The MCO has been required to develop a corrective action plan to address these deficiencies.

6

Performance Improvement Projects

Validation of Performance Improvement Projects

The CMS regulations require each state MCO to establish PIPs as part of their quality assurance program. These PIPs, which are validated using the CMS Protocol, are intended to evaluate and improve upon the processes and outcomes associated with specified health care targets. In 2016, the EQRO validated three PIPs by each MCO: one a DMMA-mandated study question, one a DMMA-mandated study topic and one a topic selected by the MCO. Table 19 below includes the study topics validated and confidence in the reported results:

Table 19. PIP Validation Score

	MCO A Confidence in Reported Results	MCO B Confidence in Reported Results
Oral health for DSHP Plus long term services and supports membership	High	Moderate
Achieving primary care visits and medication adherence for MCO A PROMISE members with a diagnosis of hypertension	High	
Reducing pediatric 10-day readmissions at children's hospital through implementation of a single point of contact strategy	High	
Improve screening for depression by MCO B network primary care practitioners		Low
Improving the rate of adolescent well visits in the MCO B member population		Moderate

Assessment for MCO A

The 2016 EQR evaluation found a high degree of confidence in the baseline development of the PIPs at MCO A. The MCO has taken the direction of DMMA, and the technical assistance provided throughout the first year of operation, and worked to move its processes and procedures from foundational to well-developed with an emphasis on continuous quality improvement. This includes development of PIP topics and baseline measurement.

Assessment for MCO B

DMMA invested significantly throughout 2015 in technical assistance for MCO B to promote a solid foundation for PIP integration. However, PIP-related data and report submissions did not demonstrate implementation of aspects covered by the technical assistance provided. The quality team at MCO B should lead a review of the technical assistance and resources provided to ensure improved results and performance in the future. Topics for the team to consider include revisiting

the rationale PIPs is aligned with broader goals and improved explanatory arguments supporting rationale for inclusion/exclusion of subgroups of the member population. The team should also look to ensure clear communication about what is being measured, how measurement occurs and to which stakeholders the measurement applies. The quality team at MCO B should collaborate to ensure appropriate indicators have been selected for PIPs. The baseline-year results are critical for rapid-cycle analysis to be performed during the initial year of interventions and for benchmarking barrier analysis results for improvement.

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