District of Columbia
Department of Health Care Finance

District of Columbia Managed Care Programs

2022 Annual Technical Report

Qlarant

DHCF Department of Health Care Finance

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MURIEL BOWSER, MAYOR

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Executive Summary

Introduction

The District of Columbia (DC or the District) Department of Health Care Finance (DHCF) aims to improve the health and well-being of DC residents by providing access to comprehensive, cost-effective, and quality health care services through multiple managed care programs. These programs, which serve more than 265,000 enrollees, include DC Healthy Families Program (DCHFP), Child and Adolescent Supplemental Security Income Program (CASSIP), and District Dual Choice Program (DDCP). Table ES-1 highlights these programs and the contracted managed care plans (MCPs) providing associated services.

Table.ES-1. DC Managed Care Programs

Managed Care Program	Contracted Managed Care Plan
DC Healthy Families Program (DCHFP), established in 1994—provides acute, primary, specialty, and select behavioral health services to qualifying children, families, and pregnant women	• AmeriHealth Caritas District of Columbia (ACDC) • CareFirst Community Health Plan District of Columbia (CFDC) • MedStar Family Choice (MFC)
Child and Adolescent Supplemental Security Income Program (CASSIP), organized in 1996—provides acute, primary, specialty, and behavioral health services to qualifying children and youth with special health care needs who receive supplemental security income	• Health Services for Children with Special Needs (HSCSN)
District Dual Choice Program (DDCP), newly established in 2022—coordinates Medicare and Medicaid services, including long term services and supports and behavioral health services, through a dual eligible special needs plan (D-SNP)	• UnitedHealthcare Community Plan (UHC)

DHCF contracts with Qlarant, an external quality review organization (EQRO), to conduct annual, independent reviews of the District's MCPs, as required in the Code of Federal Regulations (42 CFR §438.350). As the DC EQRO, Qlarant evaluates MCP compliance with federal and DHCF-specific requirements by conducting multiple external quality review (EQR) activities including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also referenced as Operational Systems Review (OSR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)

This report summarizes results from all EQR activities conducted throughout 2022 for the District's MCPs, and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. The evaluation assessed MCP compliance and performance for measurement years (MYs) 2021 and 2022, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[1]

Key Findings

Summaries highlighting key findings and performance, for participating MCPs, are below. MCP-specific strengths, weaknesses, and recommendations are identified within the MCP Quality, Access, Timeliness Assessment section of the report.

Performance Improvement Project Validation. The MCPs conducted two PIPs each and reported performance measure results for MY 2021.[2] For the Comprehensive Diabetes Care PIP, MCP PIP validation scores ranged from 90-100 percent. MCPs reported their fourth remeasurement results. Compared to baseline performance, the MCP average improved in the HbA1c Testing measure. The MCPs continued to address COVID-19 public health emergency barriers and implemented interventions accordingly. CFDC was the only MCP that achieved statistically significant improvement, and did so in several PIP measures. For the Maternal Health PIP, MCPs reported their second remeasurement results and received scores ranging from 90-97 percent. The MCP average for the Timeliness of Prenatal Care measure sustained improvement. CFDC was the only MCP that achieved statistically significant improvement in a PIP measure—Timeliness of Prenatal Care. HSCSN developed a new Childhood Obesity Management and Prevention PIP, and reported baseline performance. UHC initiated a proposal Fall Risk Management PIP.

Performance Measure Validation. Qlarant conducted two PMV audits during 2022. The first audit focused on validating the accuracy of reported PIP and CMS Adult and Child Core Set measures and the second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures. Information Systems Capabilities Assessments (ISCAs) determined MCPs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. The MCPs received overall PMV ratings of 100 percent for the PIP and Core measures and 100 percent for the EPSDT measures. All measures were assessed as "reportable."

Operational Systems Review. Qlarant conducted a comprehensive OSR in 2022. The MCPs provided evidence of having operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. MCP scores ranged from 97-100 percent. All MCPs were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, most of which related to the Grievance and Appeal System Standard.

Network Adequacy Validation. The MCPs have robust provider networks and demonstrated compliance with geographic and provider-to-enrollee requirements. During 2022, MCP performance ranged from 38-93 percent for timely access to routine and urgent care for both adults and children. Performance improved over the last year for adult access to urgent appointments and pediatric access to routine and urgent appointments. Performance declined in the adult access to routine appointments measure.

[1] CMS EQR Protocols

[2] UHC was required to submit only one PIP due to its contract start date of February 1, 2022.

Provider directory accuracy continued to decline and remains a priority requiring improvement, with MCP average performance at 29 percent. The 2022 assessments determined MCP compliance ranged from 1-53 percent. Poor performance is largely attributed to discrepancies in the Acceptance of New Patients measure; this was particularly evident in MFC's evaluation. The MCPs should continue efforts to improve the reliability of provider directory content and ensure enrollees have access to accurate provider information.

Encounter Data Validation. A medical record review resulted in an overall encounter data accuracy rate of 92 percent; the DHCF-established target was 90 percent. Individual MCP performance ranged from 84-96 percent, with HSCSN and MFC performing below the target. Insufficient diagnosis-related documentation in the medical record most frequently contributed to noncompliance. In these cases, the MCPs should educate their providers on including sufficient documentation in the medical records to support codes for billed claims.

Conclusion

Qlarant evaluated MCP compliance in providing Medicaid managed care enrollees with quality and timely access to care and concluded, on average, MCPs are meeting requirements and demonstrating their commitment to quality improvement. In most instances, stakeholders can have high confidence in their compliance with federal regulations and DHCF contract requirements. While MY 2021 performance continued to be influenced by the COVID-19 public health emergency and recovery efforts, there were signs of improvement in select PIP performance measure results, as well as timely access to routine provider appointments. Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) performance measure results, on average, did not meet the national average benchmarks.[3,4] Opportunity exists to improve results in select measures, which support goals and objectives identified in DHCF's *Medicaid Managed Care Quality Strategy.* Qlarant recommends, after four years of remeasurement, closing the Comprehensive Diabetes Care PIP and initiating a new PIP targeting a priority area, such as improving enrollee access to behavioral health services, to achieve the DHCF goal of improved access to quality, whole-person care.

All MCPs maintained or improved compliance with structural and operational standards in the OSR. This improvement may be attributed to DHCF's enhanced quality improvement approach described in its new *Managed Care Program Quality Management Manual*. DHCF is closely monitoring MCP performance and compliance, and as needed, holding MCPs accountable through corrective actions.

DHCF should continue to strive to improve District resident health outcomes by encouraging MCPs to meet and exceed quality strategy goals, and holding MCPs accountable for performance. DHCF is encouraged to amend its quality strategy and add specific DDCP-related objectives and strategies. This will further enhance DHCF's efforts to ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care for all Medicaid managed care enrollees.

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

District of Columbia Managed Care Programs

2022 Annual Technical Report

Introduction

Background

The District of Columbia (DC or District) Department of Health Care Finance (DHCF) administers DC's Medicaid managed care programs and aims to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for qualifying beneficiaries. DC's Medicaid population is diverse and includes individuals with complex medical, behavioral, and social needs. DC has developed multiple programs, over time, to effectively manage care and address the varied needs of the population.

DC Healthy Families Program (DCHFP). DCHFP, established in 1994, provides acute, primary, specialty, and select behavioral health services to qualifying children, families, and pregnant women through three risk-based managed care organizations (MCOs). Current MCOs include AmeriHealth Caritas District of Columbia (ACDC), CareFirst Community Health Plan District of Columbia (CFDC), and MedStar Family Choice (MFC). The DCHFP serves approximately 247,250 enrollees.

Child and Adolescent Supplemental Security Income Program (CASSIP). CASSIP, organized as a Medicaid demonstration program in 1996, provides acute, primary, specialty, and behavioral health services to qualifying children and youth with special health care needs who receive supplemental security income. Enrollment into the single, prepaid benefit plan, Health Services for Children with Special Needs (HSCSN), is voluntary. The CASSIP serves approximately 5,062 enrollees.

District Dual Choice Program (DDCP).[1] DDCP, newly established in 2022, integrates care for dually eligible beneficiaries through a single program, which aims to improve Medicare and Medicaid benefit coordination. The DDCP includes a dual eligible special needs plan (D-SNP), in which enrollment is voluntary. The D-SNP provides Medicare and Medicaid services, including long term services and supports and behavioral health services. UnitedHealthcare Community Plan of District of Columbia (UHC) is the single D-SNP providing these services and serves approximately 12,983 enrollees.

Collectively these entities, serving managed care enrollees, are referred to as managed care plans (MCPs) to maintain uniformity.

DHCF continues to transform its managed care program into a more organized, accountable, and person-centered system to best support the District's managed care enrollees in managing and improving their health. DHCF understands the significance of quality and its impact on health outcomes and requires the MCPs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation.[2] NCQA evaluates health care quality, provided by health plans, to their members. The accreditation encompasses an audit of NCQA standards, Healthcare Effectiveness Data and Information

[1] This report does not include an evaluation of the DDCP due to its 2022 contract start date.
[2] HSCSN is additionally required to obtain and maintain NCQA accreditation in case management.

Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).[3,4] Table 1 provides MCP NCQA accreditation status and other descriptive information.[5]

Table 1. MCP NCQA Accreditation Status

MCP	NCQA Health Plan Accreditation	NCQA Health Plan Rating	Other NCQA Accreditations, Certifications, and Distinctions	Next NCQA Review Date
ACDC	Accredited	3.5 out of 5 Stars	Electronic Clinical Data, Health Equity Accreditation, Multicultural Health Care	8/27/24
CFDC	Accredited	NA	Electronic Clinical Data	12/10/24
HSCSN	Interim	2.5 out of 5 Stars	Electronic Clinical Data	4/23/24
MFC	Interim	NA	None	Pending
UHC	Accredited	3.5 out of 5 Stars	Electronic Clinical Data	2/15/23

NA – Health Plan Rating not available due to partial data reported.

Applicable NCQA programs and distinctions achieved by one or more MCPs are described below.

Electronic Clinical Data Distinction. This distinction recognizes organizations that have an accepted rate for a non-publicly reported measure that leverages electronic clinical data and was originally introduced for the HEDIS Electronic Clinical Data System Reporting Standard.

Health Equity Accreditation and Multicultural Health Care Distinction. This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires DHCF to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of the District's MCPs. To meet these requirements, DHCF contracts with Qlarant. As the EQRO, Qlarant evaluates each MCP's compliance with federal and DC-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. During 2022, Qlarant conducted the following EQR activities:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review, also referenced as Operational Systems Review (OSR)

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[5] NCQA Health Plan Report Card, status: February 15, 2023

- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn regarding the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report summarizes Qlarant's EQR findings, based on MCP audits conducted during 2022, which focused on the established programs, DCHFP and CASSIP, and the new DDCP D-SNP, where applicable. Evaluation of the D-SNP was limited due to its February 1, 2022 contract start date. This report describes objectives, methodologies, results, and conclusions for each EQR activity. Qlarant identifies MCP strengths and weaknesses relating to quality, access, and timeliness of care provided to the managed care enrollees. This report also includes recommendations for improvement which, if acted upon, may positively impact enrollee outcomes and experiences.

Performance Improvement Projects

Objective

MCPs conduct PIPs as part of their quality assessment and performance improvement program, in accordance with 42 CFR §438.330(d). PIPs use a systematic approach to quality improvement and can be effective tools to assist MCPs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCP used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation activities assess the MCP level of improvement and provide DHCF and other stakeholders a level of confidence in results.

Methodology

DHCF required the DCHFP and CASSIP MCPs to conduct and report on two District-selected PIPs during 2022. The new DDCP was required to develop and report on one District-selected PIP during its first year of operation.

Description of Data Obtained. The MCPs documented measurement year (MY) 2021 PIP-related activities, improvement strategies, and results in their 2022 reports. Using Qlarant-developed reporting templates and worksheets, they submitted a separate report for each PIP topic to Qlarant in July 2022. The reports included validated performance measure results, a data and barrier analysis, and identified PIP follow-up activities. Qlarant provided technical assistance to the MCPs, as requested.

Technical Methods of Data Collection and Analysis. Qlarant assessed a narrative report and calculations worksheet for each PIP report.[6] Validation activities were completed in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.[7] PIP validation includes the following nine steps:

[6] The DDCP D-SNP's PIP was a proposal PIP and focused on developing a structurally sound PIP, including the project rationale, aim statement, PIP measures and population, and data collection procedures.
[7] CMS EQR Protocols

1. **Review the selected PIP topic.** Qlarant determines if the PIP topic targets an opportunity for improvement and is relevant to the MCP's population.
2. **Review the PIP aim statement.** Qlarant evaluates the adequacy of the PIP aim statement, which should frame the project and define the improvement strategy, population, and time period.
3. **Review the identified PIP population.** Qlarant determines whether the MCP identifies the PIP population in relation to the aim statement.
4. **Review the sampling method.** If the MCP studied a sample of the population, rather than the entire population, Qlarant assesses the appropriateness of the MCP's sampling technique.
5. **Review the selected PIP variables and performance measures.** Qlarant assesses whether the selected PIP variables are appropriate for measuring and tracking improvement. Performance measures should be objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on enrollee outcomes.
6. **Review the data collection procedures.** Qlarant evaluates the validity and reliability of MCP procedures used to collect the data informing PIP measurements.
7. **Review data analysis and interpretation of PIP results.** Qlarant assesses the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used and if the MCP analysis and interpretation were accurate.
8. **Assess the improvement strategies (interventions).** Qlarant assesses the appropriateness of interventions for achieving improvement. The effectiveness of an improvement strategy is determined by measuring changes in performance, according to the PIP's predefined measures. Data should be evaluated on a regular basis, and subsequently, interventions should be adapted based on what is learned.
9. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluates improvement by validating statistical significance testing results and assessing improvement compared to baseline performance.

Qlarant PIP reviewers evaluated each element of PIP development and reporting by answering a series of applicable questions for each step, consistent with CMS protocol worksheets and requirements. Steps 7 through 9, critical to PIP success, had the most impact on the validation score. Reviewers sought additional information and/or corrections from MCPs, when needed, during the evaluation. Qlarant determined a validation rating, or level of confidence, for each PIP, based on the total validation score.[8] Validation ratings include:

- ❖ 90% - 100%: high confidence in MCP results
- ❖ 75% - 89%: moderate confidence in MCP results
- ❖ 60% - 74%: low confidence in MCP results
- ❖ ≤59%: no confidence in MCP results

Results

Table 2 identifies each PIP required, by participating program and MCP, for 2022 (MY 2021).

[8] Validation rating refers to the overall confidence that a PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (*CMS EQR Protocol 1 – Validation of Performance Improvement Projects*).

Table 2. Required PIPs

2022 PIPs (MY 2021)	DCHFP	CASSIP	DDCP
PIP Topic 1	Comprehensive Diabetes Care	Childhood Obesity Management and Prevention	Fall Risk Management
PIP Topic 2	Maternal Health	Maternal Health	NA

NA - A second PIP was not required for the DDCP D-SNP, due to its February 1, 2022 contract start date.

PIP validation results for 2022 MCP-reported PIPs, including MY 2021 activities and performance measure results, are included in this report. Tables 3, 9, 16, and 20 highlight fundamental elements of the DHCF-selected PIPs. Key MCP improvement strategies and results for each PIP for the year under review follow each of these tables.

Comprehensive Diabetes Care PIP

Table 3 identifies key elements of the Comprehensive Diabetes Care PIP. Participating MCPs include ACDC, CFDC, and MFC. HSCSN's participation in this PIP ended in 2021, after reporting MY 2020 results.

Table 3. Comprehensive Diabetes Care PIP Key Elements

2022 PIP (MY 2021)	Comprehensive Diabetes Care
Program	DCHFP
MCPs	ACDC, CFDC, MFC
Performance Measures	Comprehensive Diabetes Care– 1. Blood Pressure Control (<140/90 mm Hg) 2. Eye Exam (Retinal) Performed 3. Hemoglobin A1c (HbA1c) Control (<8%) 4. HbA1c Poor Control (>9%) 5. HbA1c Testing
Measure Steward	NCQA
Population	Enrollees 18-75 years of age with type 1 and type 2 diabetes
Aim	Will implementation of targeted educational and outreach interventions improve performance in process and outcome measures for enrollees with diabetes during the measurement year?
Phase	Remeasurement 4

ACDC Interventions

ACDC completed numerous targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Prepared meal delivery program.** Provided nutritionally complete and diabetes-appropriate meals to enrollees who would benefit from proper nutrition. Addressed food instability as a social determinant of health and helped enrollees manage their chronic condition to reduce the chance of hospital readmissions.
- **Telemedicine program.** Completed home visits and video teleconferencing sessions to connect providers and enrollees. The program also provided point-of-care testing, medication management, and pharmacy follow-up.

- **Refill reminder and outreach program.** Generated a report every two weeks to identify all enrollees whose diabetes medication refill expired within the past 7 days and those about to expire within the next 14 days. The Rapid Response Outreach Team then completed outreach calls to enrollees to remind them of their refill and ask if they needed transportation to the pharmacy or would like to have their prescription refill delivered.
- **Non-emergent medical transportation.** Provided enrollees with convenient, immediate transportation for their non-emergent medical needs through the Lyft service.
- **Remote blood glucose monitoring.** Provided enrollees with a technology-based solution that recorded and shared results with their provider between visits and provided direct feedback to the enrollee via a text message or email.

ACDC PIP Measure Results

Table 4 displays ACDC's Comprehensive Diabetes Care PIP measure results and level of improvement.

Table 4. ACDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2021	Improvement	Statistically Significant Improvement
Blood Pressure Control (<140/90 mm Hg)	54.20%	51.09%~	No	Ø
Eye Exam (Retinal) Performed	57.30%	46.96%~	No	Ø
Hemoglobin A1c (HbA1c) Control (<8%)	50.18%	51.58%~	Yes	No
HbA1c Poor Control (>9%) ***(lower rate is better)***	42.34%	39.90%~	Yes	No
HbA1c Testing	83.58%	87.59%~	Yes	No

~ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

CFDC Interventions

CFDC completed multiple targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Case management and resource management.** Referred enrollees to the MCP's case management and resource management programs. Enrollees received full case management services, including care coordination and education; and resources to improve self-management.
- **Home-based/telehealth visits.** Referred enrollees to home-based or telehealth programs. The home-based nurse practitioner program provided services, such as HbA1c testing, specimen collection, and retinal exams, to help close gaps in care for the diabetes measures.
- **Healthy meal delivery service**. Utilized home delivery services to provide nutritious meals to chronically ill enrollees with diabetes.

- **Nutrition classes**. Dietitians and culinary experts designed nutrition classes to improve participant knowledge in food/nutrition/health; modify eating behaviors and cooking skills; and improve health-related metrics such as BMI, HbA1c, blood pressure, and cholesterol levels.
- **Glucometer technology**. Utilized Bluetooth technology and a prescribed meter to provide remote access for providers, case managers, and pharmacists to monitor an enrollee's health. This tracking allowed providers to review results and intervene when there was cause for concern.

CFDC PIP Measure Results

Table 5 displays CFDC's Comprehensive Diabetes Care PIP measure results and level of improvement.

Table 5. CFDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2021	Improvement	Statistically Significant Improvement
Blood Pressure Control (<140/90 mm Hg)	27.55%	51.34%~	Yes	Yes
Eye Exam (Retinal) Performed	35.58%	43.07%~	Yes	Yes
HbA1c Control (<8%)	40.15%	43.80%~	Yes	No
HbA1c Poor Control (>9%) ***(lower rate is better)***	52.55%	45.50~	Yes	Yes
HbA1c Testing	79.38%	82.00%~	Yes	No

~ Performance was likely influenced by the COVID-19 public health emergency.

MFC Interventions

MFC's Comprehensive Diabetes Care PIP was a baseline submission and did not require interventions.

MFC PIP Measure Results

Table 6 displays MFC's Comprehensive Diabetes Care PIP measure results, which includes baseline performance.

Table 6. MFC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2021	Last Measurement Year	Improvement	Statistically Significant Improvement
Blood Pressure Control (<140/90 mm Hg)	23.11%~	Not Applicable	Not Applicable	Not Applicable
Eye Exam (Retinal) Performed	29.68%~	Not Applicable	Not Applicable	Not Applicable
HbA1c Control (<8%)	38.20%~	Not Applicable	Not Applicable	Not Applicable
HbA1c Poor Control (>9%) ***(lower rate is better)***	55.47%~	Not Applicable	Not Applicable	Not Applicable
HbA1c Testing	79.81%~	Not Applicable	Not Applicable	Not Applicable

~ Performance was likely influenced by the COVID-19 public health emergency.

DCHFP MCP Annual Rates for the Comprehensive Diabetes Care PIP Measures

Figures 1-5 display DCHFP MCP annual performance rates for the Comprehensive Diabetes Care PIP measures for MYs 2017-2021. Figures also include MCP weighted averages. The CASSIP (HSCSN) participated in this PIP through MY 2020; their results are displayed for MYs 2017-2020.

Figure 1. Blood Pressure Control (<140/90 mm Hg)

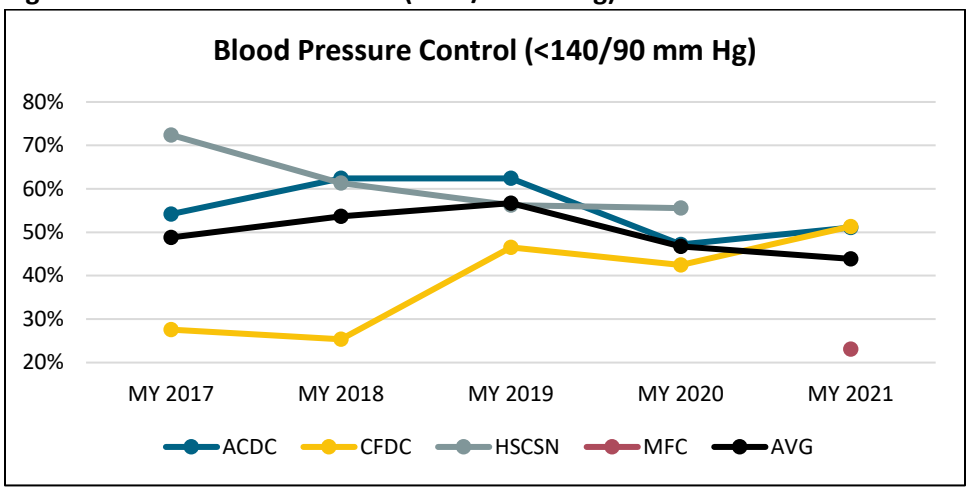


Figure 2. Eye Exam (Retinal) Performed

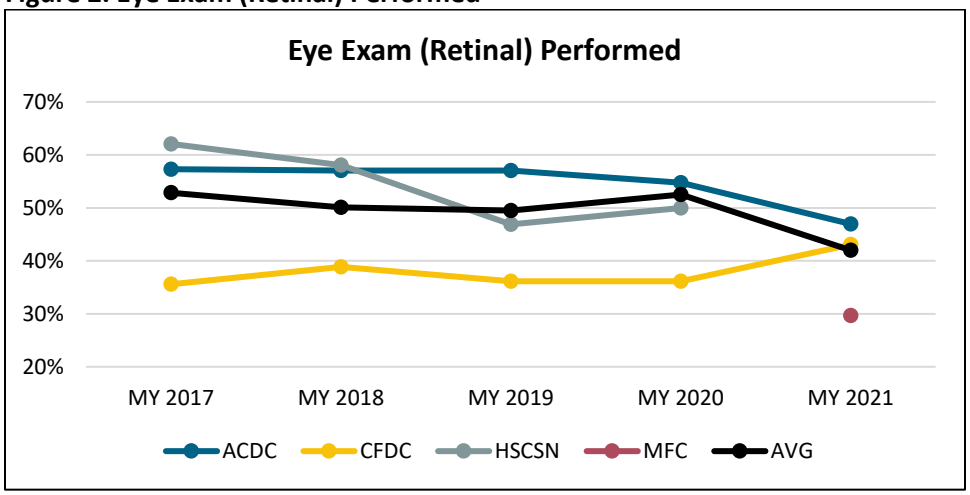


Figure 3. HbA1c Control (<8%)

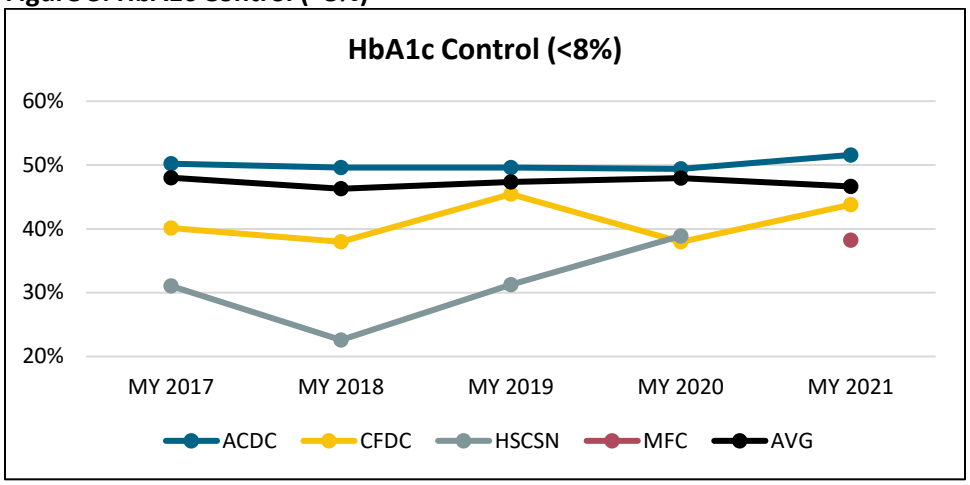


Figure 4. HbA1c Poor Control (>9%) (*Lower Rate is Better*)

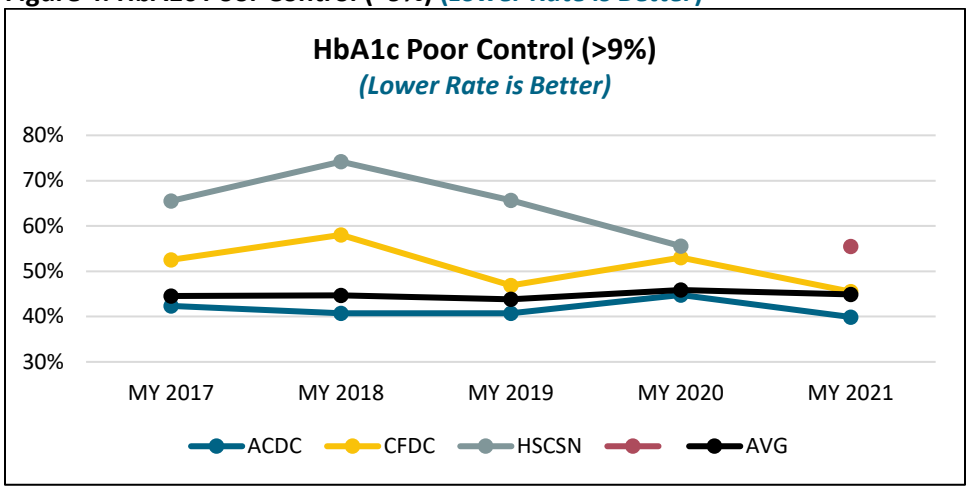
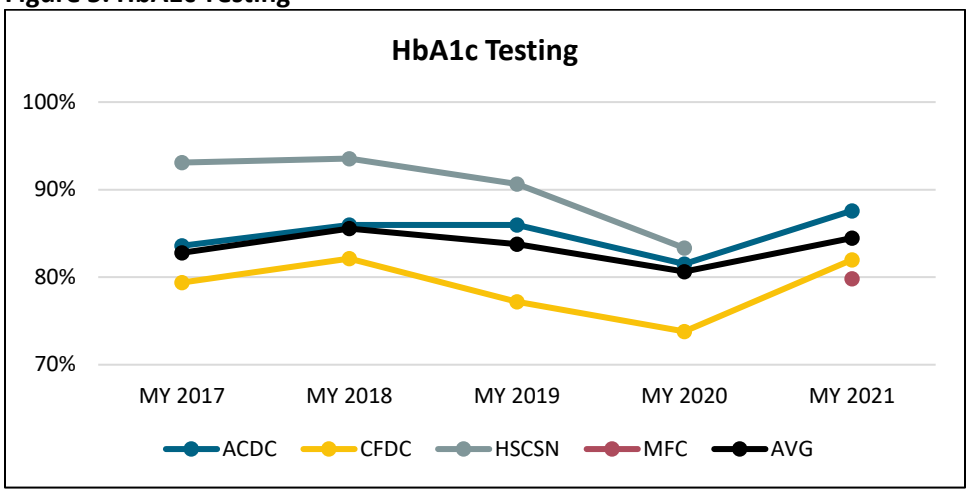


Figure 5. HbA1c Testing



DCHFP MCP PIP Validation Results

Table 7 includes DCHFP MCP results for each PIP validation step for the Comprehensive Diabetes Care PIP.

Table 7. DCHFP MCP PIP Validation Step Results - Comprehensive Diabetes Care PIP

PIP Validation Steps	ACDC	CFDC	MFC
1. Topic	Met	Met	Met
2. Aim Statement	Met	Met	Met
3. Population	Met	Met	Met
4. Sampling Method	Met	Met	Met
5. Variables and Performance Measures	Met	Met	Met
6. Data Collection Procedures	Met	Met	Partially Met
7. Data Analysis and Interpretation of Results	Met	Met	Met
8. Improvement Strategies	Met	Met	NA
9. Significant and Sustained Improvement	Partially Met	Met	NA

NA – Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 8 includes 2022 overall validation scores for each MCP's Comprehensive Diabetes Care PIP. Performance ranges from 90 percent (ACDC) to 100 percent (CFDC). MFC's PIP submission included baseline performance and was scored only on applicable elements.

Table 8. DCHFP MCP Validation Scores for the Comprehensive Diabetes Care PIP

2022 (MY 2021)	ACDC	CFDC	MFC	MCP Average
Validation Score	90%	100%	98%	96%
Confidence Level	High ❖	High ❖	High ❖	High ❖

Maternal Health PIP

Table 9 identifies key elements of the Maternal Health PIP. Participating MCPs include ACDC, CFDC, HSCSN, and MFC.

Table 9. Maternal Health PIP Key Elements

2022 PIP (MY 2021)	Maternal Health
Programs	DCHFP, CASSIP
MCPs	ACDC, CFDC, HSCSN, MFC
Performance Measures	Prenatal and Postpartum Care– 1. Timeliness of Prenatal Care 2. Postpartum Care
Measure Steward	NCQA
Population	Enrollees with live birth deliveries
Aim	Will implementation of system-level and targeted educational interventions increase the percentages of deliveries in which women had a timely prenatal visit and a timely postpartum visit during the measurement year?
Phase	Remeasurement 2

ACDC Interventions

ACDC completed numerous targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Interactive application.** Provided an innovative, interactive application to assist expectant mothers throughout their pregnancy into the postpartum period.
- **Maternity management program.** Promoted early identification of pregnancy and prenatal care. Provided follow-up on enrollees who did not keep their medical appointments.
- **Enrollee Incentives.** Offered incentives for attending a prenatal appointment in the first trimester and for completing a postpartum visit.
- **Perinatal Quality Enhancement Program.** Provided financial incentives to provider groups for completed prenatal and postpartum care services.
- **Provider incentive.** Offered an incentive to providers to send in the Obstetrics (OB) Authorization form within seven calendar days of the initial visit.
- **Well-baby and postpartum visit coordination.** Encouraged OB and pediatric group practices to schedule enrollee's postpartum appointment on the same day as the baby's one-month well-child visit to reduce scheduling burden on the enrollee.

ACDC PIP Measure Results

Table 10 displays ACDC's Maternal Health PIP measure results and level of improvement.

Table 10. ACDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2021	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.67%	86.59%~	Yes	No
Postpartum Care	79.08%	74.09%~	No	Ø

~ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

CFDC Interventions

CFDC completed multiple targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Telehealth program.** Partnered with a community program that provided health-related services and information through telecommunication technologies. The program included home visits for enrollees with high-risk pregnancies.
- **OB case management.** Offered an OB Case Management Program at its Health and Wellness Outreach Center. The intervention transitioned to virtual case management in response to the pandemic.

- **Access to experts.** Partnered with a vendor that provided enrollees with on-demand access to an expert network of nurses, nutritionists, and lactation consultants.
- **Pregnancy support program.** Partnered with a national organization, which provided perinatal and postpartum support services. The support model engages enrollees with their providers and provides an opportunity to share experiences with their peers.
- **Early pregnancy identification.** Partnered with a vendor that facilitated early identification of pregnancies and stratified pregnant women from high to low risk to ensure immediate outreach and intervention.
- **Postpartum outreach.** Targeted outreach by case management staff supported early engagement with enrollees regarding scheduling their postpartum visit.

CFDC PIP Measure Results

Table 11 displays CFDC's Maternal Health PIP measure results and level of improvement.

Table 11. CFDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2021	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	65.81%	76.40%~	Yes	Yes
Postpartum Care	69.49%	71.29%~	Yes	No

~ Performance was likely influenced by the COVID-19 public health emergency.

HSCSN Interventions

HSCSN completed several targeted enrollee, provider, and MCP interventions. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. Interventions include:

- **Individualized enrollee education.** Provided targeted 1:1 education to pregnant enrollees. The enrollee receives education, resources, and referrals to community partners and organizations.
- **Enrollee incentives.** Initiated enrollee incentives to encourage enrollee engagement. Enrollees were financially incentivized to complete virtual meetings with their care manager and to agree to a clinical goal.
- **Care management program.** Co-managed pregnant enrollees (OB Care Manager and Primary Care Manager) and supported person-centered assessments, identified barriers, and enhanced care plan development with goals to address identified barriers.
- **Early identification of pregnancies.** Utilized lab and Chesapeake Regional Information System for Patients (CRISP) data, and initial health assessments, to identify pregnancies early.

HSCSN PIP Measure Results

Table 12 displays HSCSN's Maternal Health PIP measure results and level of improvement.

Table 12. HSCSN Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2021	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.86%	82.98%~	Yes	No
Postpartum Care	60.34%	57.45%~	No	Ø

~ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

MFC Interventions

MFC's Maternal Health PIP was a baseline submission and did not require interventions.

MFC PIP Measure Results

Table 13 displays MFC's Maternal Health PIP measure results, including baseline performance.

Table 13. MFC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2021	Last Measurement Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.00%~	Not Applicable	Not Applicable	Not Applicable
Postpartum Care	69.83%~	Not Applicable	Not Applicable	Not Applicable

~ Performance was likely influenced by the COVID-19 public health emergency.

DCHFP and CASSIP MCP Annual Rates for the Maternal Health PIP Measures

Figures 6-7 display DCHFP and CASSIP MCP annual performance rates for the Maternal Health PIP measures for MYs 2019-2021. The figures also include MCP weighted averages.

Figure 6. Timeliness of Prenatal Care

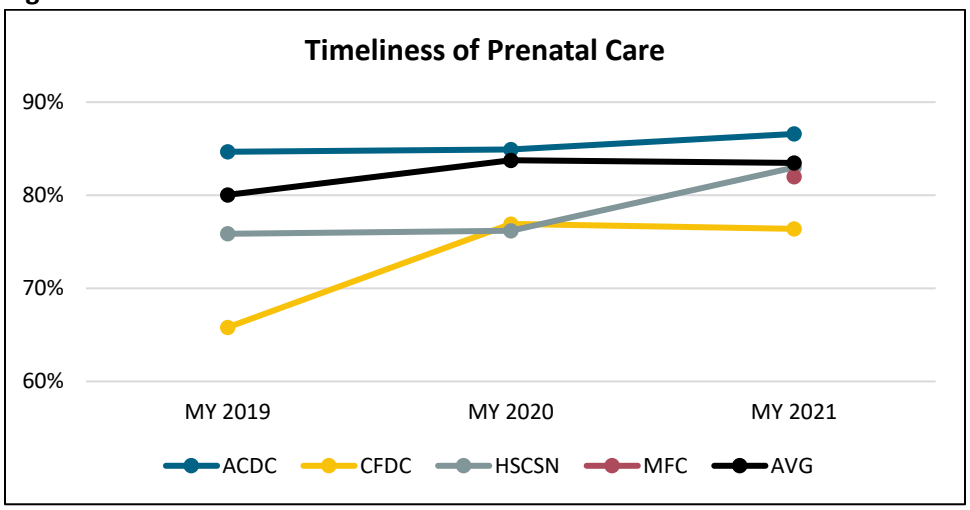
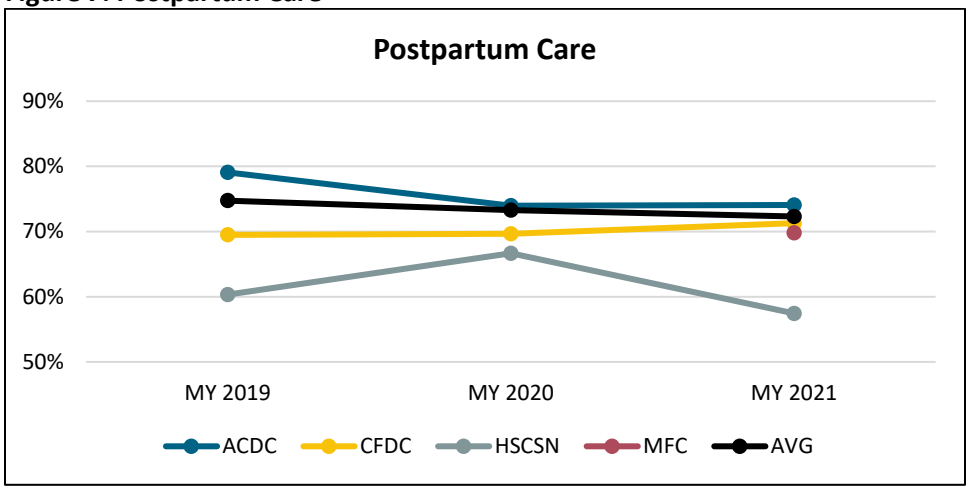


Figure 7. Postpartum Care



DCHFP and CASSIP MCP PIP Validation Results

Table 14 includes DCHFP and CASSIP MCP results for each PIP validation step for the Maternal Health PIP.

Table 14. DCHFP and CASSIP MCP PIP Validation Step Results - Maternal Health PIP

PIP Validation Steps	ACDC	CFDC	HSCSN	MFC
1. Topic	Met	Met	Partially Met	Met
2. Aim Statement	Met	Met	Met	Partially Met
3. Population	Met	Met	Met	Met
4. Sampling Method	Met	Met	Met	Met
5. Variables and Performance Measures	Met	Partially Met	Met	Met
6. Data Collection Procedures	Met	Met	Met	Partially Met
7. Data Analysis and Interpretation of Results	Met	Met	Met	Met
8. Improvement Strategies	Met	Met	Partially Met	NA
9. Significant and Sustained Improvement	Partially Met	Met	Partially Met	NA

NA - Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 15 includes 2022 overall validation scores for each MCP's Maternal Health PIP. Performance ranges from 90 percent (HSCSN) to 97 percent (CFDC). MFC's PIP submission included baseline performance and was scored only on applicable elements.

Table 15. DCHFP and CASSIP MCP Validation Scores for the Maternal Health PIP

2022 (MY 2021)	ACDC	CFDC	HSCSN	MFC	MCP Average
Validation Score	95%	97%	90%	96%	95%
Confidence Level	High ❖	High ❖	High ❖	High ❖	High ❖

Childhood Obesity Management and Prevention PIP

Table 16 identifies key elements of the Childhood Obesity Management and Prevention PIP. HSCSN is the only participating MCP.

Table 16. Childhood Obesity Management and Prevention PIP Key Elements

2022 PIP (MY 2021)	Childhood Obesity Management and Prevention
Program	CASSIP
MCP	HSCSN
Performance Measures	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— 1. Body Mass Index (BMI) Percentile Documentation (3-11 Years, 12-17 Years, Total) 2. Counseling for Nutrition (3-11 Years, 12-17 Years, Total) 3. Counseling for Physical Activity (3-11 Years, 12-17 Years, Total) Child and Adolescent Well-Care Visits— 4. Well-Care Visits (3-11 Years, 12-17 Years, 18-21 Years, Total)
Measure Steward	NCQA
Population	Measures 1-3: Enrollees 3-17 years of age who had an outpatient visit with a PCP or OB/GYN Measure 4: Enrollees 3-21 years of age
Aim	Will member, provider, and MCP interventions improve performance, over the measurement year, in the following PIP measures? • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (for enrollees ages 3-17 years of age) • Child and Adolescent Well-Care Visits (for enrollees ages 3-21 years of age)
Phase	Baseline

HSCSN Interventions

HSCSN's Childhood Obesity Management and Prevention PIP was a baseline submission and did not require interventions.

HSCSN PIP Measure Results

Table 17 displays HSCSN's Childhood Obesity Management and Prevention PIP measure results, including baseline performance.

Table 17. HSCSN Childhood Obesity Management and Prevention PIP Measure Results

Performance Measure	Baseline Year MY 2021	Last Measurement Year	Improvement	Statistically Significant Improvement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile – 3-11 Yrs	80.54%~	Not Applicable	Not Applicable	Not Applicable
BMI Percentile – 12-17 Yrs	78.42%~	Not Applicable	Not Applicable	Not Applicable
BMI Percentile – Total	79.56%~	Not Applicable	Not Applicable	Not Applicable
Counseling for Nutrition – 3-11 Yrs	77.38%~	Not Applicable	Not Applicable	Not Applicable

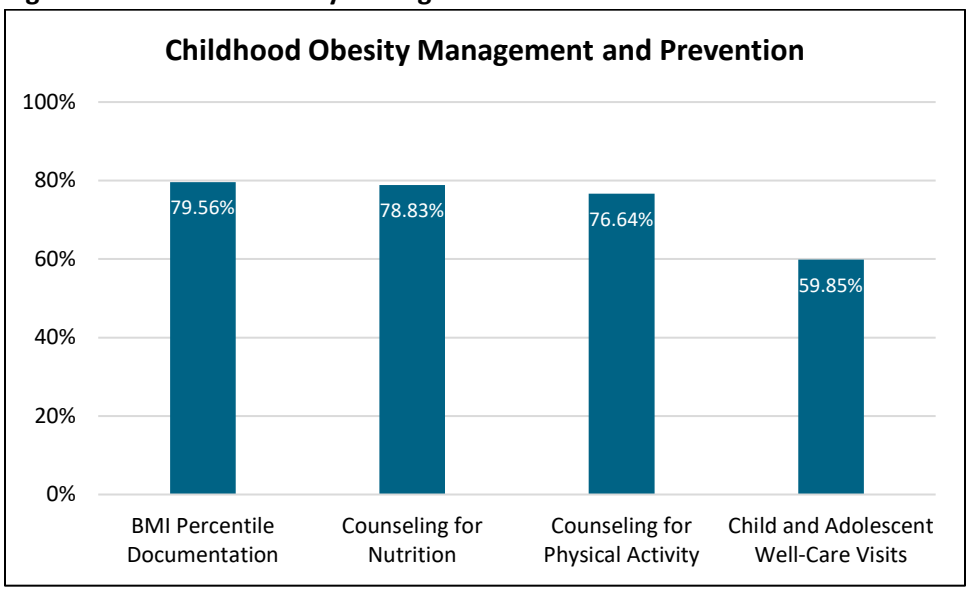
Performance Measure	Baseline Year MY 2021	Last Measurement Year	Improvement	Statistically Significant Improvement
Counseling for Nutrition – 12-17 Yrs	80.53%~	Not Applicable	Not Applicable	Not Applicable
Counseling for Nutrition – Total	78.83%~	Not Applicable	Not Applicable	Not Applicable
Counseling for Physical Activity – 3-11 Yrs	74.66%~	Not Applicable	Not Applicable	Not Applicable
Counseling for Physical Activity – 12-17 Yrs	78.95%~	Not Applicable	Not Applicable	Not Applicable
Counseling for Physical Activity – Total	76.64%~	Not Applicable	Not Applicable	Not Applicable
Child and Adolescent Well-Care Visits				
Well-Care Visits – 3-11 Yrs	65.18%~	Not Applicable	Not Applicable	Not Applicable
Well-Care Visits – 12-17 Yrs	61.37%~	Not Applicable	Not Applicable	Not Applicable
Well-Care Visits – 18-21 Yrs	47.27%~	Not Applicable	Not Applicable	Not Applicable
Well-Care Visits – Total	59.85%~	Not Applicable	Not Applicable	Not Applicable

~ Performance was likely influenced by the COVID-19 public health emergency.

HSCSN Annual Rates for the Childhood Obesity Management and Prevention PIP Measures

Figure 8 displays HSCSN annual performance rates for the Childhood Obesity Management and Prevention PIP measures for MY 2021.

Figure 8. Childhood Obesity Management and Prevention



HSCSN PIP Validation Results

Table 18 includes HSCSN results for each PIP validation step for the Childhood Obesity Management and Prevention PIP.

Table 18. HSCSN PIP Validation Step Results – Childhood Obesity Management and Prevention PIP

PIP Validation Steps	HSCSN
1. Topic	Met
2. Aim Statement	Met
3. Population	Met
4. Sampling Method	Met
5. Variables and Performance Measures	Met
6. Data Collection Procedures	Met
7. Data Analysis and Interpretation of Results	Met
8. Improvement Strategies	Not Applicable
9. Significant and Sustained Improvement	Not Applicable

NA – Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 19 includes the 2022 overall validation score for HSCSN's Childhood Obesity Management and Prevention PIP. HSCSN scored 100 percent. The MCP's PIP submission included baseline performance and was scored only on applicable elements.

Table 19. MCP Validation Scores for the Childhood Obesity Management and Prevention PIP

2022 (MY 2021)	HSCSN
Validation Score	100%
Confidence Level	High ❖

Fall Risk Management PIP

Table 20 identifies key elements of the Fall Risk Management PIP. UHC is the only participating MCP.

Table 20. Fall Risk Management PIP Key Elements

2022 PIP (MY 2021)	Fall Risk Management
Program	DDCP
MCP	UHC
Performance Measures	Fall Risk Management— 1. Discussing Fall Risk 2. Managing Fall Risk Screening, Risk Assessment, and Plan of Care to Prevent Future Falls— 3. Falls Screening 4. Falls Risk Assessment 5. Plan of Care
Measure Steward	NCQA (Fall Risk Management – Medicare Health Outcomes Survey) CMS (Screening, Risk Assessment, and Plan of Care to Prevent Future Falls)
Population	Fall Risk Management: The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: Medicaid Managed Long-Term Services and Supports (MLTSS) participants 18 years of age and older

2022 PIP (MY 2021)	Fall Risk Management
Aim	Will member education on fall prevention decrease the number of falls in enrollees 65 years of age and older during the measurement year? Will implementation of a comprehensive assessment and fall risk management plan decrease the number of falls for enrollees 18 years of age and older with a history of falls during the measurement year?
Phase	Proposal

UHC Interventions

UHC's Fall Risk Management PIP was a proposal submission and did not require interventions.

UHC PIP Measure Results

Table 21 displays UHC's Fall Risk Management PIP measures. Baseline results will be reported in the next annual report.

Table 21. UHC Fall Risk Management PIP Measure Results

Performance Measure	Baseline Year	Last Measurement Year	Improvement	Statistically Significant Improvement
Fall Risk Management				
Discussing Fall Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Managing Fall Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls				
Falls Screening	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Falls Risk Assessment	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Plan of Care	Not Applicable	Not Applicable	Not Applicable	Not Applicable

UHC PIP Validation Results

Table 22 includes UHC results for each PIP validation step for the Fall Risk Management PIP.

Table 22. UHC PIP Validation Step Results – Fall Risk Management PIP

PIP Validation Steps	UHC
1. Topic	Met
2. Aim Statement	Met
3. Population	Met
4. Sampling Method	Met
5. Variables and Performance Measures	Met
6. Data Collection Procedures	Met
7. Data Analysis and Interpretation of Results	Not Applicable
8. Improvement Strategies	Not Applicable
9. Significant and Sustained Improvement	Not Applicable

NA – Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 23 includes the 2022 overall validation score for UHC's Fall Risk Management PIP. UHC scored 100 percent. The MCP's PIP submission was a proposal, did not include baseline performance, and was scored only on applicable elements.

Table 23. UHC Validation Score for the Fall Risk Management PIP

2022	UHC
Validation Score	100%
Confidence Level	High 

Conclusion

Summary conclusions for the DCHFP, CASSIP, and DDCP PIPs are below. Specific MCP strengths, weaknesses, and recommendations are included in the MCP Quality, Access, Timeliness Assessment section, in Tables 40-44, later in the report.

Comprehensive Diabetes Care PIP

- ACDC and CFDC reported their fourth remeasurement rates for the Comprehensive Diabetes Care measures. MFC submitted baseline rates. HSCSN's participation in the PIP ended in MY 2020.
- The COVID-19 public health emergency continued to present barriers to care during MY 2021.
- The MCPs continued to engage enrollees in care via telehealth and virtual services.
- The MY 2021 MCP weighted averages improved over MY 2020 in two measures: HbA1c Testing and HbA1c Poor Control (>9%).
- All MCPs received high confidence ratings for their Comprehensive Diabetes Care PIP.

Maternal Health PIP

- ACDC, CFDC, and HSCSN reported their second remeasurement rates for the Maternal Health measures. MFC submitted baseline rates.
- In general, interventions focused on the early identification of pregnant enrollees and attempts to engage them in appropriate prenatal and postpartum care.
- Performance was mixed. The MY 2021 MCP weighted average for the Timeliness to Prenatal Care measure compared favorably to baseline performance. A negative trend was noted for the Postpartum Care measure.
- All MCPs received high confidence ratings for their Maternal Health PIP.

Childhood Obesity Management and Prevention PIP

- HSCSN reported its baseline performance for the Childhood Obesity Management and Prevention PIP.
- Measures focus on weight assessment and counseling for nutrition and physical activity, and well-care visits for children and adolescents.
- The MCP identified specific barriers, which should aid in the development of targeted interventions.

- HSCSN received a high confidence rating for the Childhood Obesity Management and Prevention PIP.

Fall Risk Management PIP

- UHC's Fall Risk Management PIP was a proposal submission; baseline performance was not required.
- Measures focus on fall risk management, including screens, assessments, and prevention.
- The MCP documented a comprehensive description of the PIP population, performance measures, and data collection plan.
- UHC received a high confidence rating for the Fall Risk Management PIP.

Performance Measure Validation

Objective

DHCF uses performance measures to monitor the performance of individual MCPs at a point in time, track performance over time, and compare performance among MCPs. DHCF requires MCPs to calculate and report measures as part of their quality assessment and performance improvement program, in accordance with 42 CFR §438.330(c). The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCP and determines the extent to which the MCP followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates are essential to ascertain whether the MCP's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows DHCF to have confidence in MCP measure results.

Methodology

Qlarant validated District-selected performance measures, including MY 2021 PIP and select CMS Adult and Child Core Set measures; and fiscal year (FY) 2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures.[9]

Description of Data Obtained. Information from several sources was used to satisfy validation requirements. These sources included, but were not limited to, the following documents and information provided by the MCP:

- Information Systems Capabilities Assessment
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- EPSDT policies and training materials, as applicable
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies, and procedures)
- Demonstrations during the site visit
- Interviews with MCP staff
- Information submitted as part of the follow-up items requested after the onsite visit

[9] District of Columbia FY 2022: October 1, 2021 through September 30, 2022.

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.[10]

The validation process was interactive and concurrent to the MCP calculating the measures. Validation activities occurred before, during, and after an onsite visit to the MCP and included two principle components:

- An overall assessment of the MCP's information systems (IS) capability to capture and process data required for reporting.
- An evaluation of the MCP's processes (e.g. source code programs) used to prepare each measure.

Essential PMV activities included:

- Review of the MCP's data systems and processes used to construct the measures.
- Assessment of the calculated rates for algorithmic compliance to required specifications.
- Verification the reported rates were reliable and based on accurate sources of information.

Qlarant conducted onsite PMV review activities in May 2022 for the PIP and Core Set measures and in October 2022 for EPSDT measures. MCP onsite PMV review activities were conducted via virtual desk audit. After approving final rates, Qlarant reported findings for the following audit elements, including documentation (data integration and control and calculation process), denominator, numerator, sampling (as applicable), and reporting. Audit element descriptions are provided below.

Documentation. Assessment of data integration and control procedures determine whether the MCP had appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. The evaluation includes reviewing and assessing documentation of measurement procedures and programming specifications, including data sources, programming logic, and source codes.

Denominator. Validation of measure denominator calculations assesses the extent to which the MCP used appropriate and complete data to identify the entire population and the degree to which the MCP followed measure specifications for calculating the denominator.

Numerator. Validation of the numerator determines if the MCP correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCP followed measure specifications for calculation of the numerator.

Sampling. Evaluation of sample size and replacement methodology specifications confirm the sample was not biased, if applicable.

Reporting. Validation of measure reporting confirms if the MCP followed DHCF specifications.

Qlarant calculated a validation rating for the MCP, based on audit element findings. The rating provides a level of confidence in the MCP's reported measure results. Validation ratings include:

[10] CMS EQR Protocols

- ❖ 95% - 100%: high confidence in MCP results
- ❖ 80% - 94%: moderate confidence in MCP results
- ❖ 75% - 79%: low confidence in MCP results
- ❖ ≤74%: no confidence in MCP results

Results

PIP and Core Set Performance Measure Validation Results

All MCPs had appropriate systems in place to process accurate claims and encounters. Table 24 includes 2022 MCP PMV results, based on the calculation of MY 2021 PIP and Adult and Child Core Set measures, as applicable. Compliance with each PMV element is reported by MCP and MCP average. The UHC PMV audit was limited, due to its contract start date of February 1, 2022.

Table 24. PIP and Core Set Measure PMV Results

Element	ACDC	CFDC	HSCSN	MFC	UHC	MCP Average
Data Integration and Control	100%	100%	100%	100%	100%	100%
Data and Process Used to Produce Measures	100%	100%	100%	100%	100%	100%
Denominator	100%	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	100%	NA	100%
Sampling	100%	100%	100%	100%	NA	100%
Reporting	100%	100%	100%	100%	NA	100%
Overall Rating	100%	100%	100%	100%	100%	100%
Reporting Designation	R	R	R	R	NA	R¨
Level of Confidence	High ❖	High ❖	High ❖	High ❖	High ❖	High ❖

R – Reportable; measures were compliant with DHCF specifications.
¨ All applicable MCPs received a "reportable" designation.
NA – Not Applicable. The element is NA due to the MCP's limited ability to report; UHC's contract start date was February 1, 2022.

Table 25 displays MCP MY 2021 PIP performance measure rates and reports each performance measure's data collection methodology. UHC did not calculate and report rates due to its contract start date of February 1, 2022.

Table 25. PIP Performance Measure Results for MY 2021

Performance Measure	Data Collection Method+	ACDC %	CFDC %	HSCSN %	MFC %	UHC %
Comprehensive Diabetes Care (DCHFP - ACDC, CFDC, MFC)						
Comprehensive Diabetes Care						
Blood Pressure Control (<140/90 mm Hg)	H	51.09	51.34	NA	23.11	NA
Eye Exam (Retinal) Performed	H	46.96	43.07	NA	29.68	NA

Performance Measure	Data Collection Method+	ACDC %	CFDC %	HSCSN %	MFC %	UHC %
HbA1c Control (<8%)	H	51.58	43.80	NA	38.20	NA
HbA1c Poor Control (>9%) *(lower rate is better)*	H	39.90	45.50	NA	55.47	NA
HbA1c Testing	H	87.59	82.00	NA	79.81	NA
Maternal Health (DCFHP - ACDC, CFDC, MFC and CASSIP - HSCSN)						
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	H	86.59	76.40	82.98	82.00	NA
Postpartum Care	H	74.09	71.29	57.45	69.83	NA
Childhood Obesity Management and Prevention (CASSIP - HSCSN)						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile – 3-11 Yrs	H	NA	NA	80.54	NA	NA
BMI Percentile – 12-17 Yrs	H	NA	NA	78.42	NA	NA
BMI Percentile – Total	H	NA	NA	79.56	NA	NA
Counseling for Nutrition – 3-11 Yrs	H	NA	NA	77.38	NA	NA
Counseling for Nutrition – 12-17 Yrs	H	NA	NA	80.53	NA	NA
Counseling for Nutrition – Total	H	NA	NA	78.83	NA	NA
Counseling for Physical – Activity 3-11 Yrs	H	NA	NA	74.66	NA	NA
Counseling for Physical – Activity 12-17 Yrs	H	NA	NA	78.95	NA	NA
Counseling for Physical – Activity Total	H	NA	NA	76.64	NA	NA
Child and Adolescent Well-Care Visits						
Child and Adolescent Well-Care Visits – 3-11 Yrs	A	NA	NA	65.18	NA	NA
Child and Adolescent Well-Care Visits – 12-17 Yrs	A	NA	NA	61.37	NA	NA
Child and Adolescent Well-Care Visits – 18-21 Yrs	A	NA	NA	47.27	NA	NA
Child and Adolescent Well-Care Visits – Total	A	NA	NA	59.85	NA	NA
Fall Risk Management (DDCP D-SNP - UHC)						
Fall Risk Management						
Discussing Fall Risk	~	NA	NA	NA	NA	~
Managing Fall Risk	~	NA	NA	NA	NA	~
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls						
Falls Screening	~	NA	NA	NA	NA	~
Falls Risk Assessment	~	NA	NA	NA	NA	~
Plan of Care	~	NA	NA	NA	NA	~

+ Administrative data collection (A): rates are calculated using claims and other supplemental data. Hybrid data collection (H): rates are calculated using administrative and medical record data.
NA - Not Applicable. MCP was not required to report the measure for the PMV activity.
~ No Data/Not Reported. UHC's contract start date was February 1, 2022; the MCP was not required to report the measure for the PMV activity.

Table 26 details the MY 2021 MCP weighted average for each PIP performance measure and compares performance to national benchmarks. The table includes the aggregate numerator events and denominator or eligible population for each measure.

Table 26. PIP Performance Measure Aggregate Information and Weighted Averages Compared to Benchmarks for MY 2021

Performance Measure	Numerator Events (Sum)	Denominator or Eligible Population (Sum)	MCP Average %	Benchmark Comparison*
Comprehensive Diabetes Care (ACDC, CFDC, MFC)				
Blood Pressure Control (<140/90 mm Hg)	4,543	10,353	43.88	♦
Eye Exams	4,211	10,029	41.99	♦
HbA1c Control (<8%)	4,676	10,029	46.63	♦
HbA1c Poor Control (>9%) ***(lower rate is better)***	4,500	10,029	44.87	♦
HbA1c Testing	8,471	10,029	84.46	♦
Maternal Health (ACDC, CFDC, HSCSN, MFC)				
Timeliness of Prenatal Care	2,134	2,557	83.46	♦
Postpartum Care	1,849	2,557	72.32	♦
Childhood Obesity Management and Prevention (HSCSN)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile – 3-11 Yrs	221	178	80.54	♦ ♦
BMI Percentile – 12-17 Yrs	190	149	78.42	♦ ♦
BMI Percentile – Total	411	327	79.56	♦ ♦
Counseling for Nutrition – 3-11 Yrs	221	171	77.38	♦ ♦
Counseling for Nutrition –12-17 Yrs	190	153	80.53	♦ ♦ ♦
Counseling for Nutrition – Total	411	324	78.83	♦ ♦
Counseling for Physical – Activity 3-11 Yrs	221	165	74.66	♦ ♦
Counseling for Physical – Activity 12-17 Yrs	190	150	78.95	♦ ♦ ♦
Counseling for Physical – Activity Total	411	315	76.64	♦ ♦
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits – 3-11 Yrs	865	1,327	65.18	♦ ♦ ♦
Child and Adolescent Well-Care Visits – 12-17 Yrs	777	1,266	61.37	♦ ♦ ♦
Child and Adolescent Well-Care Visits – 18-21 Yrs	338	715	47.27	♦ ♦ ♦
Child and Adolescent Well-Care Visits – Total	1,980	3,308	59.85	♦ ♦ ♦
Fall Risk Management (UHC)				
Fall Risk Management				
Discussing Fall Risk	~	~	~	~
Managing Fall Risk	~	~	~	~

Performance Measure	Numerator Events (Sum)	Denominator or Eligible Population (Sum)	MCP Average %	Benchmark Comparison*
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls				
Falls Screening	~	~	~	~
Falls Risk Assessment	~	~	~	~
Plan of Care	~	~	~	~

* Benchmark source: Quality Compass 2022 (MY 2021 data) National Medicaid Average for health maintenance organizations (HMOs).

♦ The DC MCP Average is below the National Average.

♦ ♦ The DC MCP Average is equal to or exceeds the National Average, but does not meet the 75th Percentile.

♦ ♦ ♦ The DC MCP Average is equal to or exceeds the 75th Percentile.

~ No Data/Not Reported. UHC's contract start date was February 1, 2022; the MCP was not required to report the measure for the PMV activity.

Table 27 displays MCP MY 2021 CMS Adult and Child Core Set performance measure rates and reports each performance measure's data collection methodology. UHC did not calculate and report rates due to its contract start date of February 1, 2022.

Table 27. Core Set Performance Measure Results for MY 2021

Performance Measure	Data Collection Method+	ACDC %	CFDC %	HSCSN %	MFC %	UHC %
Contraceptive Care – All Women Ages 15-20, LARC	A	2.72	2.27	4.31	2.27	~
Contraceptive Care – All Women Ages 15-20, Most or Moderately Effective Contraception	A	20.52	15.58	25.12	18.77	~
Contraceptive Care – All Women Ages 21–44, LARC	A	3.54	2.37	4.40	2.14	~
Contraceptive Care – All Women Ages 21–44, Most or Moderately Effective Contraception	A	22.34	14.56	29.60	16.61	~
Contraceptive Care – Postpartum Women Ages 15-20, LARC - 3 days	A	6.06	2.00	8.33$^{<30}$	4.00	~
Contraceptive Care – Postpartum Women Ages 15-20, LARC - 60 days	A	14.14	16.00	8.33$^{<30}$	16.00	~
Contraceptive Care – Postpartum Women Ages 15-20, Most or Moderately Effective Contraception - 3 days	A	9.09	2.00	8.33$^{<30}$	12.00	~

Performance Measure	Data Collection Method+	ACDC %	CFDC %	HSCSN %	MFC %	UHC %
Contraceptive Care – Postpartum Women Ages 15-20, Most or Moderately Effective Contraception - 60 days	A	29.29	34.00	16.67<30	54.00	~
Contraceptive Care – Postpartum Women Ages 21-44, LARC - 3 days	A	2.74	2.95	8.00<30	3.04	~
Contraceptive Care – Postpartum Women Ages 21-44, LARC - 60 days	A	10.45	8.23	8.00<30	9.11	~
Contraceptive Care – Postpartum Women Ages 21-44, Most or Moderately Effective Contraception - 3 days	A	13.35	10.97	12.00<30	12.15	~
Contraceptive Care – Postpartum Women Ages 21-44, Most or Moderately Effective Contraception - 60 days	A	37.48	28.27	28.00<30	31.67	~
Developmental Screening in the First Three Years of Life Age 1, Children age 1 who had a screening before or on their 1st birthday	A	18.81	35.77	9.09	18.18	~
Developmental Screening in the First Three Years of Life age 2, Children age 2 who had a screening after their 1st and before or on their 2nd birthday	A	18.90	35.77	18.75	18.97	~
Developmental Screening in the First Three Years of Life Age 3, Children age 3 who had a screening after their 2nd and before or on their 3rd birthday	A	18.84	41.61	10.00	15.48	~
Developmental Screening in the First Three Years of Life Total, Total number of children ages 1-3 with a screening in the 12 months before or on their 1st, 2nd, or 3rd birthday	A	18.85	37.71	12.77	17.44	~
Screening for Depression and Follow-Up Plan, Ages 12-17	A	0.00	0.00	0.00	0.00	~

Performance Measure	Data Collection Method+	ACDC %	CFDC %	HSCSN %	MFC %	UHC %
Screening for Depression and Follow-Up Plan, Ages 18+	A	0.54	0.38	0.00	0.26	~
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD), Ages 18-75 ***(lower rate is better)***	A	55.67	51.00	50.00<30	66.19	~
Use of Opioids at High Dosage in Persons Without Cancer, Ages 18+ ***(lower rate is better)***	A	2.94	4.02	0.00<30	0.00	~
Concurrent Use of Opioids and Benzodiazepines, Ages 18+ ***(lower rate is better)***	A	10.16	4.97	0.00<30	5.34	~
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Total (Rate 1)	A	35.91	39.90	37.50<30	63.78	~
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Buprenorphine (Rate 2)	A	34.47	38.26	37.50<30	62.99	~
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Oral Naltrexone (Rate 3)	A	1.85	2.13	0.00<30	1.57	~
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Long-acting, injectable naltrexone (Rate 4)	A	1.03	0.66	0.00<30	0.00	~
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Methadone (Rate 5)	A	0.00	0.00	0.00<30	0.00	~

+ Administrative data collection (A): rates are calculated using claims and other supplemental data. Hybrid data collection (H): rates are calculated using administrative and medical record data.
<30 - Denominator is less than 30. Caution is advised when interpreting results.
~ No Data/Not Reported. MCP was not required to report the measure for the PMV activity.

Table 28 details the MY 2021 MCP weighted average for each CMS Adult and Child Core Set performance measure and compares performance to national benchmarks. The table includes the aggregate numerator events and denominator or eligible population for each measure.

Table 28. Core Set Performance Measure Aggregate Information and Weighted Averages Compared to Benchmarks

Performance Measure	Numerator Events (Sum)	Denominator or Eligible Population (Sum)	MCP Average	Benchmark Comparison*
Contraceptive Care – All Women Ages 15-20, LARC	245	9,494	2.58	♦
Contraceptive Care – All Women Ages 15-20, Most or Moderately Effective Contraception	1,822	9,494	19.19	♦
Contraceptive Care – All Women Ages 21–44, LARC	1,153	40,632	2.84	♦
Contraceptive Care – All Women Ages 21–44, Most or Moderately Effective Contraception	7,590	40,632	18.68	♦
Contraceptive Care – Postpartum Women Ages 15-20, LARC - 3 days	10	211	4.74	♦ ♦ ♦
Contraceptive Care – Postpartum Women Ages 15-20, LARC - 60 days	31	211	14.69	♦
Contraceptive Care – Postpartum Women Ages 15-20, Most or Moderately Effective Contraception - 3 days	17	211	8.06	♦ ♦
Contraceptive Care – Postpartum Women Ages 15-20, Most or Moderately Effective Contraception - 60 days	75	211	35.55	♦
Contraceptive Care – Postpartum Women Ages 21-44, LARC - 3 days	63	2,166	2.91	♦
Contraceptive Care – Postpartum Women Ages 21-44, LARC - 60 days	209	2,166	9.65	♦
Contraceptive Care – Postpartum Women Ages 21-44, Most or Moderately Effective Contraception - 3 days	272	2,166	12.56	♦ ♦
Contraceptive Care – Postpartum Women Ages 21-44, Most or Moderately Effective Contraception - 60 days	739	2,166	34.12	♦
Developmental Screening in the First Three Years of Life Age 1, Children age 1 who had a screening before or on their 1st birthday	436	2,005	21.76	NBA
Developmental Screening in the First Three Years of Life age 2, Children age 2 who had a screening after their 1st and before or on their 2nd birthday	621	2,672	23.23	NBA
Developmental Screening in the First Three Years of Life Age 3, Children age 3 who had a screening after their 2nd and before or on their 3rd birthday	601	2,589	23.23	NBA

Performance Measure	Numerator Events (Sum)	Denominator or Eligible Population (Sum)	MCP Average	Benchmark Comparison*
Developmental Screening in the First Three Years of Life Total, Total number of children ages 1-3 with a screening in the 12 months before or on their 1st, 2nd, or 3rd birthday	1,656	7,266	22.79	♦
Screening for Depression and Follow-Up Plan, Ages 12-17	0	17,559	0.00	NBA
Screening for Depression and Follow-Up Plan, Ages 18+	386	90,316	0.43	NBA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD), Ages 18-75 ***(lower rate is better)***	412	731	56.36	NBA
Use of Opioids at High Dosage in Persons Without Cancer, Ages 18+ ***(lower rate is better)***	38	1,538	2.47	♦ ♦ ♦
Concurrent Use of Opioids and Benzodiazepines, Ages 18+ ***(lower rate is better)***	161	1,964	8.20	♦ ♦ ♦
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Total (Rate 1)	676	1,716	39.39	NBA
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Buprenorphine (Rate 2)	651	1,716	37.94	NBA
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Oral Naltrexone (Rate 3)	33	1,716	1.92	NBA
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Long-acting, injectable naltrexone (Rate 4)	14	1,716	0.82	NBA
Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64, Methadone (Rate 5)	0	1,716	0.00	NBA

* Benchmark sources— Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set, Chart Pack, January 2022, and Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set, Chart Pack, November 2021

♦ The DC MCP Average is below the National Average.

♦ ♦ The DC MCP Average is equal to or exceeds the National Average, but does not meet the 75th Percentile.

♦ ♦ ♦ The DC MCP Average is equal to or exceeds the 75th Percentile.

NBA - No benchmark available.

EPSDT Performance Measures

Qlarant completed a comprehensive EPSDT PMV audit for the DCHFP and CASSIP MCPs. Qlarant does not conduct an EPSDT audit for UHC, as the MCP does not report EPSDT measures.

All audited MCPs had appropriate systems in place to process accurate claims and encounters. Table 29 includes 2022 MCP PMV results, based on the calculation of FY 2022 EPSDT measures. Compliance with each PMV element is reported by MCP.

Table 29. EPSDT PMV Results

Element	ACDC	CFDC	HSCSN	MFC	MCP Average
Data Integration and Control	100%	100%	100%	100%	100%
Data and Process Used to Produce Measures	100%	100%	100%	100%	100%
Denominator	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	100%	100%
Sampling	NA	NA	NA	NA	NA
Reporting	100%	100%	100%	100%	100%
Overall Rating	100%	100%	100%	100%	100%
Reporting Designation	R	R	R	R	R
Level of Confidence	High ❖	High ❖	High ❖	High ❖	High ❖

NA – Not Applicable; sampling was not completed as the entire population was studied
R – Reportable; measures were compliant with DHCF specifications
¨ All MCPs received a "reportable" designation

Table 30 reports FY 2022 EPSDT measure results for each MCP.

Table 30. EPSDT Performance Measure Results

Performance Measure	ACDC	CFDC	HSCSN	MFC
Total Individuals Eligible for EPSDT for 90 Continuous Days	46,299	22,026	4,204	22,731
Average Period of Eligibility	0.96	0.95	0.95	0.94
Expected Number of Screenings	56,922	26,841	4,436	26,568
Total Screens Received	39,673	17,884	3,551	15,649
Screening Ratio	0.70	0.67	0.8	0.59
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	45,262	21,387	4,033	21,753
Total Eligibles Receiving at Least One Initial or Periodic Screen	27,675	12,410	2,887	11,612
Participation Ratio	0.61	0.58	0.72	0.53
Total Eligibles Referred for Corrective Treatment	14,455	4,891	2,754	2,942
Total Eligibles Receiving Any Dental Service From a Dentist	24,417	10,015	2,342	9,649
Total Eligibles Receiving Preventive Dental Service From a Dentist	20,374	9,014	2,170	8,800
Total Eligibles Who Received Dental Treatment Services From a Dentist	9,620	3,541	840	3,527
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	2,016	1,113	148	1,041

Performance Measure	ACDC	CFDC	HSCSN	MFC
Total Eligibles Receiving Diagnostic Dental Services	23,294	9,801	2,320	9,421
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	2,460	1,476	115	1,142
Total Eligibles Receiving Any Preventative Dental or Oral Health Service	21,327	9,614	2,192	9,254
Total Number of Screening Blood Lead Tests	4,273	1,897	154	1,603

Table 31 displays key FY 2022 EPSDT measure results, including screen, participation, and preventive dental service ratios. The table also reports the MCP weighted average for each key measure.

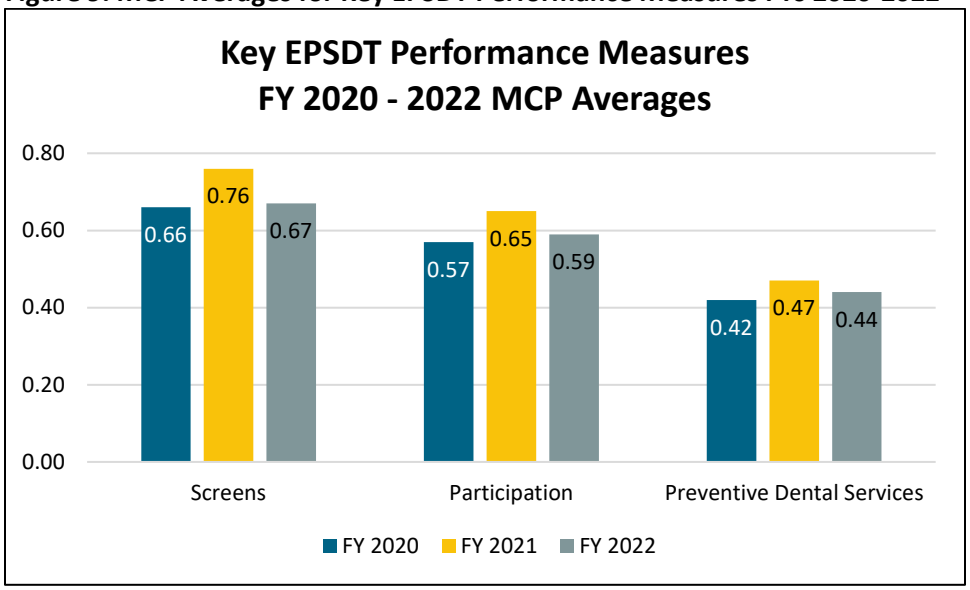
- **EPSDT Screening Ratio.** The calculation uses total screens received compared to the expected number of screens (for eligibles enrolled for 90 continuous days).
- **EPSDT Participation Ratio.** The calculation compares total eligibles who received at least one initial or periodic screen to total eligibles who should have received at least one initial or periodic screen.
- **Preventive Dental Services Ratio.** The calculation uses total eligibles receiving preventive dental services from a dentist compared to total eligibles who should receive at least one initial or periodic screen.

Table 31. FY 2022 Key EPSDT Performance Measure Results

Key EPSDT Performance Measures	ACDC	CFDC	HSCSN	MFC	MCP Average
EPSDT Screening Ratio	0.70	0.67	0.80	0.59	0.67
EPSDT Participation Ratio	0.61	0.58	0.72	0.53	0.59
EPSDT Preventive Dental Services Ratio	0.45	0.42	0.54	0.40	0.44

Figure 9 displays key EPSDT measure results over the last three years, FYs 2020-2022.

Figure 9. MCP Averages for Key EPSDT Performance Measures FYs 2020-2022



Conclusion

Aggregate summary conclusions for the PMV activities are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 40-44 within the MCP Quality, Access, Timeliness Assessment section.

PIP and Core Measure PMV

- All MCPs had information systems capable of capturing and processing data required for reporting.
- All MCPs received an overall rating of 100 percent.
- Stakeholders can have high confidence in the MCPs' performance measure calculations. UHC did not report rates due to its start date of February 1, 2022.
- The COVID-19 public health emergency continued to create barriers to care and likely influenced MY 2021 performance.
- DHCF established a goal of meeting or exceeding the national average benchmarks for PIP measures.
    - **Comprehensive Diabetes Care PIP.** None of the DCHFP weighted averages met the DHCF-established goals.
    - **Maternal Health PIP.** The DCHFP and CASSIP weighted averages for the Prenatal and Postpartum Care measures failed to meet the DHCF-established goals.
    - **Childhood Obesity Management and Prevention PIP.** The CASSIP MCP exceeded goals for all PIP measures and exceeded the 75th percentile benchmark in 6 of 13 measures.
    - **Fall Risk Management PIP.** The DDCP D-SNP did not report rates due to its contract start date of February 1, 2022.
- The DC MCP weighted averages exceeded national average benchmarks in 5 of 15 CMS Core Measures (33%). Of the 5 measures, 3 exceed the 75th percentile benchmark:

EPSDT PMV

- All MCPs had information systems capable of capturing and processing data required for reporting.
- All MCPs received an overall rating of 100%; stakeholders can have high confidence in the MCPs' performance measure calculations.
- Key MCP average EPSDT measure ratios for screens, participation, and preventive dental services declined in FY 2022, compared to FY 2021 ratios. While performance declined over the last year, the key ratios compared favorably to FY 2020 ratios.

Operational Systems Review

Objective

Operational systems reviews (OSRs), also referred to as compliance reviews, assess MCP compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of health care services provided to Medicaid enrollees. The comprehensive review determines compliance with federal and DHCF managed care program requirements. The review provides DHCF an independent assessment of MCP capabilities, which can be used to promote accountability and improve quality-related processes and monitoring.

Methodology

Qlarant conducted a comprehensive review of applicable CFR standards for the 2022 OSR. CFR standards (42 CFR §438) reviewed include:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: [Managed Care Organization] MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System

Description of Data Obtained. Obtained MCP documentation to support MY 2022 compliance for the CFR standards. The DCHFP and CASSIP MCPs provided supporting documentation for the standards under review in September 2022. Qlarant review activities occurred before, during, and after the site visit to the MCPs in October and November 2022. The DDCP D-SNP was evaluated on a separate schedule. UHC submitted documentation in April, and a virtual site review followed in May 2022.

Pre-site visit activities included evaluating policies, reports, meeting minutes, and other supporting documents obtained from each MCP. Qlarant conducted record reviews during the pre-site phase of the OSR, as well. Site visit activities focused on MCP staff interviews, process demonstrations, and follow up on record review findings. Post-site visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

Technical Methods of Data Collection and Analysis. The 2022 OSR was conducted in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care*

Regulations.[11] Qlarant conducted an interactive review with the MCP and reviewed and scored all applicable elements and components of each standard requiring evaluation. Qlarant uses the following review determinations when evaluating MCP compliance for each element and/or component:

- **Met.** Demonstrates full compliance. 1 point. Documentation and data sources provide evidence of compliance and MCP staff are able to describe processes consistent with documentation provided, if applicable.
- **Partially Met.** Demonstrates at least some, but not full, compliance. 0.5 point. Documentation is present, but the staff is unable to articulate processes or show evidence of implementation during interviews, or staff is able to describe and verify the existence of processes, but documentation is incomplete or inconsistent with practice.
- **Not Met.** Does not demonstrate compliance on any level. 0 points. Documentation and data sources are not present or do not provide evidence of compliance, and staff is unable to describe and/or verify the existence of processes required to demonstrate compliance.
- **Not Applicable.** Requirement does not apply and is not scored.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall OSR compliance score is calculated. Based on this overall score, a level of confidence in the MCP's OSR results is determined. Compliance ratings include:

- ❖ 95% - 100%: high confidence in MCP compliance
- ❖ 85% - 94%: moderate confidence in MCP compliance
- ❖ 75% - 84%: low confidence in MCP compliance
- ❖ ≤74%: no confidence in MCP compliance

Non-duplication Deeming. CMS permits the opportunity for states to use information from a private accreditation review, such as an NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming.

Non-duplication, as described in EQR protocols, is intended to reduce the administrative burden on the MCPs. When NCQA standards are comparable to federal regulations, and the MCP scored 100 percent on the applicable NCQA standards, there is an opportunity to "deem," or consider, the federal regulation as meeting requirements. This process eliminates the need to review the regulation as part of the OSR, thus reducing the administrative burden on the MCP.

DHCF permitted deeming for the 2022 OSR. To qualify for deeming, DHCF established the following criteria:

- The MCP must hold the NCQA Health Plan Accreditation.
- The MCP must demonstrate full compliance in the applicable federal regulation for the last two OSR cycles.
- The MCP must provide evidence of the most recent NCQA audit, which includes a fully compliant assessment in the applicable standards.

[11] CMS EQR Protocols

Using this information and the *NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2021 Health Plan Standards (Effective July 1, 2021 – June 30, 2022)*, Qlarant evaluated whether the MCP qualified for deeming of federal regulations in the following standards: Information Requirements, MCO, Quality Assessment and Performance Improvement Program, and the Grievance and Appeal System.

ACDC and CFDC were the only MCPs that qualified for select deeming in the 2022 OSR. HSCSN did not qualify for deeming as its NCQA accreditation was limited to Case Management. MFC did not qualify for deeming as its NCQA accreditations were limited to Interim and Case Management. UHC did not quality for deeming as its operations commenced on February 1, 2022.

Deemed elements and components were assessed as met and received 1 point each.

Results

Table 32 displays the 2022 MCP OSR results by standard and total. A level of confidence in each MCP's compliance is assigned based on the overall weighted score. The table also includes MCP averages.

Table 32. MY 2022 MCP OSR Results

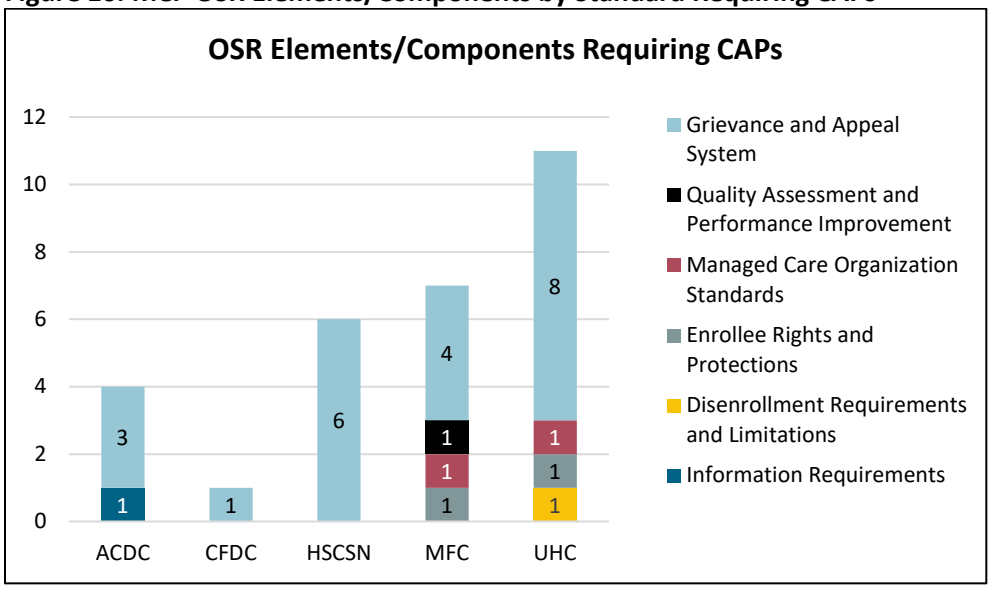
2022 OSR	ACDC	CFDC	HSCSN	MFC	UHC	MCP Average
§438.10 Information Requirements	98.33%[D]	100.00%[D]	100.00%	100.00%	100.00%	99.67%
§438.56 Disenrollment Requirements and Limitations	100.00%	100.00%	100.00%	100.00%	95.45%	99.15%
§438.100 - §438.114 Enrollee Rights and Protections	100.00%	100.00%	100.00%	97.22%	96.88%	98.88%
§438.206 - §438.242 MCO Standards (See Table 20 for additional detail)	100.00%[D]	100.00%[D]	100.00%	99.12%	99.04%	99.64%
§438.330 Quality Assessment and Performance Improvement Program	100.00%[D]	100.00%[D]	100.00%	92.86%	100.00%	98.61%
§438.402 - §438.424 Grievance and Appeal System	97.32%[D]	99.11%[D]	94.64%	96.43%	92.98%	96.09%
Special Needs Plan*	NA	NA	NA	NA	100.00%	NA
Overall Weighted Score	98.89%	99.72%	98.34%	98.06%	97.25%	98.45%
Confidence Level	High ❖	High ❖	High ❖	High ❖	High ❖	High ❖

D – Some elements/components in the standard qualified for deeming for the MCP.
* The Special Needs Plan standard applies to UHC only.

NA – Not Applicable. The standard was not reviewed or not applicable to the MCP.

MCPs are expected to demonstrate 100 percent compliance with all OSR standards. MCPs demonstrating less than 100 percent must develop a corrective action plan (CAP) to address each element or component found to not demonstrate full compliance. Figure 10 illustrates MCP CAPs required by standard.

Figure 10. MCP OSR Elements/Components by Standard Requiring CAPs



All MCPs are required to develop CAPs. The number of CAPs ranged from 1-11. All MCPs had at least one Grievance and Appeal System CAP.

Table 33 details MCP results of the MCO Standards (§438.206-§438.242) from the 2022 OSR. Performance, for each area of review, is reported as met, partially met, or not met.

- **Met.** All elements and components for the standard were fully met.
- **Partially Met.** Some, but not all, elements and components for the standard were met.
- **Not Met.** None of the elements and components for the standard were met.

Table 33. MY 2022 MCP OSR Results for MCO Standards - §438.206-§438.242

MCO Standards	ACDC	CFDC	HSCSN	MFC	UHC
§438.206 Availability of Services	Met	Met	Met	Met	Met
§438.207 Assurances of Adequate Capacity and Services	Met	Met	Met	Met	Met
§438.208 Coordination and Continuity of Care	Met	Met	Met	Met	Met
§438.210 Coverage and Authorization of Services	Met	Met	Met	Partially Met	Met
§438.214 Provider Selection	Met	Met	Met	Met	Met
§438.224 Confidentiality	Met	Met	Met	Met	Met
§438.228 Grievance and Appeal Systems	Met	Met	Met	Met	Met
§438.230 Subcontractual Relationships and Delegation	Met	Met	Met	Met	Met

MCO Standards	ACDC	CFDC	HSCSN	MFC	UHC
§438.236 Practice Guidelines	Met	Met	Met	Met	Partially Met
§438.242 Health Information Systems*	Met	Met	Met	Met	Met

*MCP Health Information Systems were evaluated as part of the PMV activity.

Table 34 details annual MCP results and MCP averages, by standard, for MYs 2020-2022.

Table 34. MYs 2020-2022 MCP OSR Results by Standard

OSR Standards	Year	ACDC	CFDC	HSCSN	MFC	UHC	MCP Average
Information Requirements	2020	97%	100%	98%	89%	NA	96.15%
	2021	100%	100%	100%	98%	NA	99.58%
	2022	98%	100%	100%	100%	100%	99.67%
Disenrollment Requirements and Limitations	2020	BS	BS	BS	BS	NA	BS
	2021	100%	100%	100%	100%	NA	100.00%
	2022	100%	100%	100%	100%	96%	99.15%
Enrollee Rights and Protections	2020	94%	100%	89%	89%	NA	93.06%
	2021	100%	100%	100%	100%	NA	100%
	2022	100%	100%	100%	97%	97%	98.88%
MCO Standards	2020	96%	100%	95%	96%	NA	96.71%
	2021	100%	100%	100%	98%	NA	99.56%
	2022	100%	100%	100%	99%	99%	99.64%
Quality Assessment and Performance Improvement Program	2020	100%	100%	93%	100%	NA	98.21%
	2021	100%	100%	93%	100%	NA	98.21%
	2022	100%	100%	100%	93%	100%	98.61%
Grievance and Appeal System	2020	98%	90%	88%	90%	NA	91.59%
	2021	98%	97%	93%	91%	NA	94.77%
	2022	97%	99%	95%	96%	93%	96.09%
Special Needs Plan	2022	NA	NA	NA	NA	100%	100.00%
Overall Weighted Score	2020	97%	96%	93%	93%	NA	94.67%
	2021	99%	99%	98%	96%	NA	98.11%
	2022	99%	100%^	98%	98%	97%	98.45%

NA - Not Applicable. No score is available as the standard was not applicable or the MCP was not reviewed.
BS - Baseline Standard: the standard was reviewed as baseline and not scored.
^ Overall weighted score is 99.72%, rounded to 100%.

Conclusion

Aggregate summary conclusions for the OSR activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 40-44, within the MCP Quality, Access, Timeliness Assessment section.

- The MCPs received overall weighted scores ranging from 97 percent (UHC) to 100 percent (rounded for CFDC) for the 2022 OSR. The MCP average was 98 percent (high confidence).
- The MCPs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its Medicaid enrollees. MCP specific strengths, weaknesses, and recommendations are detailed in the MCP Quality, Access, Timeliness Assessment section.

- All MCPs have at least one CAP required. Most CAPs are due to noncompliance with the Grievance and Appeal System Standard.
- Follow up on previous annual CAPs are detailed in the Assessment of Previous Recommendations section.

Network Adequacy Validation

Objective

MCPs must develop and maintain adequate provider networks to ensure timely access to care and services. NAV evaluates whether MCPs are meeting standards established by DHCF. NAV results provide DHCF and other stakeholders a level of confidence in provider network adequacy.

Methodology

Qlarant conducted a comprehensive assessment of each DCHFP and CASSIP MCP's provider network, available to enrollees, during MY 2022. The NAV activity was not conducted for the DDCP D-SNP during 2022; the first evaluation of the new program will occur in 2023.

Activities conducted as part of the 2022 annual network adequacy evaluation include:

- Assessment of MCP provider network geographic access and provider-to-enrollee ratios.
- Validation of the accuracy of MCP online provider directories.
- Assessment of enrollee access to timely provider appointments.

Description of Data Obtained. Qlarant obtained 2022 geographic access reports from the MCPs during the OSR. The reports conveyed MCP compliance with DHCF time and distance standards, as well as provider-to-enrollee ratios. Qlarant also obtained current provider directory information from the MCPs.

Provider directory files included the following adult and pediatric PCP information: provider name, credentials, national provider identifier, provider type, specialty, practice name, address, and telephone number.

- Adult PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 21 years of age or older. Specialties included family medicine, internal medicine, adult medicine, general medicine, family nurse practitioner, or geriatrics.
- Pediatric PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 20 years of age or younger. Specialties included family medicine, pediatrics, adolescent medicine, general medicine, or family nurse practitioner.

Technical Methods of Data Collection and Analysis. Qlarant compared MCP geographic access report statistics to provider network time, distance, and provider-to-enrollee ratio standards, assessed MCP provider access and availability compliance with timely appointment standards, and validated the accuracy of each MCP's online provider directory. An abbreviated summary of MCP provider network standards is provided below.

DHCF MCP Provider Network Standards

Mileage and travel. Care must be available within 5 miles or no more than 30 minutes travel time (from an enrollee's residence).
Network composition. All enrollees shall have at least 2 age-appropriate PCPs available meeting mileage and travel standards.
Provider-to-enrollee ratios. At least 1 PCP for every 500 enrollees and at least 1 pediatric PCP for every 500 child and adolescent enrollees.
24-hour urgent care appointment. Services must be available 24 hours a day, 7 days a week, when medically necessary.
30-day routine care appointment. Adult enrollees should obtain routine and well health assessments within 30 days. Pediatric enrollees should obtain EPSDT screening examinations within 30 days.

Qlarant randomly selected providers to survey and assess compliance with DHCF-established standards. Surveys were conducted quarterly using Qlarant-developed tools and experienced surveyors following scripts. A maximum of three telephone call attempts were made for each provider during normal business hours, except for the noon hour when offices typically close for lunch. Surveys were considered successful if the surveyor was able to reach the intended provider/practice and complete the survey.

Prior to 2020, telephone calls were conducted via secret shopper and traditional surveys. Beginning in 2020 and thereafter, telephone surveys were conducted as traditional surveys only to reduce the burden on providers.[12]

Qlarant completed online provider directory validations using provider directory data provided by the MCPs and information gathered during the telephone surveys. The online provider directory listing was considered accurate when all of the following criteria were met:

- Provider was with the practice contacted
- Provider offered the desired primary care services
- Provider accepted the listed (participating) MCP insurance
- Provider appeared in the online provider directory
- Response to provider accepting new patients matched the online provider directory
- Practice name matched the online provider directory
- Address matched the online provider directory
- Telephone number matched the online provider directory

Results

Provider Network Standards

Geographic Access. All MCPs demonstrated having at least two age-appropriate PCPs within five miles or 30 minutes of enrollees' residences.

[12] Secret shopper surveys are conducted by a surveyor posing as an enrollee, which evaluates compliance based on the enrollee experience. Traditional surveys are conducted by a surveyor who announces the purpose of the telephone survey call. This method permits the surveyor to evaluate compliance with all elements of the survey, and do so in a more expeditious manner.

Provider-to-Enrollee Ratios. All MCPs demonstrated having at least one adult PCP for every 500 adult enrollees and at least one pediatric PCP for every 500 child and adolescent enrollees.

Provider Appointment Access and Availability

Qlarant surveyed adult and pediatric PCPs during 2022. Table 35 displays results of key provider access and availability measures for each MCP and the MCP average.

Table 35. MY 2022 MCP Key Provider Access and Availability Measure Results

2022 Access and Availability	ACDC	CFDC	HSCSN	MFC	MCP AVG
Successful contact with provider	59%	53%	49%	80%	60%
Provider accepts the listed MCP	97%	88%	83%	100%	93%
Provider accepts new patients	97%	95%	90%	80%	90%

Three attempts were made to contact each provider. The successful contact average was 60 percent. Unsuccessful contacts were most frequently due to a telephone hold time greater than five minutes. For the successfully contacted providers, most accepted the identified MCP insurance (93%) and accepted new patients (90%).

Figures 11-12 illustrate MY 2022 adult and pediatric PCP compliance with routine and urgent appointment standards. Appointments were offered via in-person and telehealth. For both adults and children, timely access was better achieved with routine care, compared to urgent care.

Figure 11. MY 2022 MCP Adult PCP Appointment Compliance

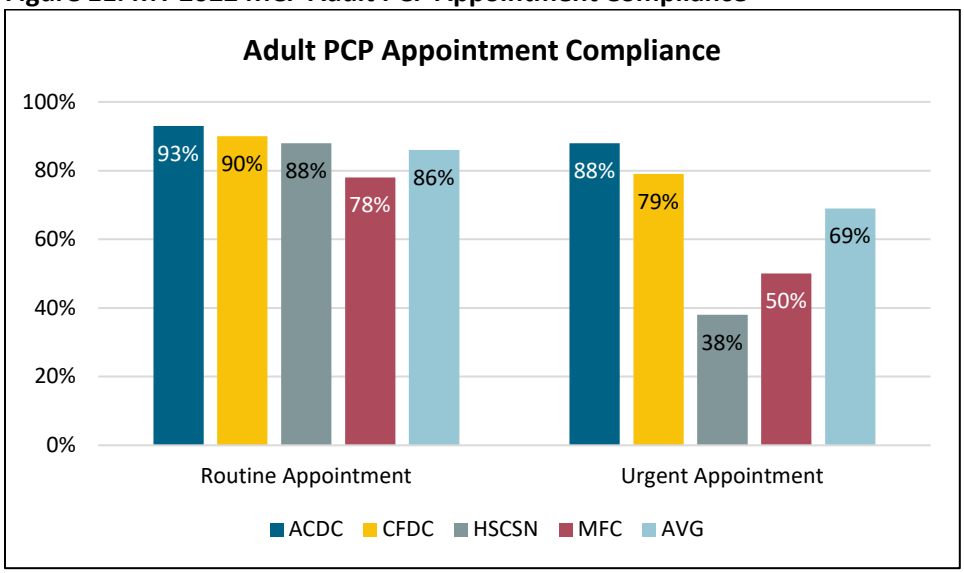
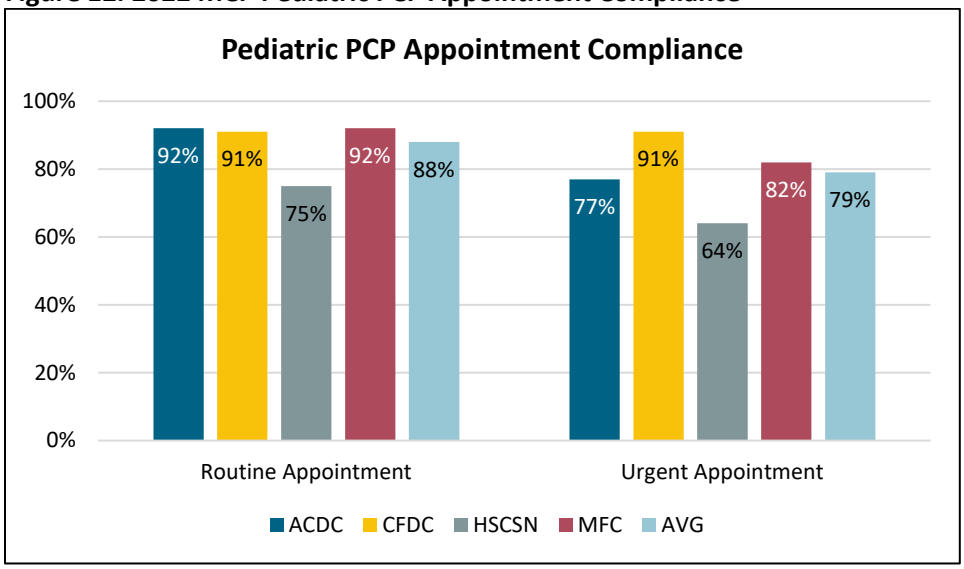


Figure 12. 2022 MCP Pediatric PCP Appointment Compliance



Figures 13-14 include the MCP averages from MYs 2020-2022. While no specific trends are identified in either the adult or pediatric PCP availability, performance improved in 2022 for all measures (compared to 2021), except for routine adult appointments.

Figure 13. MYs 2020-2022 MCP Average Adult PCP Appointment Compliance

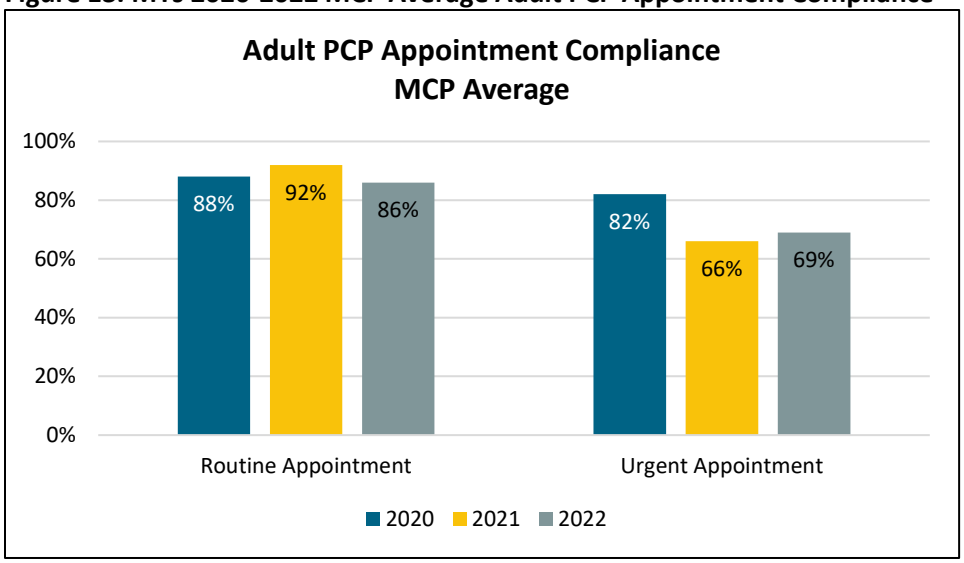
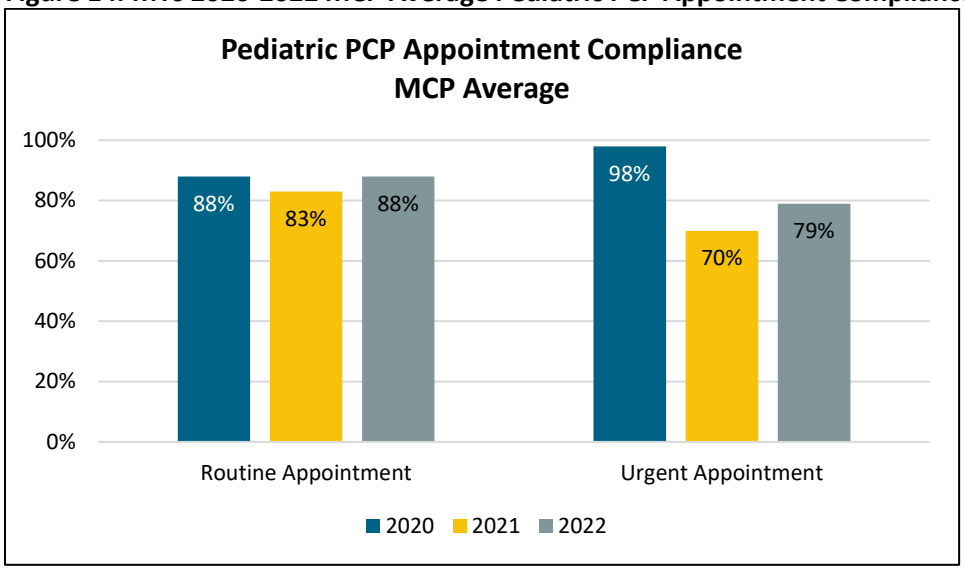


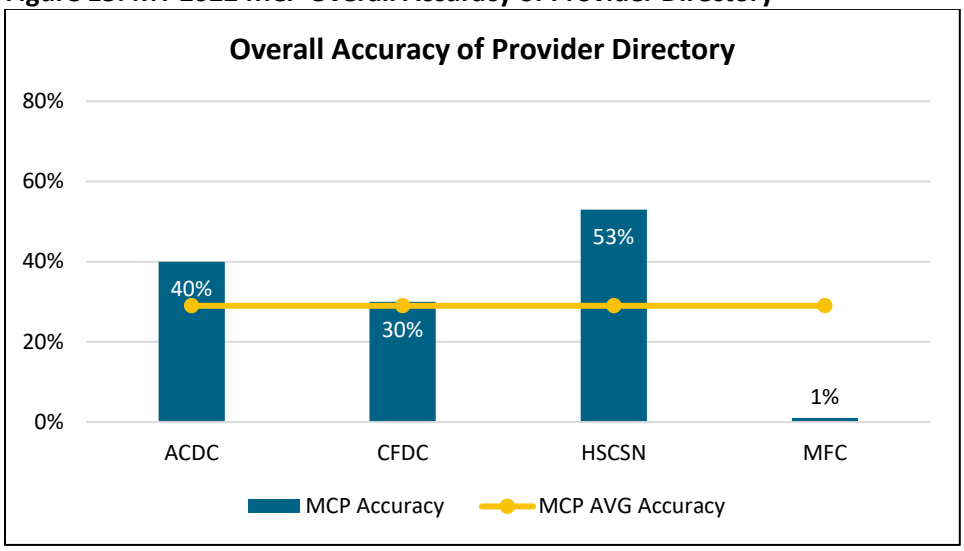
Figure 14. MYs 2020-2022 MCP Average Pediatric PCP Appointment Compliance



Provider Directory Accuracy

Figure 15 provides MY 2022 MCP overall accuracy of provider directory validation results compared to the MCP average of 29 percent. As described in the NAV methodology, each provider directory listing must meet eight criteria in order to be assessed as fully accurate.

Figure 15. MY 2022 MCP Overall Accuracy of Provider Directory



MFC had an overall accuracy rating of one percent—significantly below the MCP average. Most frequently this finding was attributed to an inaccurate representation of the provider accepting new patients.

Figure 16 illustrates overall provider directory accuracy compared to the MCP averages, and trended from MYs 2020–2022.

Figure 16. MYs 2020-2022 MCP Overall Accuracy of Provider Directory

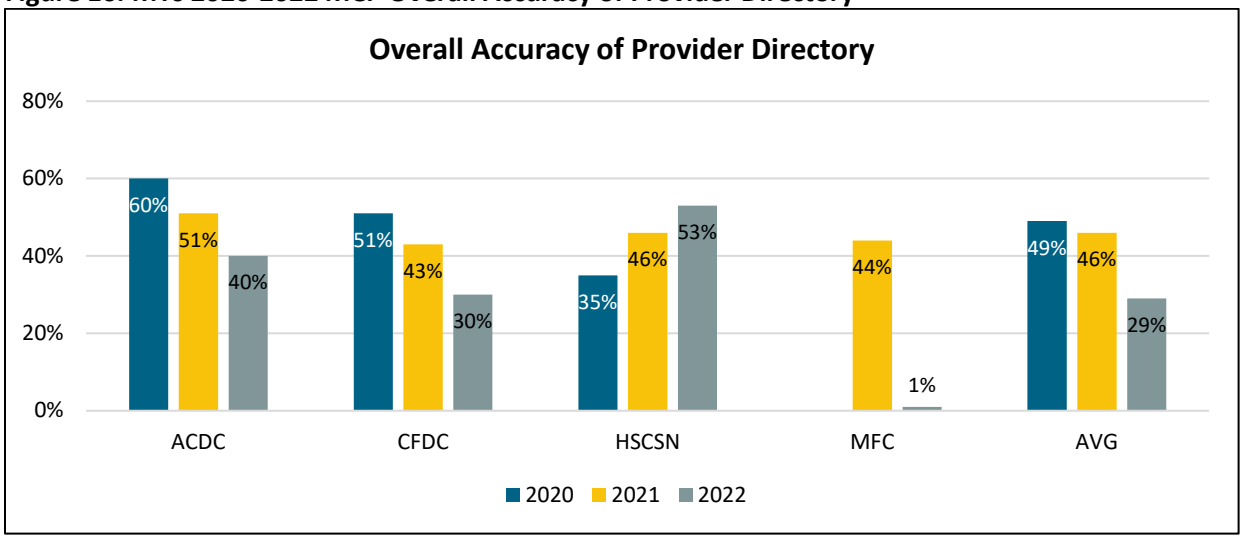
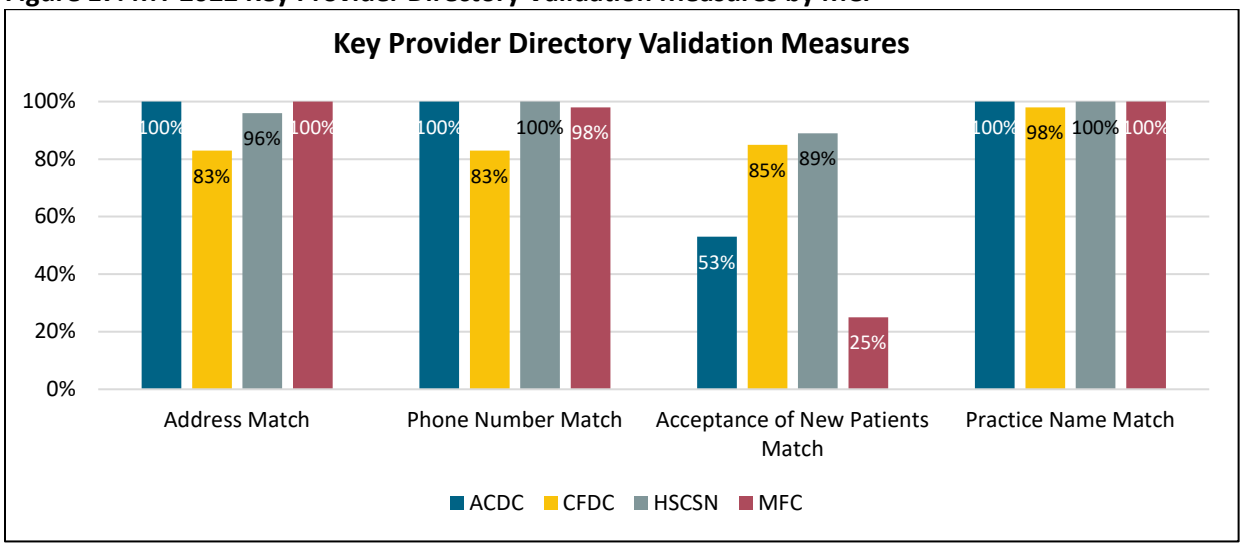


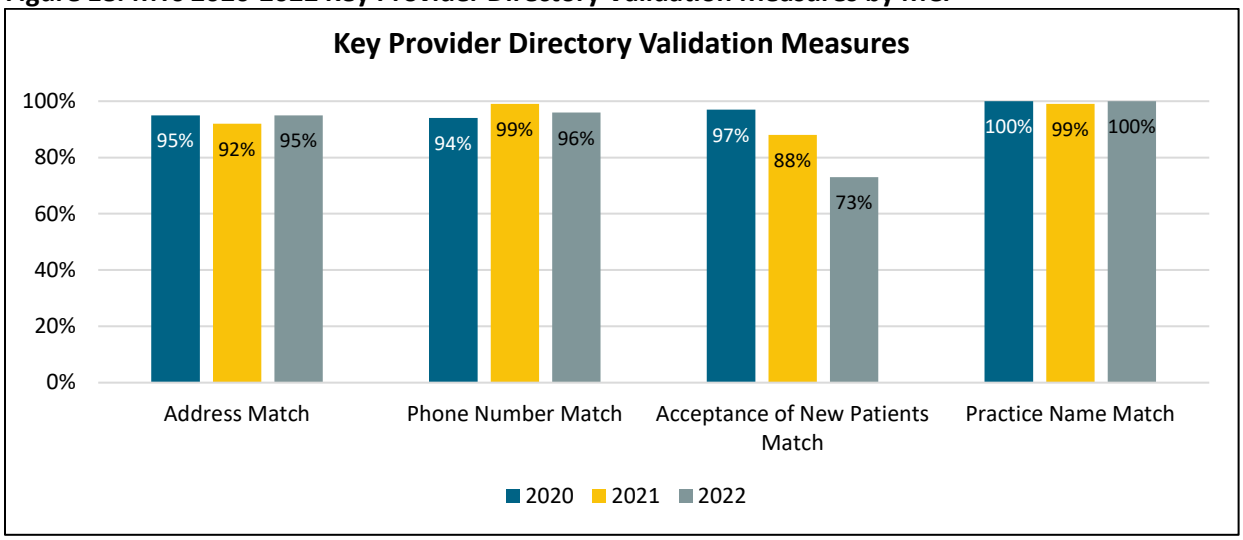
Figure 17 displays four key provider directory validation measures critical to enrollees in their search for a provider.

Figure 17. MY 2022 Key Provider Directory Validation Measures by MCP



The inaccuracy of acceptance of new patients, reflected in the provider directories, presents the most significant opportunity for improvement. Figure 18 includes key provider directory validation measure MCP averages for MYs 2020-2022.

Figure 18. MYs 2020-2022 Key Provider Directory Validation Measures by MCP



The acceptance of new patients match rates have trended down and require intervention.

Conclusion

Aggregate summary conclusions for the NAV activities are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 40-43, within the MCP Quality, Access, Timeliness Assessment section.

- All MCPs have robust PCP networks. Enrollees have access to at least 2 PCPs within 5 miles or 30 minutes of their residences.
- MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 38 percent to 93 percent for MY 2022. MCP averages reveal the following timely access compliance ratings: 86 percent for adults accessing routine care, 69 percent for adults accessing urgent care, 88 percent for children accessing routine care, and 79 percent for children accessing urgent care.
- Access to adult urgent care and pediatric routine and urgent care improved during MY 2022, compared to MY 2021, based on MCP averages. Adult access to routine care declined by six percentage points during the same time period (92% to 86%).
- Overall accuracy of MCP online provider directories ranged from 1 percent (MFC) to 53 percent (HSCSN) for MY 2022. The MCP average was 29 percent; the MCP average has declined over the last three years. Poor performance in the Acceptance of New Patients (match rate) measure is the most significant contributing factor to the low overall accuracy rate.

Encounter Data Validation

Objective

States rely on valid and reliable encounter data submitted by MCPs to make key decisions. For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. As payment methodologies evolve and incorporate value-

based payment elements, collecting complete and accurate encounter data is critical. Results of the EDV study provide DHCF a level of confidence in the completeness and accuracy of electronic encounter data submitted by the MCPs.

Methodology

Qlarant's 2022 EDV activities focused on an evaluation of provider office encounters occurring between July 1, 2020 and June 30, 2021.

Description of Data Obtained. Qlarant obtained the following data to complete the EDV study:

- Electronic encounter data file received from DHCF for the period of review (July 1, 2020 - June 30, 2021)
- Information Systems Capabilities Assessment (ISCA) and HEDIS Roadmap documentation from the MCPs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.[13] To assess the completeness and accuracy of MCP encounter data, Qlarant completed the following activities:

- Reviewed DHCF requirements for collecting and submitting encounter data.
- Reviewed each MCP's capability to produce accurate and complete encounter data, which included an evaluation of the MCP's ISCA, HEDIS Roadmap, and interviews with key MCP staff.
- Reviewed medical records to confirm electronic encounter data accuracy.

To complete the medical record reviews, Qlarant reviewers compared medical record documentation to electronic encounter data to confirm the accuracy of reported encounters. Specifically, reviewers evaluated the accuracy of diagnosis and procedure codes for the randomly selected encounters. All diagnosis and procedure codes associated with an encounter were reviewed. When documentation supported the diagnosis and procedure codes for the encounter under review, results were assessed as matching. When documentation did not support the diagnosis or procedure codes, results were assessed as not matching (or deemed as "no match").

The 2022 evaluation was the second annual EDV study completed for the DCHFP and CASSIP MCPs. During the first annual study, completed in 2021, MFC was excluded due to its contract start date of October 1, 2020. The DDCP D-SNP is also excluded from the EDV study.

Results

Qlarant found all MCPs had the capability to produce accurate and complete encounter data. Conclusions were drawn based on reviews of ISCA and Roadmap evaluations, interviews with MCP personnel critical to processes, and demonstrations of Information System processes. Table 36 indicates

[13] CMS EQR Protocols

MCP capability of producing accurate and complete encounter data, based on auditing activities completed in 2022.

Table 36. MCP Capability of Producing Accurate and Complete Encounter Data

2022 EDV	ACDC	CFDC	HSCSN	MFC
Capable of producing accurate and complete encounter data	❖	❖	❖	❖

❖ The MCP is capable of producing accurate and complete encounter data, as required by DHCF.

Qlarant's medical record review evaluated the accuracy of diagnosis and procedure codes in the electronic encounter data. Table 37 displays MCP accuracy or "match rates." A match occurs when the electronic diagnosis and procedure codes are supported by medical record documentation. The 2022 medical record reviews, evaluating encounters that occurred between July 1, 2020 and June 30, 2021, confirmed, overall, high encounter data accuracy.

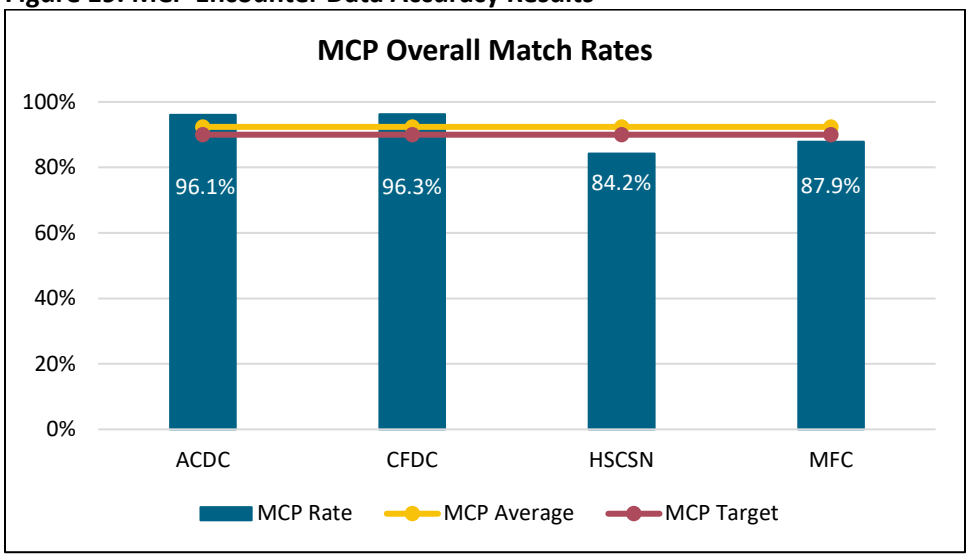
Table 37. MCP Encounter Data Accuracy

2022 EDV	ACDC	CFDC	HSCSN	MFC	MCP AVG
Accuracy or Match Rate	96.1%	96.3%	84.2%	87.9%	92.4%

The MCP-weighted average was 92.4 percent, which exceeded the DHCF-established target of 90 percent. Individual MCP performance ranged from 84.2 percent (HSCSN) to 96.3 percent (CFDC).

Figure 19 illustrates MCP overall match rates compared to the MCP average and target.

Figure 19. MCP Encounter Data Accuracy Results



ACDC and CFDC both exceeded the MCP average (92.4%) and target (90%). HSCSN and MFC fell short of both the MCP average and target.

Table 38 includes diagnosis code match rate findings and reasons for "no match."

Table 38. Diagnosis Code Findings

Diagnosis Codes	ACDC	CFDC	HSCSN	MFC	MCP Aggregate
Diagnosis Codes with a Match					
Accuracy or Match Rate	96.0%	96.0%	68.3%	76.8%	88.4%
Diagnosis Codes with "No Match"					
"No Match" Rate	4.0%	4.0%	31.7%	23.2%	11.6%
"No Match" Reasons					
Percentage of diagnosis code elements with coding errors	0.0%	0.0%	0.0%	0.3%	0.1%
Percentage of diagnosis code elements that were not supported by medical record documentation	4.0%	4.0%	31.7%	22.8%	11.5%

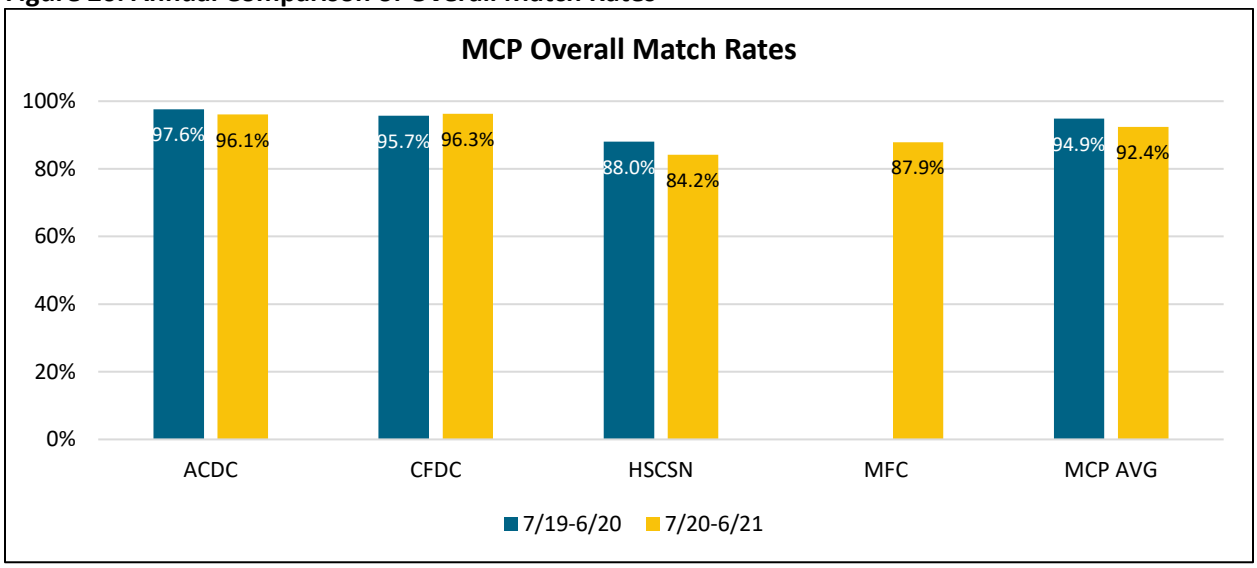
Table 39 includes procedure code match rate findings and reasons for "no match."

Table 39. Procedure Code Findings

Procedure Codes	ACDC	CFDC	HSCSN	MFC	MCP Aggregate
Procedure Codes with a Match					
Accuracy or Match Rate	96.2%	96.6%	97.9%	95.2%	96.2%
Procedure Codes with "No Match"					
"No Match" Rate	3.8%	3.4%	2.1%	4.8%	3.8%
"No Match" Reasons					
Percentage of procedure code elements with coding errors	0.3%	0.3%	0.5%	0.0%	0.2%
Percentage of procedure code elements that were not supported by medical record documentation	3.5%	3.1%	1.6%	4.8%	3.6%

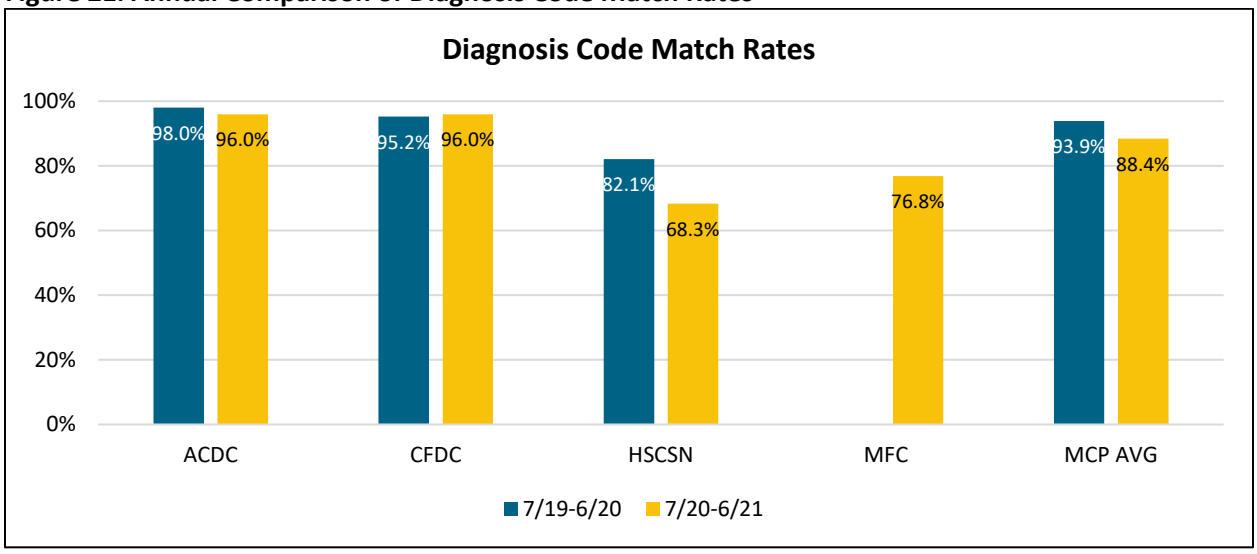
Figures 20-22 illustrate annual comparisons in overall, and diagnosis and procedure code match rates per MCP and on average.

Figure 20. Annual Comparison of Overall Match Rates



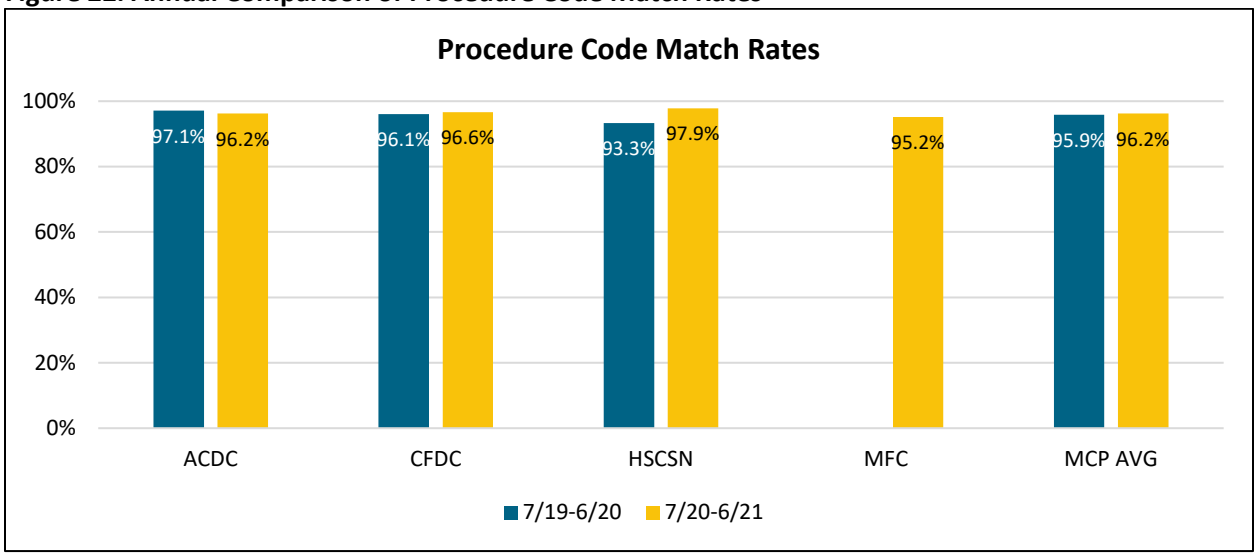
No data is available for MFC for the 7/19-6/20 period due to the MCP's October 1, 2020 contract start date.

Figure 21. Annual Comparison of Diagnosis Code Match Rates



No data is available for MFC for the 7/19-6/20 period due to the MCP's October 1, 2020 contract start date.

Figure 22. Annual Comparison of Procedure Code Match Rates



No data is available for MFC for the 7/19-6/20 period due to the MCP's October 1, 2020 contract start date.

Conclusion

Aggregate summary conclusions for the EDV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 40-43 within the MCP Quality, Access, Timeliness Assessment section.

- An evaluation of each MCP's ISCA determined all MCPs had the capability to produce accurate and complete encounter data for the period under review.
- A medical record review determined an overall high level of encounter data accuracy. The MCP overall weighted average was 92.4 percent, which exceeded the DHCF-established target of 90 percent. ACDC and CFDC met this target, while MFC and HSCSN did not.
- A match rate analysis at the diagnosis and procedure code level concluded an MCP average of 88.4 percent and 96.2 percent, respectively.
- While there was marginal improvement in the annual MCP average procedure code match rates, there were declines in the overall and diagnosis code match rates.
- Most "no match" findings were due to lack of diagnosis-related documentation in the medical record.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths and weaknesses for each MCP, based on the results of the EQR activities. These strengths and weaknesses correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for these domains:

Quality, Access, and Timeliness Definitions

Quality, as stated in the federal regulations as it pertains to EQR, is the degree to which an MCP "…increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement." (CFR §438.320).

Access (or accessibility), as defined by NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA Health Plan Standards and Guidelines*).

Timeliness, as stated by the Institute of Medicine is "reducing waits and sometimes harmful delays" and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in physicians' offices or emergency rooms and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

Tables 40-44 highlight strengths and weaknesses for each MCP. Identified strengths and weaknesses correspond to the quality, access, and/or timeliness of services delivered to MCP enrollees. Only applicable domains for each strength or weakness are identified with a (★) or (●), indicating a positive or negative impact, as described below. Not all domains were impacted by each strength or weakness. Where appropriate, weaknesses include recommendations.

★ The MCP strength identified positively impacts quality, access, and/or timeliness.
● The MCP weakness identified negatively impacts quality, access, and/or timeliness.

Examples of the quality, access, and timeliness analysis include:

- If the MCP demonstrated full compliance in the Quality Assessment and Performance Improvement Program Standard, performance would be identified with a ★ in the quality domain.
- If the MCP did *not* provide female enrollees with direct access to a women's health specialist to provide routine and preventative health care services, performance would be identified with a ● in the access domain.
- If the MCP demonstrated statistically significant improvement in an Annual Dental Visits PIP measure, performance would be identified with a ★ in all three domains, as the PIP is a quality project, which focuses on improving access to preventative dental care in a timely manner.

ACDC

Table 40. ACDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
★	★	★	**Strength.** ACDC received a score of 90% (high confidence). While not statistically significant, the MCP achieved improvement in the HbA1c Testing, HbA1c Control (<8%), and HbA1c Poor Control (>9%) measures (last measurement compared to baseline).
Maternal Health PIP			
★	★	★	**Strength.** ACDC received a score of 95% (high confidence). While not statistically significant, the MCP sustained improvement in the Timeliness of Prenatal Care measure.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** ACDC received a score of 98% in the Information Requirements Standard, contributing to the MCP's overall high confidence score. Overall, the MCP communicates required information on benefits and providers, and how to access services.
		●	**Weakness.** ACDC's Enrollee Handbook explains appeals may be filed by calling Enrollee Services within 60 calendar days from the date the notice of adverse benefit determination is mailed. This is inconsistent with current regulatory requirements. **Recommendation.** ACDC should revise its Enrollee Handbook's appeal filing timeframe to specify 60 calendar days from the date on the notice of the adverse benefit determination (not the mailing date).
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
MCO Standards			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** ACDC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** ACDC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** ACDC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** ACDC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** ACDC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** ACDC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** ACDC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** ACDC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** ACDC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** ACDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	**Strength.** ACDC received a score of 97% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
		●	**Weakness.** ACDC's appeal and fair hearing policy explains the enrollee, or the enrollee's representative, may file or request an appeal within 60 calendar days from the mailing date of the notice of adverse benefit determination. **Recommendation.** ACDC should amend its appeal and fair hearing policy and identify the timeframe for filing an appeal—60 calendar days from the date on the adverse benefit determination notice (not the mailing date).

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
	●		**Weakness.** A random sample of adverse benefit determination enrollee letters was reviewed. Most letters reviewed included the requirement for written confirmation of an oral appeal (the CFR had eliminated this requirement). Updated letter templates, excluding this requirement, did not go into production until the summer of 2022. **Recommendation.** ACDC should ensure consistent utilization of the most current adverse benefit determination letter template. This template eliminated the requirement for written confirmation of an oral appeal.
		●	**Weakness.** A random sample review of appeals found inconsistency in meeting the timeframe requirement for sending written acknowledgment of the appeal. In these cases, the date of appeal receipt was documented as the date when an enrollee's written consent was received, allowing a provider to file on their behalf, rather than the date the provider filed the appeal. **Recommendation.** ACDC should demonstrate compliance with sending the enrollee written acknowledgment to the enrollee within two business days of receipt of the appeal, regardless of who files the appeal.
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** ACDC provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	●	●	**Weakness.** ACDC received a score of 88% for timely access to adult urgent appointments. **Recommendation.** ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●	●	**Weakness.** ACDC received a score of 77% for timely access to pediatric urgent appointments. **Recommendation.** ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** ACDC received a score of 40% for overall provider directory accuracy. Most inaccuracies are attributed to results of the Acceptance of New Patients (match rate) measure. **Recommendation.** ACDC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
★			**Strength.** ACDC achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the quality of the MCP's encounter/claims data.

CFDC

Table 41. CFDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence). The MCP demonstrated sustained improvement in the Eye Exams measure and statistically significant improvement in the Blood Pressure Control (<140/90 mm Hg), Eye Exams, and Poor HbA1c Control (>9%) measures.
Maternal Health PIP			
★	★	★	**Strength.** CFDC received a score of 97% (high confidence). The MCP demonstrated sustained improvement in both PIP measures and statistically significant improvement in the Timeliness of Prenatal Care measure.
●			**Weakness.** CFDC did not identify appropriate variables to assist in answering the PIP question. **Recommendation.** CFDC should identify objective, clearly defined, time-specific variables to answer the study question.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
MCO Standards			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** CFDC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** CFDC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** CFDC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** CFDC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** CFDC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** CFDC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** CFDC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** CFDC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** CFDC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** CFDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	**Strength.** CFDC received a score of 99% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
	●		**Weakness.** CFDC's provider manual incorrectly required the appeals coordinator to send a written acknowledgment letter to the enrollee, along with instructions for completing the written signed appeal. This is inconsistent with current regulatory requirements. **Recommendation.** CFDC should revise the provider manual to eliminate the requirement for written confirmation of oral appeals filed by an enrollee.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** CFDC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	★	★	**Strength.** CFDC received a score of 90% for timely access to adult routine appointments.
	●	●	**Weakness.** CFDC received a score of 79% for timely access to adult urgent appointments. **Recommendation.** CFDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	★	★	**Strength.** CFDC received a score of 91% for timely access to both pediatric routine and urgent appointments.
	●		**Weakness.** CFDC received a score of 30% for overall provider directory accuracy. **Recommendation.** CFDC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
★			**Strength.** CFDC achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the quality of the MCP's encounter/claims data.

HSCSN

Table 42. HSCSN Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Childhood Obesity Management and Prevention PIP			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence). The MCP reported a methodologically sound PIP that included baseline performance. The MCP identified specific barriers, which should aid in the development of targeted interventions.
Maternal Health PIP			
★	★	★	**Strength.** HSCSN received a score of 90% (high confidence). While not statistically significant, the MCP sustained improvement in the Timeliness of Prenatal Care measure.
●			**Weakness.** HSCSN did not accurately identify the PIP's target population. **Recommendation.** HSCSN should identify the target population for the PIP as women who had a delivery during the MY.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●			**Weakness.** HSCSN's improvement strategies did not address root causes or barriers identified through a quality improvement process. Barriers were too generic or inappropriate. Fortunately, the majority of interventions implemented did not relate to these generic or inappropriate barriers; interventions were satisfactory. **Recommendation.** HSCSN should demonstrate that its improvement strategies address root causes or barriers and are specific in supporting improvement opportunities for each PIP measure.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** HSCSN provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** HSCSN provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Coordination and Continuity of Care requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** HSCSN provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** HSCSN provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** HSCSN provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** HSCSN provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** HSCSN received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	**Strength.** HSCSN received a score of 95% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
		●	**Weakness.** HSCSN's appeal policy specifies an appeal must be filed within 60 calendar days from the date the notice of adverse benefit determination was mailed. This is inconsistent with CFR §438.402, which identifies the appeal filing timeframe as within 60 calendar days from the date on the notice of adverse benefit determination. **Recommendation.** HSCSN should amend the appeal filing timeframe identified in the policy to 60 calendar days from the date on the notice of adverse benefit determination (not the mailing date).
		●	**Weakness.** HSCSN's authorization policy asserts the determination timeframe for standard authorization decisions is no later than 14-calendar days following receipt of the request. A sample review of enrollee files found overall compliance with the 14-calendar day notification timeframe requirement for standard preauthorization requests was 87%. **Recommendation.** HSCSN should demonstrate consistent compliance with the 14-calendar day timeframe for notification of an adverse benefit determination in response to a standard preauthorization request.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
		●	**Weakness.** HSCSN's authorization policy requires HSCSN to "resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires." It does not address the extension of the timeframe for authorization decisions. **Recommendation.** HSCSN should revise the authorization policy to require the MCP, in the event of an extension of the timeframe for an authorization decision, to issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
		●	**Weakness.** HSCSN's appeal policy asserts the timeframe for resolution of pre-service appeals is 30 calendar days from receipt of the request. This is insufficient in meeting this requirement for standard appeals, which includes notice to the affected parties within this timeframe. **Recommendation.** HSCSN should amend the appeal policy to specify the notification timeframe for written resolution of standard appeals is within 30 calendar days from receipt of the appeal.
		●	**Weakness.** HSCSN's provider manual explains an expedited appeal will be completed as expeditiously as the HSCSN enrollee's health condition requires, but within 72 hours from the date/time the appeal request was received. Although the provider manual addresses written notice of appeal resolution, no timeframe was identified. An initial sample of 10 appeal files was reviewed for compliance. One expedited appeal was found, which did not meet the required timeframe for notification of resolution. The remaining sample of 20 files was reviewed for compliance. One additional request for an expedited resolution was found; the file demonstrated compliance with the regulatory timeframe. **Recommendation.** HSCSN should update its provider manual to state the 72-hour timeframe for resolution of an expedited appeal includes enrollee written notice of appeal resolution. Additionally, HSCSN must demonstrate consistent compliance with the timeframe for notification of an expedited appeal resolution.
●			**Weakness.** A sample review of 10 adverse benefit determination notices found inconsistent compliance with HSCSN's appeal policy, which requires notice of appeal resolution be written in easily understood language. For example, the reason for an uphold decision for orthodontic services was explained as, "There must be a severe handicapping malocclusion and [the] enrollee must have [a] score of at least 26 on the handicapping labio lingual deviation (HLD) index." Other examples included terms such as subcutaneous injection, insomnia, and clinical rationale. **Recommendation.** HSCSN should demonstrate that appeal resolution letters are written in easily understood language.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** HSCSN provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	●	●	**Weakness.** HSCSN received a score of 88% and 38% for timely access to adult routine and urgent appointments, respectively. **Recommendation.** HSCSN should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●	●	**Weakness.** HSCSN received a score of 75% and 64% for timely access to child routine and urgent appointments, respectively. **Recommendation.** HSCSN should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** HSCSN received a score of 53% for overall provider directory accuracy. **Recommendation.** HSCSN should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
●			**Weakness.** HSCSN achieved an encounter data accuracy, or match rate, of 84%. The DHCF-established target was 90%. "No match" reasons were attributed to a lack of supporting documentation in the medical record. **Recommendation.** HSCSN should educate its providers on including sufficient documentation in the medical records to support codes for billed claims.

MFC

Table 43. MFC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
★	★	★	**Strength.** MFC received a score of 98% (high confidence). The MCP reported a methodologically sound PIP that included baseline performance. The MCP provided a detailed understanding of the epidemiology of diabetes and the significance of preventive health to minimize complications. MFC identified specific barriers, which should aid in the development of targeted interventions.
●			**Weakness.** MFC did not adequately address procedures to ensure data from all administrative data sources are accurate and complete. **Recommendation.** MFC should report its assurance of accurate and complete administrative data.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
Maternal Health PIP			
★	★	★	**Strength.** MFC received a score of 96% (high confidence). The MCP reported a methodologically sound PIP that included baseline performance. The MCP provided a comprehensive data analysis plan and identified system-wide barriers.
●			**Weakness.** MFC did not include an adequate population description. **Recommendation.** MFC should include women who had a delivery during the MY in the special population description.
●			**Weakness.** MFC did not include an adequate aim statement. **Recommendation.** MFC should provide a concise, answerable, and measurable aim statement/study question, which is focused on improving the percentages of deliveries in which women had the recommended prenatal care and postpartum care visits.
●			**Weakness.** MFC did not adequately address procedures to ensure data from all administrative data sources are accurate and complete. **Recommendation.** MFC should report its assurance of accurate and complete administrative data.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Set Performance Measures			
★	★	★	**Strength.** MFC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	**Strength.** MFC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** MFC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** MFC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** MFC received a score of 97% in the Enrollee Rights and Protections Standard, contributing to the MCP's overall high confidence score. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
	●		**Weakness.** MFC's emergency services policy does not assert that MFC will not deny payment for treatment obtained when a MFC representative instructs the enrollee to seek emergency services. **Recommendation:** MFC should amend its emergency services policy and assert the MCP will not deny payment for treatment obtained when a MFC representative instructs the enrollee to seek emergency services.
MCO Standards			
★	★	★	**Strength.** MFC received a score of 99% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** MFC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** MFC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
		●	**Weakness.** MFC's pharmacy authorization policy outlines the appropriate timeframes for outpatient drug authorization decisions; a decision is made within 24 hours of receiving the request, regardless of whether clinical information is received. A sample review of adverse benefit determination files resulted in 83% compliance with the required prescriber notification timeframe. **Recommendation:** MFC should consistently demonstrate compliance with the requirement for notifying the prescriber of the outcome of the preauthorization request for a covered outpatient drug, within 24 hours of receipt of the request.
MCO Standards – Provider Selection			
★	★		**Strength.** MFC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** MFC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** MFC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** MFC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** MFC provided evidence of meeting all Health Information Systems requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
Quality Assessment and Performance Improvement Program			
●			**Weakness.** MFC did not conduct and report results of an Experience of Care and Health Outcomes (ECHO) Survey, as required by its contract with DHCF. **Recommendation**. MFC should conduct and report results of its ECHO survey, as required by DHCF.
Grievance and Appeal System			
★	★	★	**Strength.** MFC received a score of 96% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
	●		**Weakness.** A sample review of 10 adverse benefit determination letters revealed one letter included the outdated requirement for written confirmation of oral appeals. Review of an additional 20 records found one other letter requiring written confirmation of an oral appeal. Both letters were from one particular vendor. Overall compliance was 93%. **Recommendation**. MFC should consistently demonstrate that adverse determination letters do not include the requirement for written confirmation of an oral appeal.
		●	**Weakness.** A sample review of enrollee grievance records found overall compliance with sending the enrollee written acknowledgment, within two business days, of grievance receipt was 93%. **Recommendation.** MFC should demonstrate consistent compliance in meeting the timeframe for sending the enrollee written acknowledgment of grievance receipt, within two business days.
		●	**Weakness.** MFC's appeals policy requires the MCP to resolve each appeal and provide written notice no later than 30 calendar days from receipt of the appeal. A sample of appeal records was reviewed for compliance with the timeframe for enrollee notification of standard appeal resolution. Overall compliance with the 30-day notification timeframe was 96%. **Recommendation.** MFC should demonstrate consistent compliance in meeting the timeframe for enrollee notification of resolution of a standard appeal.
●			**Weakness.** MFC's policy requires the MCP to convene quarterly to review all grievances received in the prior quarter. The MCP did not demonstrate compliance with this requirement. **Recommendation.** MFC should demonstrate that its Grievance and Appeal Committee meets quarterly to discuss grievance and appeal trends and opportunities for improvement, consistent with its policy.
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** MFC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
	●	●	**Weakness.** MFC received a score of 78% and 50% for timely access to adult routine and urgent appointments, respectively. **Recommendation.** MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	★	★	**Strength.** MFC received a 92% compliance rating for timely access to pediatric routine appointments.
	●	●	**Weakness.** MFC received a score of 82% for timely access to pediatric urgent appointments. **Recommendation.** MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** MFC received a score of 1% for overall provider directory accuracy. Most inaccuracies are attributed to results of the Acceptance of New Patients (match rate) measure. **Recommendation.** MFC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
●			**Weakness.** MFC achieved an encounter data accuracy, or match rate, of 88%. The DHCF established target was 90%. "No match" reasons were attributed to a lack of supporting documentation in the medical record. **Recommendation.** MFC should educate its providers on including sufficient documentation in the medical records, to support codes for billed claims.

UHC

Table 44. UHC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Fall Risk Management PIP			
★	★	★	**Strength.** UHC received a score of 100% (high confidence). The MCP reported a comprehensive description of the PIP population, performance measures, and data collection plan.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Set Performance Measures			
★	★	★	**Strength.** UHC received a score of 100% (high confidence). The limited assessment determined UHC's information systems were adequate; the MCP should be able to successfully calculate and report performance measures in the next annual review.
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** UHC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** UHC received a score of 96% (high confidence) in the Disenrollment Requirements and Limitations Standard. Overall, the MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
●	●		**Weakness.** UHC's disenrollment policy does not specify reasons the MCP may not request disenrollment. **Recommendation:** UHC should amend its disenrollment policy and assert UHC 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 (except when his or her continued enrollment impairs UHC's ability to furnish services to either this particular enrollee or other enrollees).
Enrollee Rights and Protections			
★	★	★	**Strength.** UHC received a score of 97% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes most enrollee rights and protections; and communicates information to enrollees.
●	●		**Weakness.** UHC does not adequately document its compliance with applicable federal and state laws related to nondiscrimination and protections. **Recommendation:** UHC should document, in an applicable policy, its compliance with federal and state laws, including 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 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
MCO Standards			
★	★	★	**Strength.** UHC received a score of 99% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** UHC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** UHC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** UHC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** UHC provided evidence of meeting all Coverage and Authorization of Services requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
MCO Standards – Provider Selection			
★	★		**Strength.** UHC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** UHC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** UHC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
●			**Weakness.** It was unclear if UHC had clinical practice guidelines (CPGs) in place that are in accordance with DHCF contract requirements. Additionally, there were no CPGs specific to the elderly and physical disabilities (EPD) waiver population. **Recommendation**. UHC should ensure CPGs are available and in practice, in accordance with DHCF contract requirements; and in support of the EPD population.
MCO Standards – Health Information Systems			
★			**Strength.** UHC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** UHC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
	●		**Weakness.** UHC's adverse determination notice policy did not include how an enrollee should request continuation of benefits in the required content of the adverse benefit determination notice. **Recommendation**. UHC should amend its adverse determination notice policy and include how to request continuation of benefits in the list of adverse benefit determination notice required content.
		●	**Weakness.** UHC's review timeframes policy requires the MCP to issue notice of an adverse benefit determination for termination, suspension, or reduction of previously authorized Medicaid services, within the timeframes specified in 42 CFR §431.211, 431.213, and 431.214, as amended; and all other regulatory or statutory regulatory requirements. This is insufficient in providing direction to UHC staff. **Recommendation.** UHC should revise its review timeframes policy to specify the specific regulatory timeframe for providing notice of an adverse benefit determination for termination, suspension, or reduction of a previously authorized Medicaid-covered service.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●			**Weakness.** UHC's grievance policy does not prohibit review of a grievance by an individual or subordinate of an individual involved in any previous level of review or decision-making. **Recommendation.** UHC should amend its grievance policy to ensure the individuals who make decisions on grievances are individuals who were neither involved in any previous level of review or decision-making, nor a subordinate of any such individual.
		●	**Weakness.** UHC's appeal policy requires the MCP to provide the enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The policy further explains that the enrollee will be informed of the limited time available for this, in the case of an expedited resolution. This requirement is too limited, as this same provision applies to standard appeals (§438.408(b)) and 14-calendar day extensions (§438.408(c). **Recommendation.** UHC should revise its appeal policy to extend this provision to standard appeals and 14-calendar day extensions.
●	●		**Weakness.** UHC's grievance policy does not specially address the format of the grievance resolution notice and its compliance with the standards described at §438.10. UHC does indicate in its policy that it will provide assistance to enrollees with limited English proficiency, physical disabilities, or visual or other communicative impairments. However, this is insufficient in meeting the requirements of this element. **Recommendation.** UHC should update its grievance policy to demonstrate that the format of its grievance notices complies with §438.10, such as easily understood language and format, font size no smaller than 12 point, and availability of alternate formats, through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of enrollees with disabilities or limited English proficiency.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	●		**Weakness.** UHC's appeals policies do not specially address the format of the appeal resolution notice and its compliance with the standards described at §438.10. UHC does indicate in its policy that it will provide assistance to enrollees with limited English proficiency, physical disabilities, or visual or other communicative impairments. In describing the required contents of the written notice of appeal resolution, it explains that the reason for the denial will be culturally and linguistically appropriate for the enrollee or their appointed or legally authorized representative to understand. However, this content is insufficient in meeting the requirements of this element. **Recommendation.** UHC should update its appeals policies to demonstrate that the format of its appeal resolution notices complies with §438.10, such as easily understood language and format, font size no smaller than 12 point, and availability of alternate formats, through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of enrollees with disabilities or limited English proficiency.
	●		**Weakness.** According to UHC's appeals policies, when the MCP upholds an adverse decision, the enrollee's written notification is to include the timeframe for requesting a fair hearing, the availability of UHC assistance with filing a fair hearing request, and the timeframe for requesting continuation of benefits. The policies do not require the written notice to include how to request a fair hearing or how to request continuation of benefits. **Recommendation.** UHC should include in its appeals policies that written notice of appeal resolution will include how to request a fair hearing and how to request continuation of benefits.
●		●	**Weakness.** UHC's provider manual included some information that was inaccurate or incomplete. For example, the timeframe for resolution of an enrollee grievance is specified as 90, rather than 30, calendar days and there is no mention of the availability of an expedited grievance process. There also is incomplete information on level 2 appeals, which varies based upon whether the benefit is covered by Medicare, Medicaid, or Medicaid/Medicare and the availability of continuation of benefits. **Recommendation.** UHC should revise its provider manual to include processes and a timeframe consistent with an integrated dual eligible special needs plan.
NETWORK ADEQUACY VALIDATION			
This task was not completed for UHC due to its contract effective date of February 1, 2022.			
ENCOUNTER DATA VALIDATION			
This task is not required for UHC.			

Assessment of Previous Recommendations

During the course of conducting 2022 EQR activities, Qlarant evaluated MCP compliance in addressing previous annual recommendations.[14] MCPs were expected to remedy 2021 deficiencies and demonstrate full compliance. MCPs not addressing deficiencies are at risk of not being compliant with their contracts. Assessment outcomes, included in Tables 45-48, identify if the MCP adequately addressed 2021 recommendations. Color coded symbols specify results:

- The MCP adequately addressed the recommendation.
- The MCP demonstrated some improvement, but did not fully address the recommendation.
- The MCP did not adequately address the recommendation.

ACDC

ACDC adequately addressed 4 of 7 recommendations (that could be re-evaluated), demonstrating a 57 percent compliance rating. Table 45 provides details of the 2022 assessment.

Table 45. Assessment of ACDC's Previous Annual Recommendations

2021 Recommendation	2022 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
ACDC did not achieve improvement in any measures (the last remeasurement compared to baseline performance). The MCP should continue to adapt to COVID-19 public health emergency constraints and engage enrollees in care.	While not statistically significant, ACDC achieved improvement in the HbA1c Testing, HbA1c Control (<8%), and HbA1c Poor Control (>9%) measures (MY 2021 performance compared to baseline).
Maternal Health PIP	
ACDC should amend its aim statement and clearly specify the population for the prenatal and postpartum care measures as women who had a delivery.	ACDC modified its aim statement to accurately identify the population relevant to the PIP, women who had a delivery.
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
There were no formal 2021 recommendations for ACDC.	
EPSDT Performance Measures	
There were no formal 2021 recommendations for ACDC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2021 recommendations for ACDC.	
Disenrollment Requirements and Limitations	
There were no formal 2021 recommendations for ACDC.	
Enrollee Rights and Protections	
There were no formal 2021 recommendations for ACDC.	
MCO Standards	
There were no formal 2021 recommendations for ACDC.	

[14] In some instances one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations per MCP should not be used to gauge MCP performance alone.

2021 Recommendation	2022 Assessment
Quality Assessment and Performance Improvement Program	
There were no formal 2021 recommendations for ACDC.	
Grievance and Appeal System	
ACDC should revise its appeals and fair hearing policy to eliminate the requirement for enrollee written confirmation of an oral appeal.	▲ ACDC revised its policy to eliminate the requirement to follow an oral appeal with a written, signed request.
ACDC should revise its provider manual to eliminate the requirement for enrollee written confirmation of an oral appeal.	▲ ACDC revised its provider manual to eliminate the requirement to follow an oral appeal with a written, signed request.
NETWORK ADEQUACY VALIDATION	
ACDC should educate and work with its adult PCPs to improve compliance in obtaining timely routine and urgent appointments (76% and 39% compliance in 2021).	● Compliance in obtaining timely routine and urgent appointments improved (93% and 88% in 2022). There continues to be opportunity to improve performance for urgent appointments.
ACDC should educate and work with its pediatric PCPs to improve compliance in obtaining timely routine and urgent appointments (83% and 70% compliance in 2021).	● Compliance in obtaining timely routine and urgent appointments improved (92% and 77% in 2022). There continues to be opportunity to improve performance for urgent appointments.
ACDC should improve the overall accuracy of its provider directory (51% in 2021). Provider information should be updated on a regular basis.	▼ ACDC's overall accuracy of its provider directory declined (40% in 2022). This opportunity for improvement remains in place and the recommendation continues.
ENCOUNTER DATA VALIDATION	
There were no formal 2021 recommendations for ACDC.	

CFDC

CFDC adequately addressed 6 of 9 recommendations (that could be re-evaluated), demonstrating a 67 percent compliance rating. Table 46 provides details of the 2022 assessment.

Table 46. Assessment of CFDC's Previous Annual Recommendations

2021 Recommendation	2022 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
CFDC should amend its aim statement and clearly specify the population includes enrollees 18-75 years of age with diabetes (type 1 and 2).	▲ CFDC revised its aim statement and specified the population includes enrollees 18-75 years of age with diabetes (type 1 and 2).
CFDC should identify objective, clearly defined, time-specific variables to answer the study question.	▲ CFDC identified discreet variables to answer the study question such as age, diabetes diagnosis, HbA1c levels, and blood pressure readings.
Maternal Health PIP	
CFDC should amend its aim statement and clearly specify the population as women who had a delivery for the prenatal and postpartum measures.	▲ CFDC revised its aim statement and specified the population as women who had a delivery for the prenatal and postpartum measures.
CFDC should identify objective, clearly defined, time-specific variables to answer the study question.	▼ CFDC did not identify qualifying variables to help answer the study question. This opportunity for improvement remains in place and the recommendation continues.

2021 Recommendation	2022 Assessment
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
There were no formal 2021 recommendations for CFDC.	
EPSDT Performance Measures	
There were no formal 2021 recommendations for CFDC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2021 recommendations for CFDC.	
Disenrollment Requirements and Limitations	
There were no formal 2021 recommendations for CFDC.	
Enrollee Rights and Protections	
There were no formal 2021 recommendations for CFDC.	
MCO Standards	
There were no formal 2021 recommendations for CFDC.	
Quality Assessment and Performance Improvement Program	
There were no formal 2021 recommendations for CFDC.	
Grievance and Appeal System	
CFDC should revise its adverse determination notice policy to specify all required adverse determination letter components, including reasons for the adverse benefit determination; and the right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria; and any processes, strategies, or evidentiary standards used in setting coverage limits.	▲ CFDC amended its policy and specified all required adverse determination letter components, including reasons for the adverse benefit determination; and the right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
CFDC should revise its appeals policy to eliminate the requirement for enrollee written confirmation of an oral appeal.	▲ CFDC amended its policy and removed the requirement for enrollee written confirmation of an oral appeal.
CFDC should update its provider manual to eliminate the requirement for enrollee signature of an oral appeal.	▲ CFDC amended its provider manual and eliminated the requirement for enrollee signature of an oral appeal.
NETWORK ADEQUACY VALIDATION	
CFDC received a score of 82% and 83% for timely access to adult and pediatric urgent appointments, respectively. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	● Compliance in obtaining timely pediatric urgent appointments improved (91%). However, compliance in obtaining timely adult urgent appointments decreased in 2022 (79%). This opportunity for improvement for timely access to adult urgent appointments remains and the recommendation continues.
CFDC received a score of 43% for overall provider directory accuracy. CFDC should make provider directory accuracy a priority and update information routinely.	▼ CFDC's overall accuracy of its provider directory declined (30% in 2022). This opportunity for improvement remains in place and the recommendation continues.

2021 Recommendation	2022 Assessment
ENCOUNTER DATA VALIDATION	
There were no formal 2021 recommendations for CFDC.	

HSCSN

HSCSN adequately addressed 9 of 14 recommendations (that could be re-evaluated), demonstrating a 64 percent compliance rating. Table 47 provides details of the 2022 assessment.

Table 47. Assessment of HSCSN's Previous Annual Recommendations

2021 Recommendation	2022 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
DHCF terminated the Comprehensive Diabetes Care PIP for HSCSN and replaced it with Childhood Obesity Management and Prevention. Therefore, follow-up on the Comprehensive Diabetes Care PIP recommendations from 2021 is not applicable.	
Maternal Health PIP	
HSCSN should clearly and correctly identify the full study population in its aim statement. The MCP omitted postpartum women in its aim statement and should correct this omission.	⮝ HSCSN amended the aim statement and included postpartum women as part of the study population.
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
There were no formal 2021 recommendations for HSCSN.	
EPSDT Performance Measures	
There were no formal 2021 recommendations for HSCSN.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2021 recommendations for HSCSN.	
Disenrollment Requirements and Limitations	
There were no formal 2021 recommendations for HSCSN.	
Enrollee Rights and Protections	
There were no formal 2021 recommendations for HSCSN.	
MCO Standards	
There were no formal 2021 recommendations for HSCSN.	
Quality Assessment and Performance Improvement Program	
HSCSN should ensure consistent, quarterly subcommittee reporting to the Quality Management Oversight Committee (QMOC) on key indicator dashboard performance metrics.	⮝ HSCSN provided evidence of consistent subcommittee quarterly reporting to the QMOC.
Grievance and Appeal System	
HSCSN should revise its adverse benefit determination notice policy to eliminate the enrollee's and/or provider's right to directly request a District fair hearing without first exhausting HSCSN's appeal process.	⮝ HSCSN amended its policy and eliminated the enrollee's and/or provider's right to directly request a District fair hearing without first exhausting HSCSN's appeal process.

2021 Recommendation	2022 Assessment
HSCSN should demonstrate consistent compliance in acknowledging appeals within two business days of receipt.	⮝ A random sample record review demonstrated HSCSN complied with consistently acknowledging appeals within two days of receipt.
HSCSN should revise its adverse determination notice policy and provider manual to eliminate the enrollee's written confirmation of an oral appeal.	⮝ HSCSN updated its adverse determination notice policy and provider manual to eliminate the enrollee's written confirmation of an oral appeal.
HSCSN should demonstrate consistent compliance with the 90-day resolution notice requirement for grievances.	⮝ A random sample record review demonstrated HSCSN complied with consistently providing grievance resolution notice within 90 days of grievance receipt.
HSCSN should demonstrate consistent compliance with the 72-hour resolution notice requirement for expedited appeal requests.	⮟ A random sample record review did not conclude HSCSN consistently complied with providing expedited appeal resolution notice within 72 hours of request. This opportunity for improvement remains in place and the recommendation continues.
HSCSN should demonstrate consistent compliance with the requirement to make a reasonable effort to provide oral notice of resolution for an expedited appeal request.	⮝ A random sample record review demonstrated HSCSN complied with consistently making reasonable effort to provide oral notice of resolution for an expedited appeal request.
HSCSN should demonstrate the MCP communicates changes in federal regulations or contractual requirements related to the grievance and appeal system to its providers and delegates/subcontractors.	⮝ HSCSN provided evidence of communicating changes in federal regulations or contractual requirements to its providers and delegates/subcontractors.
HSCSN should demonstrate compliance with its appeal policy, which specifies the reporting structure and frequency of reporting appeal trends, opportunities for improvement, and action items/action plans.	⮝ HSCSN demonstrated consistent compliance with appeal reporting and follow-up action plan requirements.
NETWORK ADEQUACY VALIDATION	
HSCSN received a score of 60% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	⮟ Compliance in obtaining timely adult urgent appointments decreased in 2022 (38%). This opportunity for improvement for timely access to adult urgent appointments remains and the recommendation continues.
HSCSN received scores of 76% and 82% for timely access to pediatric routine and urgent appointments, respectively. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	⮟ Compliance in obtaining timely pediatric routine and urgent appointments decreased in 2022 (75% and 64%, respectively). This opportunity for improvement for timely access to pediatric routine and urgent appointments remains and the recommendation continues.
HSCSN received a score of 46% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	● HSCSN's overall accuracy of its provider directory increased (53% in 2022); however, there is additional opportunity for improvement. The recommendation continues.

2021 Recommendation	2022 Assessment
ENCOUNTER DATA VALIDATION	
HSCSN achieved an encounter data accuracy, or match rate, of 88%. The DHCF-established target was 90%. "No match" reasons were attributed to a lack of supporting documentation in the medical record. HSCSN should educate providers on providing appropriate medical record documentation to support codes for billed claims.	⮟ HSCSN's match rate declined to 84%. This opportunity for improvement for improving medical record documentation remains and the recommendation continues.

MFC

MFC adequately addressed 17 of 22 recommendations (that could be re-evaluated), demonstrating a 77 percent compliance rating. Table 48 provides details of the 2022 assessment.

Table 48. Assessment of MFC's Previous Annual Recommendations

2021 Recommendation	2022 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
MFC should describe how the PIP topic is relevant to its population using MCP-specific data.	⮝ MFC described how the PIP topic is relevant to its population by providing an epidemiological profile on the definition of diabetes, the prevalence of type 1 and type 2 diabetes and associated age ranges, contributing risk factors to the development of the more common type 2 diabetes, and health-related complications of the condition. The MCP also compared its PIP measure performance to national benchmarks and identified opportunities for improvement.
MFC did not describe how it plans to collect data for the PIP. MFC should answer all PIP questions, as directed in the PIP instructions.	⮝ MFC described an adequate data collection plan for the PIP measures.
Maternal Health PIP	
MFC should describe how the PIP topic is relevant to its population, using MCP-specific data.	⮝ MFC reported that its baseline prenatal and postpartum care performance did not compare favorably to the national average benchmarks.
MFC should amend its aim statement to reflect all populations and measures addressed by the PIP.	⮝ MFC revised its aim statement to identify the population targeted by the PIP.
MFC should identify variables that support the PIP study question and adequately contribute to measuring performance such as gender, age, and completed service.	⮝ MFC provided measure specifications. While this response was sufficient, the MCP is encouraged to continue to refine its response and identify variables that support the PIP aim/study question and adequately contribute to measuring performance, such as gender, age, and completed service.

2021 Recommendation	2022 Assessment
MFC should address compliance with administrative data submission requirements by all applicable providers.	⮝ MFC reported its data system captured all inpatient admissions/discharges and confirmed its primary care, specialty care, and ancillary service providers submitted all encounter/utilization data.
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
Due to MFC's contract start date of October 1, 2020, a PMV audit of PIP PMs was not conducted in 2021. Therefore, this element is not applicable.	
EPSDT Performance Measures	
MFC did not collect tooth number data from its dental claims vendor and its source code did not specify tooth number. MFC should collect tooth number data and update its program source code in order to report a rate for the next annual reporting cycle.	⮝ MFC collected the tooth number data and updated its program source code to calculate and report meaningful rates.
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
MFC should update an applicable policy to indicate there is no cost sharing imposed on enrollees.	⮝ MFC updated a relevant policy, indicating there is no cost sharing imposed on enrollees.
Disenrollment Requirements and Limitations	
There were no formal 2021 recommendations for MFC.	
Enrollee Rights and Protections	
There were no formal 2021 recommendations for MFC.	
MCO Standards	
MFC should develop a tracking system to assess compliance for completing Health Risk Assessments, within 90 days of enrollment; and meet its 80% performance threshold.	⮝ MFC provided evidence of a tracking system to access compliance for completing Health Risk Assessments, as required.
The MCP should provide evidence of fully executed agreements/amendments, including required language permitting DHCF, CMS, the HHS Inspector General, the Comptroller General, or their designees access to books, records, contracts, and systems.	⮝ MFC provided evidence of fully executed delegation agreements/amendments, which included language permitting DHCF, CMS, the HHS Inspector General, the Comptroller General, or their designees access to books, records, contracts, and systems.
Quality Assessment and Performance Improvement Program	
There were no formal 2021 recommendations for MFC.	
Grievance and Appeal System	
MFC should amend its adverse benefit determination policy and require sending the enrollee an adverse benefit determination for any claims denial (clean claims only) at the time of the denial.	⮝ MFC provided a relevant adverse benefit determination policy that addresses sending the enrollee an adverse benefit determination for any claims denial (clean claims only) at the time of the denial.

2021 Recommendation	2022 Assessment
MFC should demonstrate consistent compliance in sending enrollees a written acknowledgment, within two business days, of receipt of a grievance and receipt of an appeal.	A random sample review concluded MFC provided consistent timely acknowledgement of appeals, but not grievances. This opportunity for improvement for sending enrollees a written acknowledgment, within two business days, of receipt of a grievance remains; and the recommendation continues.
MFC should revise its grievance and appeal policy to include the requirement to ensure that individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making, nor a subordinate of any such individual.	MFC revised its policy to include the requirement to ensure that individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making, nor a subordinate of any such individual.
MFC should revise its grievance policy to address the requirement to ensure that individuals who make decisions on grievances are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.	MFC amended its grievance policy and included the requirement that ensures individuals who make decisions on grievances are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
MFC's appeals policy requires that an appeal filed orally be followed by a written, signed request, unless the enrollee or authorized representative requests an expedited resolution. This is inconsistent with federal regulations that have eliminated the requirement for written confirmation of an oral appeal. The MCP should revise the policy to eliminate the requirement for written confirmation of an oral appeal.	MFC amended its appeals policy and eliminated the requirement for written confirmation of an oral appeal.
MFC should demonstrate consistent compliance in sending enrollees written resolution of a grievance within 90 calendar days of grievance receipt.	A random sample record review determined MFC consistently met the 90-calendar day timeframe for providing written resolution of a grievance.
MFC should demonstrate consistent compliance in meeting the requirement to provide written resolution of a standard appeal within 30 calendar days.	A random sample of appeal records was reviewed for compliance with the timeframe for enrollee notification of standard appeal resolution. Overall compliance with the 30-day notification timeframe was 96% (up from 90% in 2021). MFC should continue to work toward 100% compliance in meeting the timeframe for enrollee notification of resolution of a standard appeal. While performance improved, this finding remains an opportunity for improvement and the recommendation continues.
MFC should demonstrate consistent compliance in making a reasonable attempt to provide oral notice to the enrollee of an expedited appeal resolution.	A random sample record review determined MFC consistently attempted to provide oral notice of expedited appeal resolutions.

2021 Recommendation	2022 Assessment
MFC should revise its grievance policy to address the requirement for maintaining an accurate and accessible record of grievances for monitoring by the District and CMS.	▲ MFC amended its policy and included the requirement to maintain an accurate and accessible record of grievances for monitoring by the District and CMS.
NETWORK ADEQUACY VALIDATION	
MFC received a score of 82% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	▼ MFC's compliance in obtaining timely adult urgent appointments decreased in 2022 (50%). This opportunity for improvement for timely access to adult urgent appointments remains and the recommendation continues.
MFC received scores of 77% and 50% for timely access to pediatric routine and urgent appointments, respectively. The MC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	● MFC compliance in obtaining timely pediatric routine and urgent appointments improved in 2022 (92% and 82%, respectively). Performance in the pediatric routine appointment measure is adequate; however, performance in the pediatric urgent appointment measure continues to remain an opportunity for improvement. The recommendation remains in place.
MFC received a score of 44% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	▼ MFC's overall accuracy of its provider directory declined significantly (1% in 2022). This finding was largely attributed to an inaccurate representation of the provider accepting new patients (match rate). Provider directory accuracy remains an opportunity for improvement and the recommendation continues.
ENCOUNTER DATA VALIDATION	
Due to MFC's contract start date of October 1, 2020, the EDV activity was not conducted in 2021. Therefore, this element is not applicable, as there are no recommendations to follow up on.	

UHC

UHC's contract commenced on February 1, 2022; therefore, an assessment of previous annual recommendations is not applicable.

State Recommendations

Quality Strategy Goals

DHCF continuously strives to improve the health and well-being of the District's residents. DHCF's mission focuses on improving health outcomes by providing access to comprehensive, cost-effective, and quality health care services. To provide a means for achieving this mission, DHCF drafted its *Medicaid Managed Care Quality Strategy*.[15] Table 49 identifies Quality Strategy goals, using the Institute for Healthcare Improvement Triple Aim framework.

[15] District of Columbia Department of Health Care Finance Medicaid Managed Care Quality Strategy, January 30, 2020

Table 49. DHCF Quality Strategy Goals

Triple Aim Pillar	DHCF Goals	Objectives and Strategies to Achieve Goals
BETTER CARE Improving the patient experience of care	1. Ensure access to quality, whole-person care	• Promoting effective communication between patients and their care providers • Supporting appropriate case management and care coordination • Addressing physical and behavioral health comorbidities
HEALTHY PEOPLE, HEALTHY COMMUNITY Improving the health of District residents	2. Improve management of chronic conditions	• Improving management of pre-diabetes and diabetes • Improving comprehensive behavioral health services
	3. Improve population health	• Improving maternal and child health • Reducing health disparities • Promoting preventive care
PAY FOR VALUE Reducing the cost of health care	4. Ensure high-value, appropriate care	• Incorporating pay for performance programs in all MCP contracts • Directing MCP payments for primary enhancement and local hospital services

Evaluating and Holding MCPs Accountable for Quality Performance

DHCF evaluates MCP progress in meeting Quality Strategy goals through:

- Quality and appropriateness of care assessments
- National performance measures
- Monitoring and compliance
- EQR activities

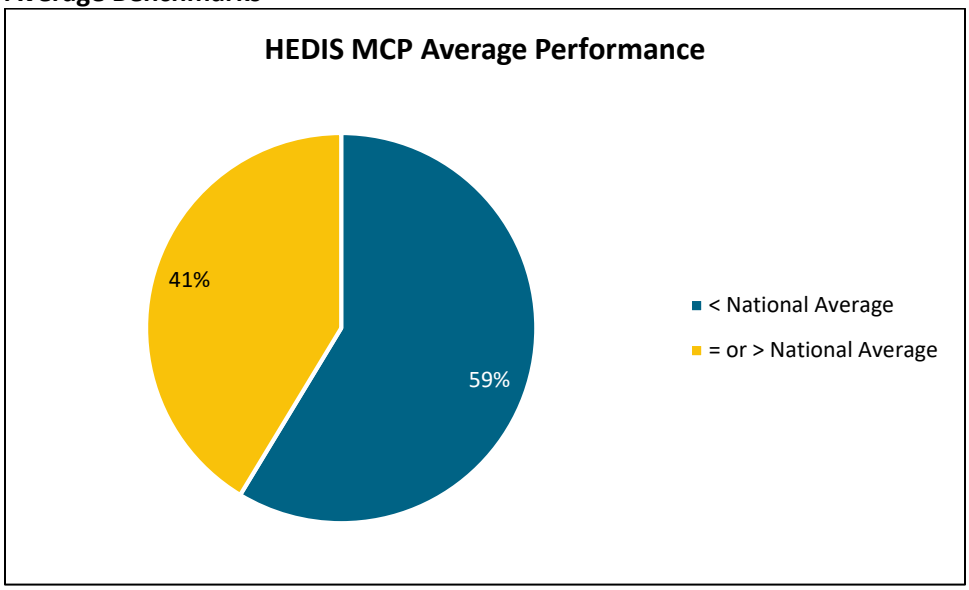
DHCF also holds MCPs accountable through procedures outlined in its *Managed Care Program Quality Management Manual*. The manual describes MCP performance expectations and required follow-up corrective actions. Based on performance, and whether the occurrence is first time or repeated, DHCF may issue a non-compliance warning letter, require a CAP or enhanced monitoring, and/or sanction the noncompliant MCP. As demonstrated in Tables 45-48, which evaluated compliance with previous annual recommendations, this strategy has largely proven its effectiveness.

DHCF has also developed a Managed Care Program Accountability Set, which uses select industry-standard quality performance measures to hold MCPs accountable for their performance and to drive quality improvement. This newly established program uses minimum performance level (MPL) and high performance level (HPL) benchmarks to evaluate MCP performance, and is projected to go into effect October 1, 2024. The MCPs will be required to meet the MPL for measures established by DHCF. MCPs failing to meet the MPLs for select measures may have to develop a CAP or participate in enhanced monitoring, and/or complete technical assistance sessions. MCPs meeting or exceeding HPL benchmarks will receive public recognition.

Recommendations on How DHCF Can Target Quality Strategy Goals and Objectives

The intent of the Medicaid Managed Care Quality Strategy is to provide an overarching framework for DHCF to drive quality and performance improvement among its contracted MCPs, with the ultimate goal of improving health outcomes for its enrollees. While MCPs are committed to quality and have developed strategies to demonstrate improvement, they are all in a position in which there is an opportunity to close gaps in care and quality. An analysis of HEDIS and CAHPS survey measures, included in Appendix A1 and A2, respectively, demonstrate MCP averages fall short of meeting national average benchmarks in many measures relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care. Figure 23 illustrates the DC MCP averages performed better than national average benchmarks in 41 percent of select HEDIS measures. While this is an improvement compared to the previous annual rate of 35 percent, it falls short in comparison to national performance, and signifies an opportunity for improvement. This same type of analysis was not completed for the CAHPS survey measures (as done in pervious ATRs), due to an excessive number of small denominators (less than 100 responses).

Figure 23. MY 2021 HEDIS MCP Average Performance Compared to National Average Benchmarks



Qlarant makes several recommendations below for DHCF to consider. Recommendations describe how DHCF can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to DC managed care enrollees.

After the MCPs report MY 2022 performance in 2023 for the Comprehensive Diabetes Care PIP, they will have reported five years of remeasurement results. ***Qlarant recommends*** DHCF close out the Comprehensive Diabetes Care PIP and implement a replacement PIP targeting Goal 2, which includes improving comprehensive behavioral health services. An example of a PIP targeting this goal and objective includes Improving Mental Health by targeting Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up After Hospitalization for Mental Illness measures.

The MCPs are required to conduct an initial screening of each enrollee's physical, behavioral, and social needs upon enrollment. Barriers exist to obtaining this critical information from enrollees, which can negatively impact care coordination and management. ***Qlarant recommends*** DHCF establish targets for the MCPs to complete initial screenings within 30, 60, and 90 days. MCPs should make multiple attempts to obtain and complete these screenings, which provide valuable information, including identification of risk factors, such as social determinants of health (SDoH), chronic conditions, substance use, mental health disorders, and other health and safety issues. If MCPs improve compliance in completing these screenings, they can potentially achieve improvements related to Goals 1-3 by ensuring access to quality, whole-person care; improving the management of chronic conditions; and improving population health.

Qlarant reports on key measures from the CAHPS experience of care survey in Appendix A2. Overall, the MCPs performed below the national average on the Rating of Health Plan measure. ***Qlarant recommends*** DHCF review CAHPS survey performance and identify one or more measures for the MCPs to target and direct strategies to improve performance. For example, Qlarant recommends MCPs aim to improve performance in the Rating of Health Plan measure. Targeting this measure aligns with Goal 1, ensuring access to quality, whole-person care.

The MCPs are required to resolve, track, and report enrollee grievances. The MCPs should be addressing barriers and improving enrollee experiences. ***Qlarant recommends*** DHCF develop, or have Qlarant develop, a focused study on enrollee grievances that aggregates and analyzes MCP grievances. The study should identify trends, barriers, and actions to improve performance. This will provide DHCF with additional insight into enrollee grievances and support the Triple Aim Pillar, improving the patient experience of care.

DHCF is implementing a new Managed Care Program Accountability Set program to hold MCPs responsible for their performance and encourage improvements. ***Qlarant recommends*** DHCF leverage EQRO expertise in selecting meaningful measures, MPLs, HPLs, and analysis of results. This accountability program has the potential to positively impact performance related to all four Quality Strategy goals.

Confidence levels in MCP compliance have been established for EQR tasks, including PIP validation, PMV, and OSRs. For example, an MCP scoring between 95 and 100 percent in the OSR task is assigned a high confidence level, meaning stakeholders can have high confidence in the MCP's level of compliance with structural and operational standards. Levels of confidence have not been established for NAV or EDV. ***Qlarant recommends*** DHCF work with the EQRO to establish confidence levels for these activities, so all EQR tasks have clear thresholds to assist MCPs in driving process improvement and DHCF in holding them accountable. This recommendation supports all DHCF Quality Strategy goals, but specifically enhances DHCF's ability to hold MCPs accountable to meet specific performance thresholds.

DHCF is implementing a new District Dual Choice Program, which includes a D-SNP effective February 1, 2022. ***Qlarant recommends*** DHCF collaborate with the EQRO and provide an opportunity for the EQRO to orient and provide technical assistance to the D-SNP to ensure it is developing a sound quality program and meeting operational standards. Developing a compliant structure and strategy to build upon will help facilitate success and support DHCF goals.

DHCF is expanding behavioral health services in its Medicaid managed care program. ***Qlarant recommends*** DHCF identify specific behavioral health performance measures, monitor baseline

performance, and set targets that drive performance improvement. Consider incorporating such measures into the Managed Care Program Accountability Set. This recommendation supports Goals 1 and 2 and their respective objectives of addressing behavioral health comorbidities and improving comprehensive behavioral health services.

DHCF is holding MCPs accountable, as previously described, by way of procedures outlined in its *Managed Care Program Quality Management Manual*. This strategy appears to make an impact. The 2022 EQR activities found MCPs fully addressed the majority of recommendations made in 2021—ACDC: 57 percent, CFDC: 67 percent, HSCSN: 64 percent, and MFC: 77 percent. ***Qlarant recommends*** DHCF continue to hold MCPs responsible for performance and require corrective actions. These improvements influence performance and advancements in meeting Goals 1-3.

DHCF's *Medicaid Managed Care Quality Strategy* identifies objectives and strategies to achieve goals, which are meaningful to DCHFP and CASSIP. ***Qlarant recommends*** DHCF update the Quality Strategy to also include objectives and strategies related to the new District Dual Choice Program. This will provide a quality improvement framework and help the D-SNP prioritize initiatives to meet DHCF-established goals to ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care.

Conclusion

As the District's contracted EQRO, Qlarant evaluated DHCF's managed care programs, including DCHFP, CASSIP, and DDCP, to assess compliance with federal and DC-specific requirements. Review and validation activities occurred over the course of 2022 and assessed MY 2021 and MY 2022 performance, as applicable. Qlarant evaluated each participating MCP and found:

- For the Comprehensive Diabetes Care PIP, the DCHFP MCPs reported their fourth remeasurement results. Overall, there is a high level of confidence in MCP PIP-reported activities and findings. An analysis of the MCP weighted averages concluded performance improved over baseline performance in one measure, HbA1c Testing. Performance improved over previous annual reporting (MY 2021 compared to MY 2020) in HbA1c Testing and HbA1c Poor Control (>9%). The MCPs continued to engage enrollees via telehealth and virtual services to address COVID-19 public health emergency barriers to care.
- The DCHFP and CASSIP MCPs reported their second remeasurement results for the Maternal Health PIP. Overall, there is a high level of confidence in MCP PIP-reported activities and findings. Most interventions focused on the early identification of pregnant enrollees and attempts to engage them in appropriate prenatal and postpartum care. These efforts contributed to success in achieving sustained improvement in the Timeliness of Prenatal Care measure (MCP weighted average).
- The CASSIP MCP implemented a new PIP, Childhood Obesity Management and Prevention. HSCSN reported baseline performance and achieved a high confidence rating in its PIP.
- The DDCP D-SNP initiated a proposal PIP, Fall Risk Management. UHC reported a comprehensive description of the PIP population, performance measures, and data collection plan, and received a high confidence rating.
- All MCPs had appropriate systems in place to process accurate claims and encounters. All MCPs received "reportable" designations for the calculation of PIP, CMS Adult and Child Core Set, and EPSDT measures.

- MCPs had operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. The overall 2022 weighted OSR score was 98 percent, which demonstrates improvement compared to the previous two OSRs. All MCPs were required to complete CAPs, most of which related to the Grievance and Appeal System Standard.
- MCPs have robust PCP networks demonstrating compliance with geographic and provider-to-enrollee requirements. MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 38 to 93 percent for 2022. Access to adult urgent and pediatric routine and urgent care improved during 2022, compared to 2021, based on MCP averages. A six-percentage point decline was noted for adult access to routine care. Overall accuracy of MCP online provider directories continued to decline. The Acceptance of New Patients (discrepancies) measure is the leading contributing factor to the low overall accuracy rate.
- A medical record review, for the EDV activity, determined an overall high level of encounter data accuracy (92%). While performance declined over this last year (down from 95%), it exceeded the DHCF-established target of 90 percent for the second annual EDV study.
- All MCPs demonstrated strengths and weaknesses in the areas of quality, access, and timeliness. MCPs should address specific recommendations made to improve performance in these areas.
- The MCPs adequately addressed most, but not all, of their previous annual recommendations. MCPs should focus efforts on addressing all recommendations to demonstrate improvements in quality, access, and timeliness.
- DHCF continues to strive to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services through its managed care programs. DHCF's *Medicaid Managed Care Quality Strategy* provides a framework to achieve improvements and ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care.
- DHCF should consider implementing Qlarant's recommendations, which if acted upon, may improve processes and close gaps in care and quality. Recommendations describe how DHCF can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to DC managed care enrollees.

Appendix 1 - HEDIS® Measures Collected and Reported to NCQA

The table below includes 2022 (MY 2021) Health Care Effectiveness Data and Information Set (HEDIS®) performance measure results for each District of Columbia managed care plan (MCP) and a comparison to National Committee for Quality Assurance (NCQA) Quality Compass Medicaid Health Maintenance Organization (HMO) benchmarks. The MCP average is compared to benchmarks, using a diamond rating system, as defined below.

♦♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.
♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.
♦ MCP rate is below the NCQA Quality Compass National Average.

Table 1. Appendix 1 – HEDIS Performance Measures

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (18-64 Yrs)	48.00	59.65	NA	NA	NA	NC
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (3 months-17 Yrs)	92.39	93.62	NA	95.00	NA	NC
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (65+ Yrs)	NA	NA	NA	NA	NA	NC
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Total)	66.82	75.00	NA	83.08	NA	NC
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44 Yrs)	69.28	54.11	80.82	50.84	63.76	♦
AAP	Adults' Access to Preventive/Ambulatory Health Services (45-64 Yrs)	79.91	67.00	NA	63.30	NA	NC
AAP	Adults' Access to Preventive/Ambulatory Health Services (65+ Yrs)	74.82	69.35	NA	72.33	NA	NC
AAP	Adults' Access to Preventive/Ambulatory Health Services (Total)	73.05	58.52	80.82	55.21	66.90	♦
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	NA	NA	NA	NA	NA	NC
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.03	30.00	43.01	NA	NA	NC
ADV	Annual Dental Visit (11-14 Yrs)	62.42	53.87	62.75	44.62	55.92	♦♦
ADV	Annual Dental Visit (15-18 Yrs)	60.14	49.69	57.86	39.59	51.82	♦♦
ADV	Annual Dental Visit (19-20 Yrs)	41.34	32.52	47.58	27.95	37.35	♦♦♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
ADV	Annual Dental Visit (2-3 Yrs)	50.56	47.27	51.05	35.09	45.99	♦ ♦ ♦
ADV	Annual Dental Visit (4-6 Yrs)	59.58	53.55	62.77	42.83	54.68	♦
ADV	Annual Dental Visit (7-10 Yrs)	62.12	55.06	63.57	46.06	56.70	♦
ADV	Annual Dental Visit (Total)	58.48	51.14	59.49	41.52	52.66	♦ ♦
AMB	Ambulatory Care - Emergency Dept Visits/1000 MM (Total)	54.68	48.15	64.11	46.68	53.41	♦ ♦ ♦
AMB	Ambulatory Care - Outpatient Visits/1000 MM (Total)	309.99	218.98	277.59	218.48	256.26	♦
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	54.91	48.48	31.25	54.17	47.20	♦
AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment	36.13	31.96	15.63	37.88	30.40	♦
AMR	Asthma Medication Ratio (12-18 Yrs)	56.02	NA	69.61	NA	NA	NC
AMR	Asthma Medication Ratio (19-50 Yrs)	52.23	64.10	62.50	NA	NA	NC
AMR	Asthma Medication Ratio (5-11 Yrs)	70.70	NA	81.31	NA	NA	NC
AMR	Asthma Medication Ratio (51-64 Yrs)	50.98	NA	NA	NA	NA	NC
AMR	Asthma Medication Ratio (Total)	56.94	66.28	73.86	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11 Yrs)	NA	NA	NA	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17 Yrs)	30.91	NA	42.17	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	29.17	NA	35.71	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11 Yrs)	NA	NA	NA	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17 Yrs)	38.18	NA	61.45	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	36.11	NA	56.25	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11 Yrs)	NA	NA	NA	NA	NA	NC

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17 Yrs)	36.36	NA	43.37	NA	NA	NC
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	33.33	NA	37.50	NA	NA	NC
APP	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	~	45.30	NA	43.53	NA	NC
APP	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment – Initiation of AOD – Other Drug Abuse or Dependence (Total)	~	35.73	NA	31.26	NA	NC
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11 Yrs)	NA	NA	NA	NA	NA	NC
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Yrs)	NA	NA	NA	NA	NA	NC
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	31.58	NA	27.27	NA	NA	NC
BCS	Breast Cancer Screening	59.87	45.10	~	NA	NA	NC
CBP	Controlling High Blood Pressure	50.36	46.96	NA	32.36	NA	NC
CCS	Cervical Cancer Screening	57.22	51.15	54.48	29.44	48.07	♦
CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	51.09	51.34	51.52	23.11	44.27	♦
CDC	Comprehensive Diabetes Care - Eye Exams	46.96	43.07	51.52	29.68	42.81	♦
CDC	Comprehensive Diabetes Care - HbA1c Control (<8%)	51.58	43.80	30.30	38.20	40.97	♦
CDC	Comprehensive Diabetes Care - HbA1c Testing	87.59	82.00	84.85	79.81	83.56	♦
CDC	Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) *Lower is Better*	39.90	45.50	63.64	55.47	51.13	♦
CHL	Chlamydia Screening in Women (16-20 Yrs)	74.01	63.97	71.81	74.46	71.06	♦♦♦♦
CHL	Chlamydia Screening in Women (21-24 Yrs)	78.73	72.99	80.23	73.20	76.29	♦♦♦♦
CHL	Chlamydia Screening in Women (Total)	76.27	68.69	75.83	73.84	73.66	♦♦♦♦
CIS	Childhood Immunization Status - Combination 10	19.71	18.98	23.81	18.98	20.37	♦
CIS	Childhood Immunization Status - Combination 3	48.66	38.20	58.73	38.44	46.01	♦
CIS	Childhood Immunization Status - Combination 7	37.23	32.12	39.68	31.14	35.04	♦
CIS	Childhood Immunization Status - DTaP	59.37	45.01	71.43	43.07	54.72	♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
CIS	Childhood Immunization Status - Hepatitis A	76.64	63.75	90.48	74.21	76.27	♦
CIS	Childhood Immunization Status - Hepatitis B	72.99	61.31	73.02	56.20	65.88	♦
CIS	Childhood Immunization Status - HiB	76.40	61.80	82.54	54.01	68.69	♦
CIS	Childhood Immunization Status - Influenza	34.06	29.44	42.86	29.93	34.07	♦
CIS	Childhood Immunization Status - IPV	78.10	63.50	82.54	55.23	69.84	♦
CIS	Childhood Immunization Status - MMR	77.62	65.69	92.06	68.37	75.94	♦
CIS	Childhood Immunization Status - Pneumococcal Conjugate	60.58	45.50	69.84	42.09	54.50	♦
CIS	Childhood Immunization Status - Rotavirus	52.80	41.12	53.97	37.23	46.28	♦
CIS	Childhood Immunization Status - VZV	77.62	65.21	93.65	72.02	77.13	♦
COU	Risk of Continued Opioid Use >= 15 Days (18-64 Yrs) *Lower is Better*	3.30	1.98	1.08	2.53	2.22	♦♦♦♦
COU	Risk of Continued Opioid Use >= 15 Days (65 Yrs) *Lower is Better*	NA	NA	NA	NA	NA	NC
COU	Risk of Continued Opioid Use >= 15 Days (Total) *Lower is Better*	3.29	1.97	1.08	2.62	2.24	♦♦♦♦
COU	Risk of Continued Opioid Use >= 30 Days (18-64 Yrs) *Lower is Better*	1.75	0.96	1.08	0.89	1.17	♦ ♦ ♦
COU	Risk of Continued Opioid Use >= 30 Days (65 Yrs) *Lower is Better*	NA	NA	NA	NA	NA	NC
COU	Risk of Continued Opioid Use >= 30 Days (Total) *Lower is Better*	1.75	0.95	1.08	0.89	1.17	♦ ♦ ♦
CRE	Cardiac Rehabilitation - Achievement (18-64 Yrs)	0.61	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Achievement (65 Yrs)	NA	NA	~	NA	NA	NC
CRE	Cardiac Rehabilitation - Achievement (Total)	0.61	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Engagement 1 (18-64 Yrs)	0.00	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Engagement 1 (65+ Yrs)	NA	NA	~	NA	NA	NC
CRE	Cardiac Rehabilitation - Engagement 1 (Total)	0.00	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Engagement 2 (18-64 Yrs)	0.61	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Engagement 2 (65 Yrs)	NA	NA	~	NA	NA	NC
CRE	Cardiac Rehabilitation - Engagement 2 (Total)	0.61	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Initiation (18-64 Yrs)	0.00	0.00	~	0.00	NA	NC
CRE	Cardiac Rehabilitation - Initiation (65+ Yrs)	NA	NA	~	NA	NA	NC

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
CRE	Cardiac Rehabilitation - Initiation (Total)	2.00	2.00	~	0.00	NA	NC
CWP	Appropriate Testing for Children with Pharyngitis (18-64 Yrs)	57.81	48.48	NA	55.67	NA	NC
CWP	Appropriate Testing for Children with Pharyngitis (3-17 Yrs)	85.85	49.25	NA	83.05	NA	NC
CWP	Appropriate Testing for Children with Pharyngitis (65+ Yrs)	NA	NA	NA	NA	NA	NC
CWP	Appropriate Testing for Children with Pharyngitis (Total)	64.48	48.68	72.22	61.83	61.80	♦
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (13-17 Yrs)	~	NA	NA	NA	NA	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (18+ Yrs)	~	4.48	NA	3.10	NA	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (Total)	~	4.47	NA	3.09	NA	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (13-17 Yrs)	~	NA	NA	NA	NA	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (18+ Yrs)	~	1.92	NA	1.55	NA	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (Total)	~	1.92	NA	1.54	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (18-64 Yrs)	49.41	27.98	29.03	5.52	27.99	♦
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (6-17 Yrs)	45.83	40.00	42.11	NA	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (Total)	49.17	28.66	36.23	5.88	29.99	♦
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (18-64 Yrs)	34.57	20.17	25.81	2.45	20.75	♦
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (6-17 Yrs)	20.83	23.33	28.95	NA	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (Total)	33.70	20.33	27.54	2.65	21.06	♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (13-17 Yrs)	~	NA	NA	NA	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (18-64 Yrs)	~	29.36	NA	19.74	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (65+ Yrs)	~	NA	NA	NA	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (Total)	~	29.36	NA	20.78	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (13-17 Yrs)	~	NA	NA	NA	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (18-64 Yrs)	~	13.57	NA	11.84	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (65+ Yrs)	~	NA	NA	NA	NA	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (Total)	~	13.57	NA	12.99	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (18-64 Yrs)	30.29	18.09	NA	6.88	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (6-17 Yrs)	56.96	NA	73.85	NA	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (Total)	35.57	23.56	60.98	9.84	32.49	♦
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (18-64 Yrs)	19.54	9.55	NA	4.13	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (6-17 Yrs)	44.30	NA	47.69	NA	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (Total)	24.48	14.67	40.24	6.56	21.49	♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
HDO	Use of Opioids at High Dosage (HDO) *Lower is Better*	1.06	2.79	NA	2.27	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+ Yrs)	~	4.66	NA	2.05	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	~	4.65	NA	2.05	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18 + Yrs)	~	10.68	NA	10.34	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	~	10.68	NA	10.34	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+ Yrs)	~	1.98	NA	1.47	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	~	1.96	NA	1.45	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+ Yrs)	~	4.12	NA	2.83	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	~	4.09	0.00	2.81	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+ Yrs)	~	40.81	NA	35.38	NA	NC

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	~	40.76	NA	35.38	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13 - 17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+ Yrs)	~	45.30	NA	43.53	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13 - 17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+ Yrs)	~	35.97	NA	31.55	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17 Yrs)	~	NA	NA	NA	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+ Yrs)	~	36.84	NA	33.30	NA	NC
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	~	36.68	21.21	33.13	NA	NC
IMA	Immunizations for Adolescents - Combination 1	75.43	64.96	86.22	55.96	70.64	♦
IMA	Immunizations for Adolescents - Combination 2	47.20	31.87	53.06	24.57	39.18	♦ ♦
IMA	Immunizations for Adolescents - HPV	50.61	37.47	55.10	27.01	42.55	♦ ♦
IMA	Immunizations for Adolescents - Meningococcal	76.64	68.37	87.76	58.39	72.79	♦
IMA	Immunizations for Adolescents - Tdap/Td	80.54	71.53	90.31	60.34	75.68	♦
KED	Kidney Health Evaluation for Patients With Diabetes (18-64 Yrs)	44.68	45.72	33.33	44.07	41.95	♦ ♦ ♦
KED	Kidney Health Evaluation for Patients With Diabetes (65-74 Yrs)	46.67	57.63	NA	51.52	NA	NC
KED	Kidney Health Evaluation for Patients With Diabetes (75-85 Yrs)	50.00	56.67	NA	44.44	NA	NC
KED	Kidney Health Evaluation for Patients With Diabetes (Total)	44.74	46.17	33.33	44.28	42.13	♦ ♦ ♦
LBP	Use of Imaging Studies for Low Back Pain	85.96	87.81	NA	81.75	NA	NC
LSC	Lead Screening in Children	72.99	53.04	82.81	55.23	66.02	♦ ♦
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females *Lower is Better*	0.38	0.22	0.88	0.11	0.40	♦ ♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
PBH	Persistence of Beta-Blocker Treatment after a Heart Attack	65.38	NA	NA	58.06	NA	NC
PCE	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	91.21	84.93	~	86.80	NA	NC
PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	72.38	63.01	~	69.60	NA	NC
PCR	Plan All-Cause Readmissions (18-64) *Lower is Better*	0.97	1.34	NA	1.43	NA	NC
POD	Pharmacotherapy for Opioid Use Disorder (16-64 Yrs)	15.73	16.36	NA	21.98	NA	NC
POD	Pharmacotherapy for Opioid Use Disorder (65+ Yrs)	NA	NA	NA	NA	NA	NC
POD	Pharmacotherapy for Opioid Use Disorder (Total)	15.38	17.12	NA	23.40	NA	NC
PPC	Prenatal and Postpartum Care - Postpartum Care	74.09	71.29	57.45	69.83	68.17	♦
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	86.59	76.40	82.98	82.00	81.99	♦
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	42.05	47.06	NA	48.57	NA	NC
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	NA	NC
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	50.56	49.64	NA	42.68	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	73.68	NA	NA	NA	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	74.47	NA	NA	NA	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	74.12	NA	NA	NA	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	66.07	NA	NA	NA	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	65.71	NA	NA	NA	NA	NC
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	65.87	NA	NA	NA	NA	NC
SPD	Statin Therapy for Patients With Diabetes - Received Statin Therapy	67.38	64.57	NA	NA	NA	NC
SPD	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	65.07	50.69	NA	NA	NA	NC
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.47	NA	~	NA	NA	NC

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	77.23	53.34	83.33	80.47	73.59	♦
UOP	Use of Opioids From Multiple Providers - Multiple Pharmacies *Lower is Better*	7.56	5.98	NA	5.48	NA	NC
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies *Lower is Better*	3.82	2.85	NA	4.50	NA	NC
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers *Lower is Better*	29.93	26.21	NA	31.90	NA	NC
URI	Appropriate Treatment for Upper Respiratory Infection (18-64 Yrs)	87.14	88.30	NA	89.80	NA	NC
URI	Appropriate Treatment for Upper Respiratory Infection (3 months-17 Yrs)	98.03	98.91	98.21	97.56	98.18	♦♦♦♦
URI	Appropriate Treatment for Upper Respiratory Infection (65+ Yrs)	NA	NA	NA	NA	NA	NC
URI	Appropriate Treatment for Upper Respiratory Infection (Total)	94.57	95.22	97.76	95.17	95.68	♦ ♦ ♦
W30	Well-Child Visits in the First 30 Months of Life (0-15 Months)	56.45	39.21	51.95	43.36	47.74	♦
W30	Well-Child Visits in the First 30 Months of Life (15-30 Months)	33.49	17.45	15.79	5.71	18.11	♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (12-17 Yrs)	74.80	80.00	78.42	53.68	71.73	♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (3-11 Yrs)	77.22	79.35	80.54	59.27	74.10	♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	76.39	79.56	79.56	57.42	73.23	♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Yrs)	74.80	85.19	80.53	52.21	73.18	♦ ♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Yrs)	72.57	79.35	77.38	57.09	71.60	♦ ♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	73.33	81.27	78.83	55.47	72.23	♦ ♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Yrs)	73.17	85.93	78.95	52.21	72.57	♦ ♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Yrs)	71.31	73.91	74.66	54.18	68.52	♦ ♦

Measure		ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	71.94	77.86	76.64	53.53	69.99	♦ ♦
WCV	Child and Adolescent Well-Care Visits (12-17 Yrs)	62.22	50.18	61.37	45.47	54.81	♦ ♦
WCV	Child and Adolescent Well-Care Visits (18-21 Yrs)	36.36	27.67	47.27	22.18	33.37	♦ ♦ ♦
WCV	Child and Adolescent Well-Care Visits (3-11 Yrs)	62.32	52.49	65.18	50.27	57.57	♦ ♦
WCV	Child and Adolescent Well-Care Visits (Total)	58.36	48.43	59.85	44.93	52.89	♦ ♦

HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Benchmark source: *Quality Compass 2022 (Measurement Year 2021 data) National Medicaid Average for All Lines Business and Quality of Care for Adults in Medicaid.*

♦♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.

♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.

♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.

♦ MCP rate is below the NCQA Quality Compass National Average.

NC No Comparison: No Comparison made due to no rate and/or no benchmark available.

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

~ No Data/Not Reported: Not reported due to measure not required for reporting or newly added, replaced, or retired.

Appendix 2 – CAHPS® Survey Results

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey

The CAHPS Health Plan Survey collects information on enrollees' experiences with health plans and their services. The survey measure tables include 2022 (MY 2021) results for each District of Columbia managed care plan (MCP) and a comparison to the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid Health Maintenance Organization (HMO) benchmarks. The MCP average is compared to benchmarks, using a diamond rating system, as defined below.

♦♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.
♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.
♦ MCP rate is below the NCQA Quality Compass National Average.

Table 1. Appendix 2 – CAHPS Health Plan Survey Measures, Medicaid Adult and Child

Member Experience - Medicaid Population	ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
ADULT MEDICAID SURVEY						
Getting Care						
Getting Needed Care Composite (% Always or Usually)	82.66	74.03	NA	NA	NA	NC
Ease of Getting Needed Care (% Always or Usually)	86.36	76.53	NA	NA	NA	NC
Ease of Seeing a Specialist (% Always or Usually)	78.95	71.54	NA	NA	NA	NC
Getting Care Quickly Composite (% Always or Usually)	73.25	70.06	NA	NA	NA	NC
Ease of Getting Urgent Care (% Always or Usually)	71.96	NA	NA	NA	NA	NC
Ease of Getting a Check-up or Routine Care (% Always or Usually)	74.54	66.31	NA	NA	NA	NC
Satisfaction with Physicians						
Rating of Personal Doctor (% 9 or 10)	71.14	63.77	68.00	NA	67.64	♦
Rating of Specialist Seen Most Often (% 9 or 10)	70.00	68.10	NA	NA	NA	NC
Rating of All Health Care (% 9 or 10)	57.34	54.64	NA	NA	NA	NC
Coordination of Care (% Always or Usually)	83.19	NA	NA	NA	NA	NC
Overall Ratings						
Rating of Health Plan (% 8, 9, or 10)	80.46	72.07	72.55	NA	75.03	♦

Member Experience - Medicaid Population	ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
Rating of All Health Care (% 8, 9, or 10)	81.19	73.71	NA	NA	NA	NC
Rating of Personal Doctor (% 8, 9, or 10)	86.59	80.68	84.00	NA	83.76	♦ ♦
Rating of Specialist Seen Most Often (% 8, 9, or 10)	85.63	78.45	NA	NA	NA	NC
Additional Measures						
How Well Doctors Communicate Composite (% Always or Usually)	95.89	92.01	NA	NA	NA	NC
Doctor Explained Things (% Always or Usually)	96.39	94.58	NA	NA	NA	NC
Doctor Listened Carefully (% Always or Usually)	95.38	92.12	NA	NA	NA	NC
Doctor Showed Respect (% Always or Usually)	96.92	95.21	NA	NA	NA	NC
Doctor Spent Enough Time (% Always or Usually)	94.87	86.14	NA	NA	NA	NC
Customer Service Composite (% Always or Usually)	90.35	86.60	NA	NA	NA	NC
Customer Service Provided Information/Help (% Always or Usually)	86.96	79.45	NA	NA	NA	NC
Customer Service Was Courteous/Respectful (% Always or Usually)	93.75	93.75	NA	NA	NA	NC
Forms Easy to Fill Out (No + Usually + Always)	97.62	93.91	90.20	NA	93.91	♦
Additional Adult Medicaid Effectiveness of Care Measures						
Flu Vaccinations for Adults (% Yes)	43.77	47.31	39.44	NA	43.51	♦ ♦
Advising Smokers and Tobacco Users to Quit (% Sometimes, Usually, or Always)	75.74	73.29	NA	NA	NA	NC
Discussing Cessation Medications (% Sometimes, Usually, or Always)	52.07	47.97	NA	NA	NA	NC
Discussing Cessation Strategies (% Sometimes, Usually, or Always)	48.82	46.90	NA	NA	NA	NC
CHILD MEDICAID SURVEY						
Getting Care						
Getting Needed Care Composite (% Always or Usually)	NA	NA	78.56	NA	NA	NC
Ease of Getting Needed Care (% Always or Usually)	78.57	NA	82.56	NA	NA	NC
Ease of Seeing a Specialist (% Always or Usually)	NA	NA	74.56	NA	NA	NC
Getting Care Quickly Composite (% Always or Usually)	NA	NA	81.31	NA	NA	NC
Ease of Getting Urgent Care (% Always or Usually)	NA	NA	NA	NA	NA	NC
Ease of Getting a Check-up or Routine Care (% Always or Usually)	71.11	NA	78.84	NA	NA	NC
Satisfaction with Physicians						
Rating of Personal Doctor (% 9 or 10)	72.84	NA	79.83	NA	NA	NC
Rating of Specialist Seen Most Often (% 9 or 10)	NA	NA	69.52	NA	NA	NC
Rating of All Health Care (% 9 or 10)	66.67	NA	68.75	NA	NA	NC
Coordination of Care (% Always or Usually)	NA	NA	NA	NA	NA	NC

Member Experience - Medicaid Population	ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
Overall Ratings						
Rating of All Health Care (% 8, 9, or 10)	78.01	NA	81.82	NA	NA	NC
Rating of Personal Doctor (% 8, 9, or 10)	83.95	NA	87.98	NA	NA	NC
Rating of Specialist Seen Most Often (% 8, 9, or 10)	NA	NA	83.81	NA	NA	NC
Rating of Health Plan (% 8, 9, or 10)	82.93	NA	78.13	NA	NA	NC
Rating of Health Plan (9+10)	66.34	NA	64.84	NA	NA	NC
Additional Measures						
How Well Doctors Communicate Composite (% Always or Usually)	89.19	NA	93.27	NA	NA	NC
Doctor Explained Things (% Always or Usually)	90.68	NA	92.78	NA	NA	NC
Doctor Listened Carefully (% Always or Usually)	94.17	NA	94.44	NA	NA	NC
Doctor Showed Respect (% Always or Usually)	92.44	NA	97.21	NA	NA	NC
Doctor Spent Enough Time (% Always or Usually)	79.49	NA	88.64	NA	NA	NC
Customer Service Composite (% Always or Usually)	NA	NA	91.67	NA	NA	NC
Customer Service Provided Information/Help (% Always or Usually)	NA	NA	90.35	NA	NA	NC
Customer Service Was Courteous/Respectful (% Always or Usually)	NA	NA	92.98	NA	NA	NC
Forms Easy to Fill Out (No + Usually + Always)	96.06	NA	93.31	NA	NA	NC
Additional Child Medicaid Children with Chronic Conditions (CCC) Population Measure Survey						
Getting Needed Information (% Always or Usually)	NA	NA	89.86	~	NA	NC
Access to Prescription Medicines (% Always or Usually)	NA	NA	83.77	~	NA	NC
Coordination of Care for Children With Chronic Conditions (% Yes)	NA	NA	NA	~	NA	NC
Personal Doctor Who Knows Child (% Yes)	NA	NA	93.23	~	NA	NC
Access to Specialized Services (% Always or Usually)	NA	NA	62.42	~	NA	NC
Rating of Health Plan (9+10)	NA	NA	NA	~	NA	NC

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♦♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.

♦♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.

♦♦ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.

♦ MCP rate is below the NCQA Quality Compass National Average.

NC No Comparison: No Comparison made due to no rate or/and no benchmark available

NA Small Denominator: The organization followed the specifications, but the denominator was too small (<100) to report a valid rate

~ No Data: No rate reported due to new measure, measure retired, or survey not conducted

CAHPS Mental Health Care Survey—Experience of Care and Health Outcomes (ECHO)

The CAHPS ECHO Survey collects information on enrollees' experiences with behavioral health care and services. Table 2 includes 2022 (MY 2021) results for each District of Columbia MCP and a comparison to the SPH Analytics ECHO benchmarks. The MCP average is compared to benchmarks, using a diamond rating system, as defined below.

♦♦♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB 90th Percentile.
♦♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB Average, but does not meet the 75th Percentile.
♦ MCP rate is below the SPH Analytics 2020 ECHO BoB Average.

Table 2. Appendix 2 – CAHPS ECHO Survey Measures, Adult

Experience of Care and Health Outcomes (ECHO) Survey	ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
ADULT SURVEY						
Getting Treatment Quickly Composite	67.5	67.0	~	~	67.25	♦
In the last 12 months, how often did you get the professional counseling you needed on the phone?	64.4	65.0	~	~	64.70	♦♦♦
In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	67.6	59.0	~	~	63.30	♦
In the last 12 months, not counting the times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?	70.4	76.0	~	~	73.20	♦
How Well Clinicians Communicate	83.0	89.0	~	~	86.00	♦
In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	82.1	81.0	~	~	81.55	♦
In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	82.9	91.0	~	~	86.95	♦
In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	90.2	96.0	~	~	93.10	♦
In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?	74.4	87.0	~	~	80.70	♦

Experience of Care and Health Outcomes (ECHO) Survey	ACDC %	CFDC %	HSCSN %	MFC %	MCP AVG %	Comparison to Benchmarks
In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?	85.4	89.0	~	~	87.20	♦
Informed About Treatment Options	46.9	64.0	~	~	55.45	♦ ♦ ♦
In the last 12 months, were you told about self-help or support groups, such as consumer-run groups or 12-step programs?	45.0	62.0	~	~	53.50	♦ ♦ ♦
In the last 12 months, were you given information about different kinds of counseling or treatment that are available?	48.8	66.0	~	~	57.40	♦ ♦
Access to Treatment and Information from Health Plan	75.4	40.0	~	~	57.70	♦
In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval from your health plan?	88.2	41*	~	~	64.60	♦
In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?	62.5*	38*	~	~	50.25	♦
Office Wait Time - Seen within 15 minutes of appointment time (% Always/Usually)	61.0	53.0	~	~	57.00	♦
Informed about Medication Side Effects	76.5	82.0	~	~	79.25	♦
Received Information about Managing Condition	65.9	83.0	~	~	74.45	♦
Informed about Patient Rights	70.7	85.0	~	~	77.85	♦
Ability to Refuse Medication and Treatment	70.0	78.0	~	~	74.00	♦
Rating of Counseling or Treatment	68.3	87.0	~	~	77.65	♦ ♦

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♦♦♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB 90th Percentile.

♦♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB 75th Percentile, but does not meet the 90th Percentile.

♦♦ MCP rate is equal to or exceeds the SPH Analytics 2020 ECHO BoB Average, but does not meet the 75th Percentile.

♦ MCP rate is below the SPH Analytics 2020 ECHO BoB Average.

*Sample size <30: Use results with caution when sample sizes are <30

~ No Data: No rate reported due to new measure, measure retired, or survey not conducted

ACDC and CFDC conducted a Child ECHO survey; however, sample sizes were too small to report results.

Neither HSCSN nor MFC conducted the ECHO surveys, Adult or Child.

Appendix 3 – Transition from Fee-for-Service to Managed Care

Objective

In October 2021, the District of Columbia Department of Health Care Finance transitioned Medicaid fee-for-service (FFS) beneficiaries into managed care. These beneficiaries were enrolled in one of three Medicaid managed care plans (MCPs): AmeriHealth Caritas District of Columbia (ACDC), CareFirst Community Health Plan District of Columbia (CFDC), or Medstar Family Choice (MFC).

DHCF sought to obtain enrollee feedback on the experience of this transition. WBA Research was contracted to collect and report enrollee experiences regarding their transition into managed care. Feedback was sought on how easy the transition into managed care was, enrollees' experience with their initial plan, whether and why they switched plans, and their satisfaction with their current managed care plan.[1]

Methodology

WBA Research administered a mixed-methodology survey involving email with a telephone follow-up contact for eligible ACDC, CFDC, and MFC adult enrollees. Invitations to participate in the survey were extended to those who transitioned to an MCP in October 2021 and who had a telephone number or email address on file. An invitation was emailed to 6,846 eligible enrollees on February 16, 2022. The email contained a link to the online survey. Follow-up reminder emails were sent to enrollees; this was followed by telephone contact. Survey outreach was concluded on March 30, 2022.

Enrollees were asked a series of questions related to their transition into managed care experience, and were asked to respond using a scale from 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*.

WBA Research reported 359 surveys were completed (ACDC: 112, CFDC: 139, and MFC: 117).

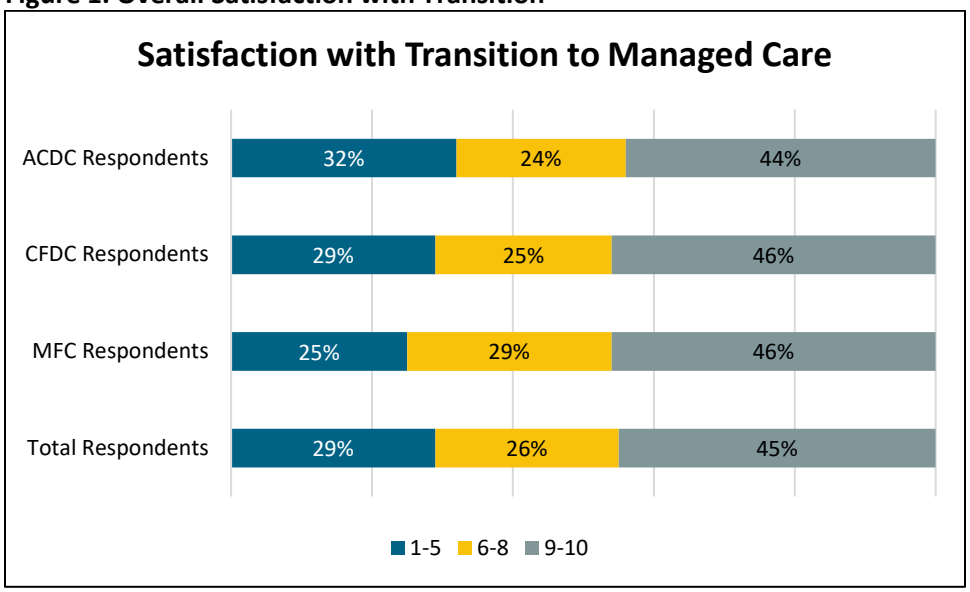
Results

Overall Satisfaction with Transition

Figure 1 illustrates enrollees' overall satisfaction with their transition from FFS to managed care.

[1] WBA Research is a National Committee for Quality Assurance (NCQA) certified survey vendor. The organization is certified to conduct HEDIS®/CAHPS® surveys. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Figure 1. Overall Satisfaction with Transition



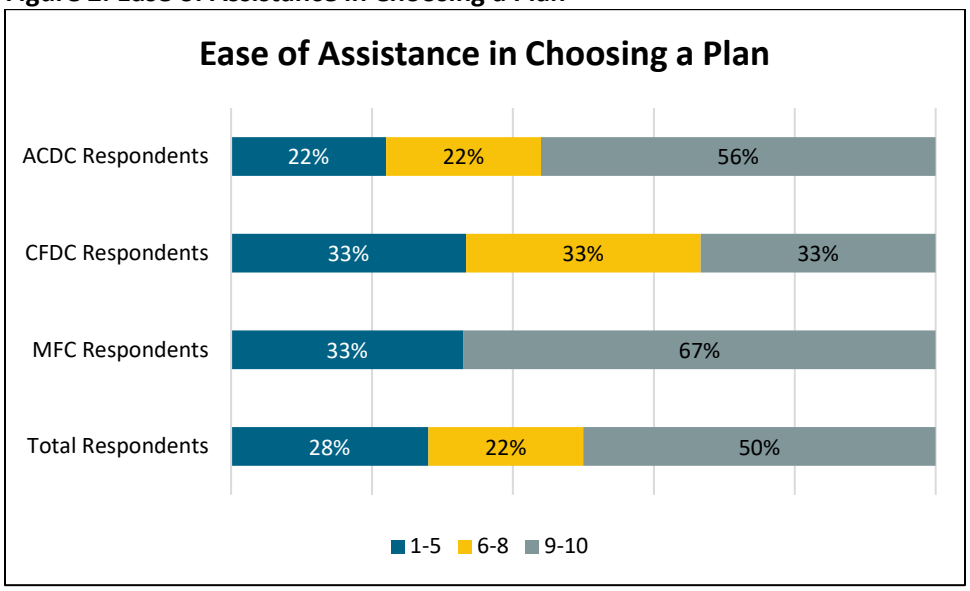
Scale: 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*

More than four in ten enrollees (45%) rated their satisfaction with the transition from FFS to managed care as a 9 or 10.

Satisfaction with Switching Plans

Enrollees had an opportunity to switch MCPs after they transitioned into managed care. Of the 359 enrollees surveyed, 36 enrollees (10%) chose to switch plans. Figure 2 displays enrollee satisfaction with getting assistance with choosing an MCP.

Figure 2. Ease of Assistance in Choosing a Plan



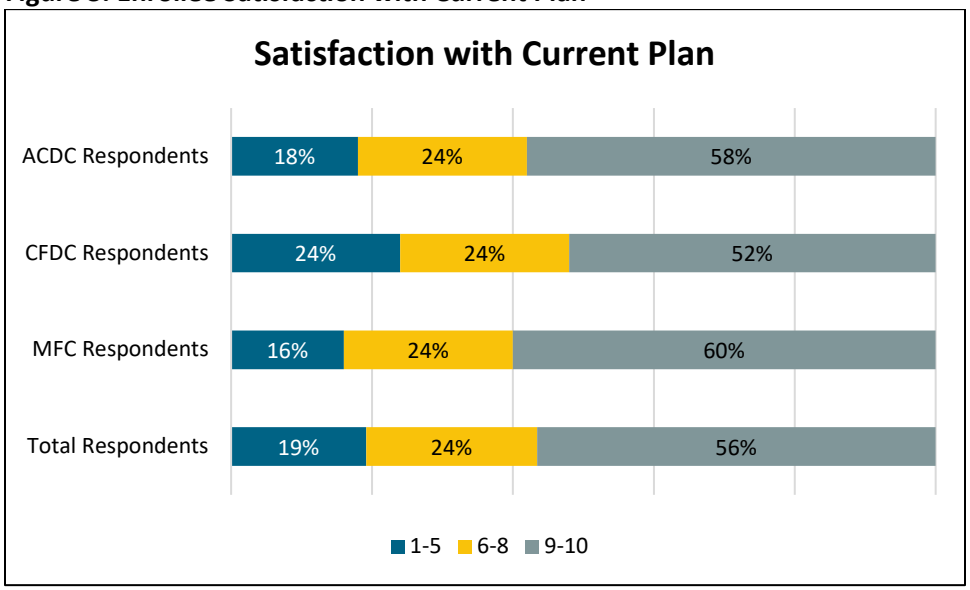
Scale: 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*

The primary reason for switching plans was the enrollee's doctor was not in the MCP's network.

Satisfaction with Current Plan

Figure 3 illustrates enrollee satisfaction with their current MCP.

Figure 3. Enrollee Satisfaction with Current Plan

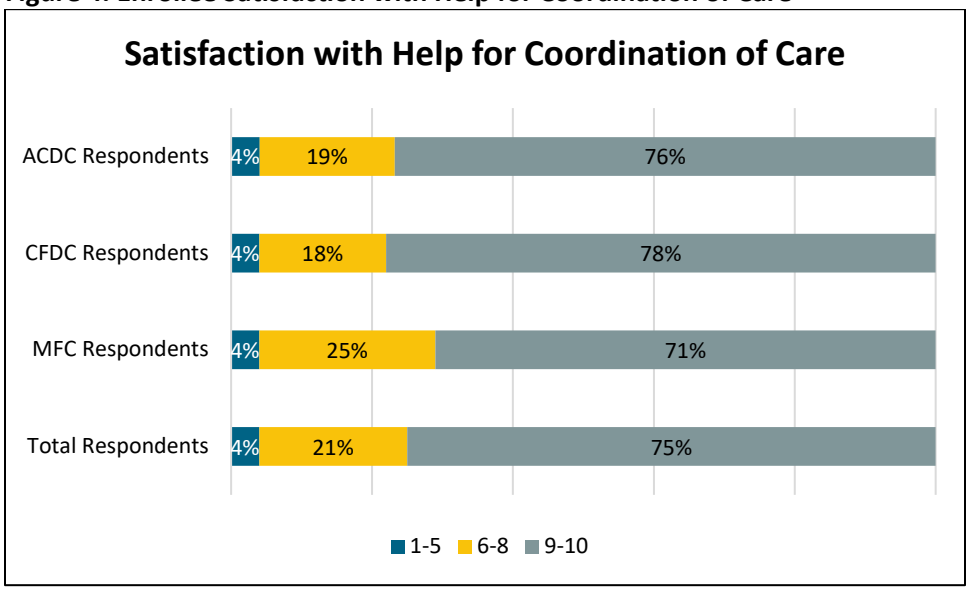


Scale: 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*

When asked about their satisfaction with their current MCP, more than five in ten enrollees (56%) rated their satisfaction as a 9 or 10.

Figure 4 displays enrollee satisfaction with help received for coordinating their care.

Figure 4. Enrollee Satisfaction with Help for Coordination of Care

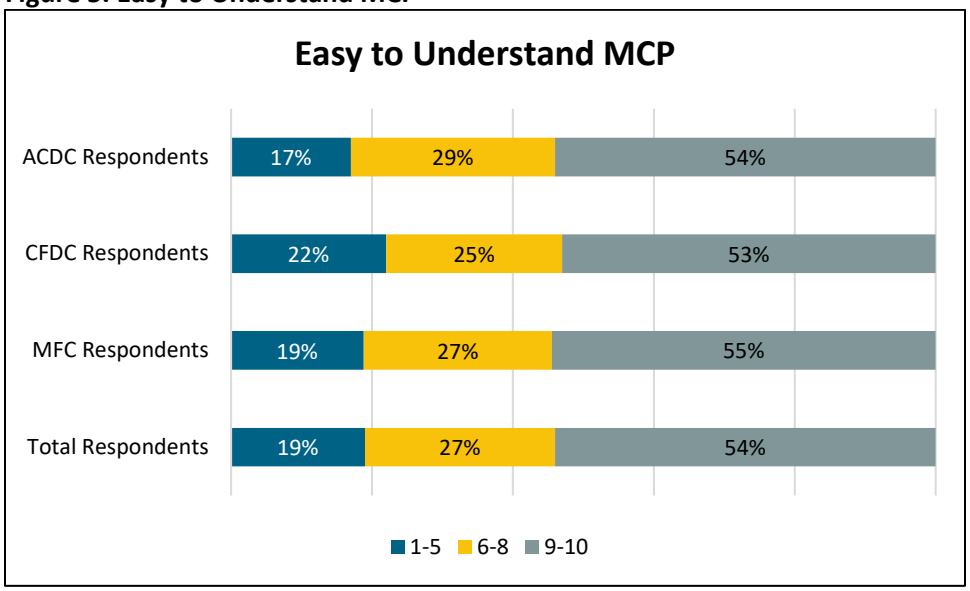


Scale: 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*

Three-fourths of enrollees (75%) rated their satisfaction with the help they received for coordinating their care as a 9 or 10.

Figure 5 illustrates enrollee ease in understanding their MCP.

Figure 5. Easy to Understand MCP



Scale: 1 to 10, with 1 being *very dissatisfied* and 10 being *very satisfied*

More than one-half of enrollees reported their plan was very easy to understand (rated 9 or 10). Those who said their plan was easy to understand, most often mentioned that it was the way the information was explained in person or on the phone, or how information was broken down to help the enrollee understand. Among those who said their plan was hard to understand, the most often mentioned reason was because no information was sent or given to them to help them understand the process or their benefits.