

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance



MEDICAID MANAGED CARE

QUALITY STRATEGY

For Public Comment: December 27, 2019

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I. Introduction

The Department of Health Care Finance (DHCF) continually strives to improve the health and well-being of the residents of the District of Columbia. This is evident through our vision, mission, values, and strategic priorities.

Vision: All residents in the District of Columbia have the supports and services they need to be actively engaged in their health and to thrive.

Mission: The Department of Health Care Finance works to improve health outcomes by providing access to comprehensive, cost-effective and quality health care services for residents of the District of Columbia.

Values:

1. Professionalism – Treating all recipients and community partners with respect and dignity
2. Accountability – Ensuring that the efficiencies built into the Medicaid managed care program are effective
3. Compassion – For those who are unable to afford comprehensive health insurance
4. Teamwork – Partnering with the community to address social determinants of health
5. Empathy – For those with chronic conditions and provide special incentives to providers to improve access to, and quality of care

Strategic Priorities:

- Building a health system that provides whole person care
- Ensuring value and accountability
- Strengthening internal operational infrastructure

To help achieve our vision and mission, DHCF plans to move towards a fully managed care Medicaid program over the next five years. This move aims to transform the managed care program into a more organized, accountable, and person-centered system that best supports the District’s Medicaid beneficiaries in managing and improving their health.

A. Managed Care Program Goals, Objectives, Overview

Effective on March 17, 1993, the Council of the District of Columbia (DC) adopted D.C. Law 9-247, the Medicaid Managed Care Amendment Act of 1992, which requires the establishment of a managed care program for Medicaid beneficiaries. The goal of the DC Medicaid managed care program is to promote healthy outcomes of the enrolled populations in the most cost-effective manner possible. The District’s Medicaid population is diverse, including individuals with existing complex medical and social needs and those at high-risk or increasing risk for health care disparities. These beneficiaries may be impacted by a range of social factors, including homelessness that must be recognized within effective plans of care. In alignment with DHCF’s strategic priorities, the Medicaid managed care program shall have

a clear focus on achieving better health outcomes, health care innovation and cost-effective quality healthcare.

Since 1994, the District has enrolled children and families, pregnant women, and children with special needs into managed care, which covers acute, primary, specialty, and certain behavioral health services. All beneficiaries, except children with special needs and Medicare and Medicaid dual eligible beneficiaries, are enrolled in a managed care organization (MCO) on a mandatory basis. In 1996, a Medicaid demonstration project was begun for children and youth who have special health care needs and receive Supplemental Security Income (SSI) benefits or are SSI-eligible. This program is called the Child and Adolescent Supplemental Security Income Program (CASSIP), and enrollment is voluntary. This program provides acute, primary, specialty, and behavioral health services through a single, prepaid benefit plan.

Although the Medicaid managed care program began as a Medicaid waiver, in 1998 the District was granted state plan authority and subsequently extended coverage to families earning up to 200 percent of the Federal Poverty Level (FPL) through a combined Medicaid and State Children's Health Insurance Program (CHIP). The managed care program utilizes three risk-based MCOs to provide services to Medicaid beneficiaries in the District's Healthy Families Program (DCHFP) and a risk-sharing arrangement with a fourth health plan to provide services to Medicaid beneficiaries eligible for the District's CASSIP program.¹ In 2010 DHCF expanded coverage to childless adults with incomes up to 200% of FPL. DHCF's four managed care plans serve over 190,000 DC residents, approximately 75% of the Medicaid population. DHCF does not have an MCO that only serves Medicare and Medicaid dually eligible enrollees. On a voluntary basis, duals may enroll in any of the District's MCOs.

In 2017, DHCF issued a request for proposal for procurement of managed care services for the District's Medicaid beneficiaries. As a result, the District implemented new, five-year contracts with three MCOs to provide healthcare services to District Medicaid enrollees: Amerigroup DC, AmeriHealth Caritas DC, and Trusted Health Plan. As a result of a protest, that contract was cancelled in 2018 and a subsequent procurement resulted in the same health plans receiving the award. The current contract is from May 2019 through September 2023. The District's CASSIP contractor did not change and is currently in a five-year contract from 2016-2021. Table 1 lists beneficiary enrollment in the Medicaid managed care program and fee-for-service (FFS) program.

¹ For purposes of this Quality Strategy, the three MCOs and one CASSIP contractor are referred to collectively as MCOs.

Table 1: Beneficiary enrollment by program type, May 2019²

DC Healthy Families Program Type	Enrollment
Managed Care Program	196,048
Amerigroup DC	42,996
AmeriHealth Caritas DC	116,934
Trusted Health Plan	31,044
Health Services for Children with Special Needs, Inc. (CASSIP)	5,074
Fee-For-Service Program	61,157
Total Number of Beneficiaries	257,205

In September 2019, DHCF announced that nearly 22,000 individuals currently in the FFS program will be transitioned to the Medicaid managed care program, effective October 1, 2020.³ Additionally, between 2020-2025, DHCF plans to transition more populations and services traditionally covered under the FFS program to the managed care program.⁴ Health care costs for individuals with FFS coverage can be up to five times greater than persons in managed care as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays. Today, these beneficiaries must manage their health care needs without assistance or care coordination. By joining the managed care program, this population will receive access to much needed care coordination, and as a result, improved health outcomes.

B. DHCF Quality Management Structure Overview

DHCF’s Health Care Delivery Management Administration (HCDMA) is responsible for oversight of the delivery of health care services to managed care enrollees. Its Division of Quality and Health Outcomes (DQHO) is the lead for implementing the quality strategy. DQHO relies on several partners for successful oversight:

- External Quality Review Organization (EQRO):** Federal regulations mandate states that operate a Medicaid managed care program to contract with an independent EQRO to conduct annual reviews of the quality, accessibility, and timeliness of services provided to MCO enrollees.
- MCOs:** DHCF also relies on information from the MCO performance metric reporting, grievances and complaints, contract compliance oversight, and Quality Assurance and Performance Improvement (QAPI) reports. In addition, the MCOs support the management structure through performance improvement projects (PIPs), quality

² District of Columbia Department of Health Care Finance. Enrollment Report, September 2019.

³ To effectuate these changes, DHCF will work with the Office of Contracting and Procurement (OCP) to re-bid the contracts for its managed care program. The current contractors in the managed care program – AmeriHealth Caritas of DC (AmeriHealth), Amerigroup, and Trusted Health Plan (Trusted) will operate the program as presently organized for Fiscal Year 2020.

⁴ For more information on the District’s Medicaid reform efforts, please refer to Medical Care Advisory Council meeting agenda and materials at <https://dhcf.dc.gov/page/dc-medical-care-advisory-committee>.

improvement collaboratives, health and wellness programs, and care coordination activities.

- **Other Partners:** DHCF partners with other state agencies (e.g., DC Health, Department of Behavioral Health), providers and provider organizations (e.g., DC Primary Care Association), and national organizations (e.g. National Committee for Quality Assurance (NCQA)).

C. Goals and Objectives

The District of Columbia’s Medicaid Managed Care Quality Strategy utilizes the Institute for Healthcare Improvement framework for optimizing health system performance (also referred to the “Triple Aim”). The strategic goals and objectives of DHCF programs are organized within the three pillars of the Triple Aim: improving the patient experience of care; improving the health of District residents; and reducing the costs of health care (*see table 2*).⁵

Table 2: District of Columbia Quality Strategy Triple Aim, Goals, and Objectives

The Triple Aim	Goals	Objectives
Better Care Improving the patient experience of care	1. Ensure access to quality, whole-person care	1.1 Promote effective communication between patients and their care providers
		1.2 Support appropriate case management and care coordination
		1.3 Address physical and behavioral health comorbidities
Healthy People, Healthy Community Improving the health of District residents	2. Improve management of chronic conditions	2.1 Improve management of pre-diabetes and diabetes
		2.2. Improve comprehensive behavioral health services
	3. Improve population health	3.1 Improve maternal and child health
		3.2 Reduce health disparities
		3.3 Promote preventative care
4. Ensure high-value, appropriate care	4.1 Incorporate pay for performance programs in all MCO contracts	
	4.2 Direct MCO payments for primary care enhancement and local hospital services	

⁵ Institute for Healthcare Improvement: IHI Triple Aim Initiative, accessed December 15, 2019. <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>.

The 10 objectives (1.1-4.2) outlined above are tied to focused interventions (described in detail in Section IV) used to drive improvements within, and in many cases, across the four Goals set forth in this Quality Strategy. To assess performance on these Goals, these interventions are tied to a set of quality measures by which progress is assessed. The crosswalk of objectives to quality measures is available in Appendix I. DHCF utilizes HEDIS, CMS Core Set, and other rigorously tested and standardized measures. The District has long required its MCOs to be NCQA accredited and thus annually complete and submit all applicable HEDIS measures designated by the NCQA as relevant to Medicaid. The MCOs are required to contract with an NCQA-certified HEDIS auditor to validate the processes of the health plan in accordance with NCQA requirements. In addition, MCOs annually conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (adult survey, child survey, and children with chronic conditions survey) using an NCQA-certified CAHPS survey vendor.

As other populations, services, and programs are included in managed care, DHCF will assess the need to adjust the goals, objectives, and measures required to monitor performance. DHCF will continue reporting a subset of the Adult and Child Core Set measures to CMS, with the goal of increasing the number of Adult and Child Core Set measures it reports over time. DHCF is actively exploring use of electronic clinical quality measures (eCQM) via Health Information Exchange (HIE), which will support appropriate measure selection for all Medicaid populations.

D. Development & Review of Quality Strategy

The formal process to develop and review DHCF's Quality Strategy occurs no less than every three years unless there is a significant change. Significant changes include events such as a change to the delivery system model; addition of new populations or services; new managed care procurements; or significant changes to the federal regulations governing quality. The effectiveness of the quality strategy is assessed annually through the recommendations provided by the EQRO in collaboration with DHCF, a review of the MCOs' performance on HEDIS measures and CAHPS surveys and evaluating their quality programs described in their QAPI submissions. Additional information is gleaned from reviews of grievance and complaint logs, performance improvement projects, and through the public comment process for new regulations.

In 2019, DHCF solicited input from the public by presenting an executive summary of the key elements of the MCO Quality Strategy to the Medical Care Advisory Council. Feedback from these various stakeholder meetings was incorporated into the final strategy, which was made available for a 30-day public comment period via DHCF's website and submitted to the CMS for approval. The final DHCF Managed Care Quality Strategy is available on the DHCF website.

II. Assessment

A. Quality and Appropriateness of Care

i. State Procedures for Assessing Quality and Appropriateness of Care

DHCF utilizes several mechanisms in its assessment of the quality and appropriateness of care furnished to all MCO enrollees, including:

- **Contract Management:** All MCO contracts include quality reporting requirements and oversight activities that allow DHCF to identify trends and issues in a timely manner. The MCOs are required to report to DHCF on topics including, but not limited to: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, utilization, grievances and appeals, progress on performance improvement projects, provider network adequacy, marketing and outreach activities, and care coordination. DHCF convenes regular meetings with the health plans to provide feedback on compliance with contract requirements and on performance relative to benchmarks. The DHCF requires MCOs to take corrective action for occurrences of non-compliance or poor performance under the Medicaid managed care contract, including but not limited to instances where the DHCF determines the MCO's quality improvement efforts are inadequate or improved performance is necessary due to identified weaknesses within operations of the MCO.⁶
- **Data Collection and Monitoring:** At least annually, DHCF collects HEDIS and other performance measure data from its MCOs and compares their performance to national benchmarks, state program performance, and prior health plan performance.
- **Performance Improvement Projects (PIP):** DHCF requires each MCO to complete at least two PIPs annually, in accordance with 42 CFR § 438.330(d).
- **Quality Assessment and Performance Improvement Plan (QAPI):** Each MCO must annually submit a QAPI to DQHO along with an assessment of performance on the previous year's QAPI.
- **Encounter Data Accuracy:** DHCF contracts with an external actuary to verify the accuracy and completeness of the encounter data submissions and associated payments.
- **Annual Quality Improvement Activities Conducted by the EQRO:** Activities include validation of PIPs, assessment of network adequacy, and compliance review. A summary of the activities conducted by DHCF's contracted EQRO is discussed in detail in Section C below (Monitoring and Compliance).

⁶ For more information on DHCF's process for addressing MCO-Non-compliance to contract provisions and performance benchmarks, please refer to Appendix II, DHCF Informational Bulletin Compliance Actions in the Managed Care Program.

ii. Identification of Age, Race, Ethnicity, Sex, Primary Language, and Special Health Care Needs

Age, Race, Ethnicity, Sex, and Primary Language

At the time of Medicaid enrollment, individuals are asked to voluntarily report their age, race, ethnicity, and primary language. These data are shared with the MCOs in order to ensure the delivery of culturally and linguistically appropriate services to members. Each MCO must have in place written guidelines and procedures to ensure beneficiaries are provided covered services without regard to race, color, gender, creed, religion, age, national origin, ancestry, marital status, sexual orientation, political affiliation, personal appearance, or physical or mental disability.

The MCOs shall provide to beneficiaries and potential beneficiaries, free of charge, competent, professional, oral interpretation services utilizing the District’s Language Access Line (or comparable services) or through on-site professional interpretation services, regardless of the language spoken, at all points of contact. In addition, MCOs shall require that all Network Providers follow the requirements of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1974, and other District requirements.⁷ All written materials must be made available in any language that the Medicaid enrollee requests. DHCF also requires all MCOs to submit a demographics report on a monthly basis which contains information on District ward, race, and sex in conjunction with the required HEDIS measures around race, ethnicity, and language diversity.

Enrollees with Special Health Care Needs

The MCOs are required to have policies and procedures to identify adults and children with special health care needs including utilizing a DHCF approved screening tool. They are also required to ensure that enrollees with special health care needs receive care coordination and case management services and have access to a specialist appropriate for the enrollee’s condition and identified needs. Adults and children with special health care needs are defined as follows:

- Adults who have an illness, condition or disability that results in limitation of function, activities or social roles in comparison with accepted adult age-related milestones in general areas of physical, cognitive, emotional and/or social growth and/or development, or people who have seen a specialist more than three times in the last year. This definition includes, but is not limited to, individuals who self-identify as having a disability or who meet DHCF’s standard of limited English proficiency.

⁷ The DC Language Access Act at 2–1933 states that a covered entity shall provide translations of vital documents into any non-English language spoken by a limited or no-English proficient population that constitutes 3% or 500 individuals, whichever is less, of the population served or encountered, or likely to be served or encountered, by the covered entity in the District of Columbia.

- A child with special health care needs is defined as a person under 21 years of age with a chronic, physical, developmental or behavioral condition that requires health and related services of a type or amount beyond that which is required by children generally. This may include a child who receives SSI, a child whose disabilities meets the SSI definition, a child in foster care, and a child with developmental delays or disabilities who needs special education and related services under the Individuals with Disabilities Education Act (IDEA).

CASSIP is a voluntary managed care program for children and adolescents with special health care needs. This program provides all the benefits of the risk-based MCO, with the added requirement to provide respite services for families and the option of choosing as the enrollee's primary care provider (PCP), a specialist who has the experience and expertise in the treatment of the enrollee's special health care needs.

iii. Efforts and Initiatives to Reduce Disparities in Health Care

DHCF is committed to addressing health equity in its managed care program. All new initiatives are developed with the knowledge that the District's Medicaid population is diverse, including individuals with complex medical and social needs and those at high-risk or increasing risk for health care disparities.

MCOs are required to develop a Quality Assessment and Performance Improvement (QAPI) Program, which describes the MCO's systematic approach for assessing and improving the quality of care utilizing the continuous quality improvement framework. The QAPI program must include a mechanism for reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes. Analysis of interventions must compare health care utilization data for enrollees by subgroups, such as, race/ethnicity, language, and DC ward, prior year performance and, where possible, against regional and national benchmarks. Annually, the MCOs are required to submit an evaluation report highlighting QAPI program successes and lessons learned.⁸

B. National Performance Measures

i. Required National Performance Measures Identified

Because all risk-based MCOs are required to have NCQA Health Plan Accreditation as a condition of contracting in the District, MCOs collect and report the full roster of HEDIS/CAHPS measures to DHCF. The CASSIP plan is required to report all measures that have a denominator greater than 30, in alignment with NCQA Health Plan Accreditation Standards and Guidelines. DHCF reviews performance on an annual basis and sets benchmarks based either on the national average or prior performance.

⁸ For more information on MCO QAPI requirements, please refer to Appendix III, Requirements for the Quality Assurance and Performance Improvement (QAPI) Program.

ii. **CMS Core Set Measures for Children and Adults in Medicaid/CHIP**

DHCF voluntarily reports on a subset of the CMS' Child and Adult Core Set measures that align with HEDIS. DHCF also reports to CMS a subset of Core Set measures for both the managed care and FFS populations. Additionally, DHCF submits to CMS the annual EPSDT Report, Form CMS-416.

C. Monitoring and Compliance

DHCF has detailed procedures for the regular oversight, monitoring, and evaluation of its MCOs. DHCF conducts ongoing compliance reviews and data analyses to monitor the MCOs' compliance with contract requirements and to proactively identify issues that could put enrollees at risk. Activities include:

- Defining data quality and network access standards
- Holding bi-monthly operational meetings with each MCO
- Contracting with an EQRO to perform an independent annual review
- Monitoring encounter data to assess trends in service utilization
- Reviewing logs of complaints, grievances, and appeals
- Analyzing effectiveness of annual PIPs
- Monitoring MCOs' NCQA accreditation status

DHCF requires MCOs to submit a comprehensive series of reports, which are used for oversight and monitoring. These reports are submitted monthly, quarterly, or annually on a variety of topics such as: case management and care coordination; PIPs; financial reports; quality strategic outcome plan; and provider network geo-access reports. The findings from the MCO reports are analyzed by DHCF and discussed on an ongoing basis and with the MCOs at the bi-monthly operational meetings.

When compliance and/or performance is deemed to be below the established benchmark or contractual requirement, DHCF may provide technical assistance, impose a corrective action, and/or impose financial penalties as necessary. In addition to the oversight and monitoring mechanisms detailed above, DHCF may make modifications or additions to performance metrics and incentives; and data and reporting requirements as necessary. These modifications/additions will either be part of a contract amendment or as an implementation of new initiatives.

Intermediate Sanctions

As specified in 42 CFR §438.702, DHCF has established and may impose intermediate sanctions, including:

1. Civil money penalties;
2. Appointment of temporary management for an MCO;
3. Granting enrollees the right to terminate enrollment without cause;
4. Suspension of all new enrollment; and

5. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

DHCF may use these intermediate sanctions to address any MCO non-compliance with the contract and poor performance. Determinations will be based on findings from MCO reporting, onsite surveys, enrollee or other grievances, financial status, or any other source.

D. External Quality Review and Non-Duplication of EQR Activities

To ensure the District's MCOs provide care and services that meet acceptable standards for quality, timeliness and accessibility of services, DHCF contracts with an EQRO to conduct an annual, external, independent review. DHCF's contracted EQRO is Qlarant Quality Solutions, Inc.

In accordance with Federal regulations, Qlarant conducts the following mandatory activities to assess MCO performance in the District:

1. Conduct an operational systems review (OSR), of MCOs' operations to assess compliance with State and Federal standards for quality program operations;
2. Perform performance measure validation on required performance measures, including source code validation and medical record overreads;
3. Validation of required PIPs, including proper identification of MCO, provider, and beneficiary barriers and interventions;
4. Network Adequacy Validation (NAV), including:
 - a. Geo-access reporting to determine if the network is compliant with the District's time and distance standards;
 - b. A secret shopper survey to evaluate compliance with access and availability of services; and
 - c. A review of the accuracy and completeness of each MCO's provider directory.
5. Development and Implementation of the Quality Rating System (QRS) and accompanying Consumer Report Card; and
6. Completion of a comprehensive Annual Technical Report (ATR) to evaluate DHCF's compliance with overall quality, access and timeliness standards.

Information and recommendations from the EQRO reports assist DHCF in determining compliance with the contractual requirements and evidence for technical assistance, enhanced monitoring, corrective action plans, or monetary penalties.

EQR Standards Using Medicare or Private Accreditation Reviews

The risk-based MCOs are required to obtain and maintain full NCQA Health Plan Accreditation. The CASSIP plan is required to complete only the HEDIS component of the accreditation. All MCOs are required to obtain NCQA Case Management Accreditation. The EQRO may use information about the MCOs obtained from NCQA accreditation findings to

complete required EQR activities. The EQRO also includes the results and findings from the OSR in the ATR.

III. State Standards

A. Access Standards

DHCF requires the MCOs to meet five access standards: availability of services, network capacity, appointment availability, and coordination and continuity of care. Meeting these standards further support the District's overall goals and objectives for improving the patient experience of care; improving the health of District residents; and reducing the costs of health care of the Managed care quality strategy.

i. Availability of Services

Maintain and Monitor a Network of Appropriate Providers

DHCF's MCO contracts require the MCOs provide, or arrange for, the delivery of all medically necessary covered health services enrollees. This includes assuring that they follow provider panel access standards by considering the following:

- Anticipated Medicaid enrollment;
- Expected service usage based on a consideration of member health care needs;
- The number and types (specialization) of providers required to deliver contracted Medicaid services;
- The number of providers accepting new Medicaid patients;
- The geographic location and distance, as well as travel time required between providers and enrollees;
- Appointment availability; and
- Appropriate provider locations for enrollees with physical disabilities.

MCOs are required to submit their panel of network providers to DHCF in order to demonstrate that the range of preventative, primary care and specialty services offered is adequate in number, mix, and geographical distribution to meet the needs of the anticipated number of enrollees in the service area. If the MCO's provider panel is unable to provide medically necessary covered services, the MCO is required to contract with an out-of-network provider.

For enrollees with special health care needs or who are determined to need a course of treatment or regular care monitoring, DHCF requires MCOs to have mechanisms in place in order to allow direct access to specialists appropriate for the member's condition and identified needs.

DHCF monitors the adequacy of provider networks through monthly reports, secret shopper surveys, utilization, and complaints, grievance/appeal logs. Corrective actions are taken when necessary.

Access to a Women's Health Specialist

MCOs are required to allow female enrollees to have a women's health specialist in addition to a PCP (or, at the enrollee's option, in lieu of a PCP). MCOs must also provide female enrollees with direct access (without referral) to a women's health specialist within the network for covered women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. Female enrollees are entitled to timely access to family planning (Title X) services, in or out of network.

Provide for a Second Opinion from a Qualified Health Professional

The MCO contract requires that enrollees must be afforded the opportunity to a second opinion. If an appropriately qualified network provider is not available, the MCO must arrange for a second opinion outside the network at no charge to the enrollee.

Adequate and Timely Coverage of Services Not Available in Network and payment for those services

In the event the MCO's network is insufficient to furnish a specialty service, the MCO shall pay for the cost of out-of-network services, for as long as the MCO is unable to provide the services through a network provider. Additionally, if an enrollee with special health care needs is unable to secure a new network provider within three business days, the MCO shall arrange for covered services from an out-of-network provider at a level of service comparable to that received from a network provider until the MCO is able to arrange for such service from a network provider. The MCO shall pay for such services at a rate negotiated by the MCO and the out-of-network provider. The MCO shall cover and pay for emergency services regardless of whether the provider furnishing the services is a network provider. The MCO is required to coordinate with out-of-network providers with respect to authorization and payment in these instances and ensure that cost of the services and transportation to the Enrollee is no greater than it would be if the services were furnished within the MCOs provider network.

Assure Providers Meet State Standards for Timely Access to Care and Services

MCOs must maintain a provider network that is sufficient to provide timely access to the full range of covered services, considering the urgency of the need for services, including after-hours coverage. In addition, the MCOs' network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to the Medicaid FFS program, if the provider serves only Medicaid enrollees.

Services included in the MCO contract must be available 24 hours a day, 7 days a week, when medically necessary. The District has set timely access standards for non-urgent

appointments (*see Table 3*). In addition, the wait time for a primary care appointment should not be greater than 45 minutes if the enrollee arrived early.

MCOs must have written policies and procedures for monitoring and sanctioning providers who are either out of compliance with state standards for timely access to care and services, or have been excluded, suspended or debarred from participating in any District, State, or Federal health care benefit program, in accordance with §438.606. The MCO must provide these policies and procedures to their network providers.

Table 3: DC Managed Care Program Timely Access Appointment Standards

Provider Type	Appointment Type	Timely Access for Non-Urgent Appointments*
Primary Care	New Enrollee Appointment	45 days from enrollment or 30 days from request, whichever is sooner.
	Routine Appointment	30 days from request
	Well-Health for Adults 21+	30 days from request
	No-Urgent Referrals	30 days from request
	Diagnosis and Treatment of Health Condition (<i>not urgent</i>)	30 days from request
	Initial pregnancy	10 days from request
	Family planning	10 days from request
Specialists	Non-Urgent Referral	30 days from request
	Initial pregnancy	10 days from request
	Family planning	10 days from request
Pediatrics (EPSDT)	New Enrollee Appointment	60 days from enrollment or sooner to comply with periodicity schedule
	EPSDT Examination	30 days from request
	IDEA Part C Multidisciplinary Evaluation	30 days from referral
	IDEA Part C Treatment	25 days from signed IFSP
Mental Health	Outpatient	<ul style="list-style-type: none"> • Within 7 days of discharge from a psychiatric inpatient facility or a psychiatric residential treatment facility (PRTF). • Within 30 days of discharge from an acute care admission.

*Days = calendar days

ii. Assurances of Adequate Capacity and Services

Assurance of Capacity to Serve Expected Enrollment

In order to assess the adequacy of the provider network, MCOs are required to submit a list of all network providers, provide summary reports by specialization, and submit all provider contracts to DHCF. On a weekly basis, the MCOs are sent an electronic file that contains the District's provider panel allowing for a reconciliation of any discrepancies between the MCO panel and what is contained within DHCF's Medicaid Management Information System (MMIS). Another component of DHCF's monitoring and oversight is the network adequacy validation performed by the EQRO to determine the MCOs compliance with the District's network adequacy and access requirements.

Mechanisms/Monitoring to Ensure Provider Compliance

The District has developed time, distance, and timely access standards. MCOs provide geo-access reports to demonstrate compliance. MCOs must ensure that, at a minimum, they can meet the time and distance standards for the following provider types:

- Primary Care, Obstetric-Gynecological, Specialty Care, Mental Health, Hospital, and Laboratory - *5 miles or 30 minutes from the beneficiary's residence*
- Pharmacy - *2 miles from the beneficiary's residence*

Culturally Competent Services to All Participants

MCOs are required to respond with sensitivity to the needs and preferences of culturally and linguistically diverse enrollees. To ensure that all enrollees are treated in an appropriate manner, MCOs must ensure provider compliance with policies and procedures that promote cultural competency in accordance with the DC Language Access Act of 2004. This includes free translations of marketing and member materials into non-English languages.

MCOs are responsible for promoting the delivery of services in a culturally competent manner, to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. MCOs must inform providers of their obligation to provide oral translation, oral interpretation, and sign-language services to their enrollees. Additionally, MCOs must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, and person-centered care delivery approaches.

iii. Coordination and Continuity of Care

MCOs must ensure that each enrollee has an ongoing source of care appropriate to his or her needs, especially during transitions between health plans or health systems. This is of paramount importance for enrollees with special health care needs. In accordance with the MCO contract, MCOs shall be required to provide or arrange for all medically necessary services, authorization, referrals, case management, and/or assistance in accessing services. MCOs may subcontract or enter into a single-case agreement in order to meet the health care and support needs of their enrollees.

Medicaid enrollees are permitted to retain their current provider(s) for up to 60 calendar days from the effective date of enrollment in the receiving MCO, unless the enrollee has been identified as an individual with special health care needs. Enrollees identified as having special health care needs shall receive continuation/coordination of services for up to 90 calendar days or until the enrollee may be reasonably transferred without disruption. MCOs shall also allow enrollees to maintain their previously authorized Medicaid services, including frequency and payment rate, for the duration of the prior authorization or for 60 days from enrollment (90 days for individuals with special health care needs), whichever is less.

The MCO may prior authorize or assist the enrollee to access services through an in-network provider when any of the following occur:

- The enrollee's condition stabilizes and the MCO can ensure no interruption to services;
- The enrollee chooses to change to a network provider;
- A change in medical status occurs that warrants a change in service; or
- Quality of care concerns with the provider are identified.

MCOs must reimburse out-of-network providers for beneficiaries who are transitioning to a different MCO or FFS program. MCOs must request approval from DHCF prior to transferring an enrollee with a special health care need within the ninety 90-day transition period. Whether the beneficiary is transferring from FFS program or another MCO:

- The entity that previously served the beneficiary must provide historical utilization data. Utilization data consists of claims, medical records, case management notes, data collected from social determinants surveys, and any other data that is relevant to the health of the enrollee.
- If the enrollee is assigned to a new provider, the new provider(s) must be able to obtain copies of the enrollee's medical records from the newly assigned MCO or DHCF, as appropriate.

iv. Coverage and Authorization of Services

Amount, Duration, and Scope of Each Service

MCOs are required to cover and pay for diagnostic, screening, and preventive clinical services that are assigned a grade of A or B (strongly recommended or recommended, respectively) by the United States Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices; preventive care and screening of infants, children and adults recommend by the Health Resources and Services Administration's Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine. Preventive services shall be recommended by a physician or other licensed practitioner of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of

1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.), or comparable law in the state where the provider is licensed.

The MCO contract further requires that MCOs furnish services in an amount, duration, and scope that is:

- No less than the amount, duration, and scope for the same services furnished to beneficiaries through an FFS arrangement; and
- Are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the service is furnished.

MCOs shall not arbitrarily deny or reduce the amount, duration, or scope of a Medicaid service solely because of a diagnosis, type of illness, or condition of the enrollee.

Medical Necessity

MCOs are responsible for determining medical necessity for services and supplies for enrollees. Medical necessity is met if the service:

- Meets generally accepted standards of medical practice;
- Is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
- Is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
- Is the lowest cost alternative that effectively addresses and treats the medical problem;
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- Is not provided primarily for the economic benefit or convenience of anyone other than the recipient.

MCOs are allowed to place appropriate limits on services for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose; the services supporting individuals with ongoing or chronic conditions, or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and for family planning services that are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.

Authorization of Services

The MCO's written Utilization Management (UM) policies and procedures defines its prior authorization process. This process must include the use of review criteria and a utilization review decision algorithm that conforms to managed care industry standards. Specifically, the policies and procedures must:

- Have the flexibility to efficiently authorize medically necessary services;

- Ensure that the review criteria for authorization determinations are applied consistently;
- Require that the reviewer consult with the requesting provider when appropriate;
- Identify services available upon an enrollee's direct request;
- Identify services that require pre-service authorization;
- Identify services that require concurrent review;
- Indicate circumstances that warrant post-service review;
- Include MCO's special procedures for management of high-cost and high-risk cases; and
- Include a clear statement that MCO is legally prohibited from denying services based upon cost.

In order to ensure consistency in the review process and to provide effective guidance, MCO utilization reviewers must make authorization determinations consistent with the medical necessity criteria and at no time shall any covered services be denied based upon cost. At least annually, MCOs must evaluate the consistency with which utilization reviewers apply standardized criteria in decision making and complete inter-rater reliability testing with all reviewers.

MCOs shall ensure that compensation to individuals or entities that conduct UM activities is not structured with the provision of incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee. MCOs are to maintain a record of all authorization requests, including standard and expedited requests. This information must be provided to DHCF upon request.

As a further check on the authorization process, the MCO's Chief Medical Officer must be responsible for overseeing the authorization decisions of the UM program to ensure that decisions are based on all relevant medical information available about the enrollee and in accordance with evidence-based clinical practice standards. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical experience in treating the enrollee's condition or disease.

Prior authorization decisions shall be communicated within prescribed timelines and on a template provided by DHCF. The MCO shall give the enrollee and requesting provider written and/or oral notice of any adverse benefit determination at least 10 days before the date of the action. Notices of adverse determinations are sent to the requesting provider as well as the enrollee. The MCO's Notice of Adverse Benefit Determination shall meet all Federal and District requirements that includes, at a minimum, the following information:

- The reason(s) for the adverse benefit determination;
- The enrollee's right to file an Appeal with the MCO;
- The enrollee's right to directly request a District Fair Hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination;

- The procedures for exercising the enrollee’s Appeal and Fair Hearing rights;
- The circumstances under which an expedited resolution of the adverse benefit determination is permitted and how to request it;
- The enrollee’s right to have his or her benefits continued pending resolution of the Appeal or Fair Hearing if the conditions specified in the contract are met;
- The enrollee’s right to receive assistance from the Medicaid Ombudsman and how to contact the Ombudsman; and
- The enrollee’s right to obtain free copies of certain documents, including the Enrollee’s medical records used to make the decision and the medical necessity criteria, referenced in the adverse benefit determination.

B. Structure and Operation Standards

i. Credentialing and Re-Credentialing

All MCOs must develop and maintain written policies and procedures for the credentialing and re-credentialing of all network providers to ensure the covered services are provided by appropriately licensed and accredited providers. These policies and procedures shall, at a minimum, comply with federal, state and NCQA standards. DHCF has also mandated that all MCO contracted providers have credentialing information on file or accessible by the District.

DHCF requires that MCOs use the NCQA Health Plan Standards and Guidelines credentialing and re-credentialing requirements as the District’s standard and requirement for all MCOs when initially credentialing and when re-credentialing providers in connection with policies, contracts, and agreements providing basic health care services. MCOs may not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. MCOs must ensure that the provider has met all applicable credentialing criteria before the provider can be listed as an in-network provider. If any MCO delegates the credentialing or re-credentialing process to another entity, the MCO must retain the authority to approve, suspend, or terminate any subcontractors.

Upon DHCF’s request, the MCO must be able to demonstrate the record keeping associated with maintaining this documentation and/or submit documentation verifying that all necessary contract documents have been appropriately completed.

DHCF prohibits the employment or contracting of providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. MCOs must notify DHCF when credentialing is denied for program integrity reasons.

ii. Enrollee Information

To assist potential enrollees, DHCF maintains current information about the Managed Care Program on its website (<https://dhcf.dc.gov/>). This includes information about

Medicaid Managed Care Benefit Package, links to each of the MCO websites, and, in 2019, a comparison of the District's MCOs on key performance indicators. The District's enrollment broker maintains a phone line and is responsible for providing unbiased education and selection services for the MCOs. All informational materials developed by DHCF, the enrollment broker, and the MCOs will be made available in formats and languages that ensure their accessibility, including that materials are provided at an appropriate reading level.

Each MCO is required to produce an enrollee handbook which includes the following information:

- Benefits provided, including the amount, duration and scope of those benefits, and guidance on how and where to access benefits, including transportation, family planning services and supplies from out-of-network providers;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP;
- The extent to which, and how, after-hours and emergency coverage are provided;
- Beneficiary rights and responsibilities;
- The process of selecting and changing the enrollee's PCP;
- Grievance, appeal, and State fair hearing procedures and timeframes;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries and how to access auxiliary aids and services, including additional information in alternative formats or languages; and
- Information on how to report suspected fraud or abuse.

MCOs are permitted to provide this information by mail or email (only if beneficiary has expressed consent for email) in addition to posting online.

MCOs must compile a directory of its network providers in a format specified by DHCF. The directory must be made available to enrollees and potential enrollees and include the following information:

- Provider names (first, middle, last)
- Group affiliation(s) (i.e., organization or facility name(s), if applicable)
- Street address(es) of service location(s)
- Telephone number(s) at each location
- Website URL(s)
- Provider specialty
- Whether provider is accepting new beneficiaries
- Provider's linguistic capabilities, (i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office)
- Whether provider has completed cultural competency training
- Office accessibility (i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment)

- Telephone number that beneficiaries can call to confirm the information in the directory

This information must be made available in electronic form, and upon request, in paper form. Per 42 CFR § 438.10, information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO receives updated provider information. Provider directories must be posted on the MCO's website.

iii. Confidentiality

MCOs must have a management information system capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality of protected health information in accordance with Health Insurance Portability and Accountability Act, the District's Mental Health Information Act, and 42 C.F.R. Part 2, including special privacy and confidentiality provisions related to people with HIV/AIDS, mental illness, and alcohol and drug abuse disorders.

All MCO contracted providers must complete training and education on privacy and confidentiality of protected health information. The MCO provider manual must also address privacy and security procedures and additional protections for maintaining enrollee privacy and confidentiality. All reporting must comply with privacy and confidentiality standards in accordance 45 CFR parts 160 and 164, subparts A and E.

iv. Enrollment and Disenrollment

Newly eligible Medicaid beneficiaries shall be initially enrolled in FFS Medicaid and shall have 30 days from the date of notice sent by the enrollment broker to select an MCO. If a newly eligible beneficiary fails to select an MCO within 30 days of enrollment, DHCF, through its enrollment broker, shall auto-assign such individuals and families on approximately an equal and random basis among MCOs. Newly eligible beneficiaries that are auto-assigned or voluntarily select an MCO shall have 90 days from the date of managed care enrollment to transfer to another MCO.

Within 10 business days of the birth of an infant to a woman enrolled in the plan, the MCO shall notify DHCF by completing all fields in the Deemed Newborn forms and log and submit to designated staff at the Department of Human Services' Economic Security Agency, which is responsible for Medicaid eligibility determinations, within 10 business days to ensure newborns are enrolled timely. From the time of birth, the newborn must remain an enrollee of the MCO to which he/she was assigned until a separate Medicaid number is assigned. Upon assignment, the parent can choose to enroll the newborn in a different MCO.

MCOs may only request disenrollment of enrollees when the MCO is notified that the enrollee is ineligible for services or upon suspicions of fraud or deceptive use of MCO services by the enrollee. Consistent with the ADA, DHCF determines if the individual is a qualified person with a disability and, if so, shall specify the reasonable accommodations that MCO shall make to continue provision of services. Risk-based

MCOs may request that DHCF disenroll a Medicaid enrollee who has been admitted to a Medicaid approved Residential Treatment Center, Psychiatric Residential Treatment Facility, Nursing Home, Nursing Facility, Skilled Nursing Facility, or other long-term care facility or is incarcerated and who is expected to remain in the facility for 30 consecutive days.

v. Grievance and Appeals System

DHCF has implemented a grievance and appeals system that meets the standards in the federal regulations (42 CFR §§ 438.228, 438.400, 438.402). Enrollees or authorized representatives may file a grievance, orally or in writing, to express dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., quality of care concerns or behavior of a provider) with the MCOs at any time. In the event of an adverse benefit determination, in which the MCOs must give enrollees timely and adequate notice in writing consistent with 42 CFR §438.10, the enrollee may file an appeal with the MCO. Should the MCO not resolve the appeal to the enrollee's satisfaction, they have access to a state fair hearing. A provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee.

The MCO shall issue a written acknowledgement of the receipt of an appeal or a grievance within two business days of receipt. The MCO shall dispose of the grievance and notify the enrollee or the enrollee's designee in writing of the decision no later than sixty calendar days from the date the MCO receives the grievance or as expeditiously as the enrollee's health condition requires. In handling grievances and appeals, each MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers for use by persons with hearing or speech difficulties. DHCF require MCOs to report monthly on their grievance and appeal processes and outcomes.

vi. Sub-contractual Relationships and Delegation

MCOs shall evaluate a prospective subcontractor's ability to perform the activities to be delegated before a written agreement is executed. When an MCO enters into a sub-contractual arrangement all contracts or written arrangements/agreements between the MCO and any subcontractor must specify that the delegated activities or obligations are: 1) in compliance with the MCO's contract obligations; and 2) either provide for the revocation of the delegation or specify remedies in instances where the subcontractor has not performed satisfactorily.

Additionally, MCOs shall monitor the independent contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the District, consistent with industry standards, or District MCO laws and regulations. If the MCO identifies deficiencies or areas for improvement, the MCO shall take corrective actions.

C. Measurement and Improvement Standards

i. Practice Guidelines

The MCOs shall adopt and disseminate clinical practice guidelines relevant to its enrollees for the provision of preventive, acute, and chronic medical and behavioral healthcare services. All practice guidelines shall be based on valid and reliable scientific clinical evidence or drawn from expert and professional provider consensus which includes the results of peer-reviewed studies. The MCOs shall adopt practice guidelines in consultation with network practitioners located in the District. These practice guidelines shall be reviewed, updated, and approved periodically, as appropriate, at least every two years by the MCO's Quality Improvement Committee or a designated clinical committee.

The practice guidelines shall be disseminated to all network providers, and shall be readily available through mail, fax, e-mail, or through the MCO's website. Practice guidelines shall be made available upon request to enrollees and potential enrollees. The MCO shall utilize the application of practice guidelines to assist practitioners and enrollees in decision making as it pertains to appropriate health care utilization management for specific clinical circumstances and behavioral health care services.

ii. Quality Assessment and Performance Improvement Program

MCOs are required to develop, maintain and operate a Quality Assessment and Performance Improvement (QAPI) program, which shall be reviewed and/or revised annually and submitted to DHCF for approval. The MCO must maintain a well-defined QAPI structure that includes a planned, systematic approach to improving clinical and non-clinical processes and enrollee health outcomes (*See Appendix III*).

The MCO is also required to use performance measures including, but not limited to, HEDIS, CAHPS, provider surveys, and enrollee satisfaction surveys to assess the effectiveness of its QAPI program. The QAPI program shall include iterative processes for assessing and monitoring quality performance, including but not limited to: barrier analysis, identifying opportunities for improvement, implementing targeted and system interventions, and continuous monitoring for effectiveness through the utilization of quality improvement principles.

Conduct Performance Improvement Projects

MCOs conduct at least two DHCF chosen PIPs annually using a report template provided by the EQRO. The EQRO develops the study methodologies and validates the data reported. Results are presented in final reports due 18 months after each study begins.

DHCF required the MCOs to conduct two PIPs on Pediatric Asthma and Perinatal Health and Birth Outcomes from FY 2015 through FY 2018. In FY 2018, DHCF added PIPs on Comprehensive Diabetes Care and Behavioral Health. PIPs on Pediatric Asthma; Perinatal Health and Birth Outcomes; and Behavioral Health were retired in

FY 2019. A PIP on Maternal Health, which includes timeliness of prenatal care and access to contraceptive care, was added, and the PIP on Comprehensive Diabetes Care was maintained.

Utilization of Services

The MCO contract requires that the QAPI include mechanisms to detect both underutilization and overutilization of services. The MCO must use required performance measures to analyze the delivery of services and quality of care, over and underutilization of services, disease management strategies, and outcomes of care.

Mechanisms to Assess the Quality and Appropriateness of Care

The MCO contract requires that the QAPI include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. Requirements include, but are not limited to:

1. Ensuring that each enrollee is assigned a PCP, which may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, pediatric physician (when appropriate for the enrollee), osteopath, clinic or Federally Qualified Health Center (FQHC), nurse practitioner, or a subspecialty physician when appropriate to an enrollee's special health care needs;
2. Providing care coordination and case management services;
3. Direct access to a specialist as appropriate for the enrollee's condition and identified needs; and
4. The availability of appropriate accommodations.

Comply with the District's Annual QAPI Review

The MCO's QAPI is reviewed annually as part of the external quality review process. The District's MCO contract requires that the MCO must fully cooperate and collaborate with all EQRO activities, personnel, and any requests for data/documentation/reports.

In addition, MCOs are required to conduct an annual evaluation of its QAPI program, which at a minimum must include:

- Analysis of improvements in the access and quality of health care and services for enrollees, due to quality assessment and improvement activities, and targeted interventions carried out by the MCO;
- Consideration of trends in service delivery and health outcomes over time, including monitoring of progress on performance goals and objectives; and
- Annual submission of information on the effectiveness of the MCO's QAPI program to network providers, upon request to enrollees, and to DHCF through the annual compliance review or upon request.

iii. Health Information Systems

MCOs must maintain a health information system that collects, analyzes, integrates and reports data as specified by DHCF. The system must provide information on the areas including, but not limited to, utilization, claims, grievance and appeals, as well as enrollment and disenrollment for reasons other than loss of Medicaid eligibility.

Collect Data on Participant and Provider Characteristics and on Services

MCOs must provide for:

- Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees;
- Submission of enrollee encounter data to the District at a frequency and level of detail to be specified by the State, based on program administration, oversight and program integrity needs;
- Submission of all enrollee encounter data that the District is required to report to CMS;
- Specifications for submitting encounter data to the District in the required format;
- State review and validation of encounter data;
- Validation of the completeness and accuracy of reported encounter data and that it precisely reflects the services provided to the enrollees;
- Timely submission of data; and
- Policies and procedures to monitor data completeness, consistency and validity including an attestation process.

The MCOs are required to have internal procedures to ensure that data reported to DHCF are tested for validity, accuracy, and consistency on a regular basis. At a minimum, the MCOs must verify the accuracy and timeliness of reported data, screen the data for completeness, logic, and consistency. They must also collect service information in standardized formats to the extent feasible and appropriate. The MCO must ensure that reportable data, when allowed to be reported based on a sample, reflects a sufficient sample size to accurately reflect the enrollee population. The MCOs must also agree to cooperate in data validation activities that may be conducted by DHCF, by making available to DHCF's specifications, medical records, claims records, and a sample of any other data.

IV. Improvement and Interventions

A. Improving Quality of Care through Interventions

Table 4: Linking Objectives to Interventions

Objectives	Interventions							
	My DC Health Home (SMI)	My Health GPS (Chronic Condition)	Telemedicine	Performance Improvement Projects (PIP)	Behavioral Health Integration	Value based Purchasing (VBP)	Perinatal Summit and Taskforce	Behavioral Health Transformation Demonstration
1.1 Promote effective communication between patients and their care partners	✓	✓	✓					
1.2 Support appropriate case management and care coordination	✓	✓		✓	✓			✓
1.3 Address physical and behavioral health comorbidities	✓	✓			✓			✓
2.1 Improve management of pre-diabetes and diabetes	✓	✓	✓	✓				
2.2. Improve comprehensive behavioral health services	✓				✓			✓
3.1 Improve maternal and child health			✓	✓			✓	✓
3.2 Reduce health disparities				✓	✓			
3.3 Promote preventative care				✓		✓	✓	✓
4.1 Incorporate pay for performance programs in all MCO contracts						✓		
4.2 Direct MCO payments for primary care enhancement and local hospital services						✓		

i. Performance Improvement Projects

Each MCO is required to annually conduct performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and interventions, significant improvement in clinical or non-clinical care areas that are expected to have a favorable effect on health outcomes. The MCOs' PIPs must include measurements of performance using objective quality indicators, implementation and reporting of interventions to achieve improvement in quality, evaluation of the effectiveness of the

interventions, and planning and initiation of activities for increasing or sustaining improvement. As of FY 2019, DHCF requires the MCOs to conduct two PIPs, one on Comprehensive Diabetes Care and one on Maternal Health.

Comprehensive Diabetes Care - According to the CDC's Surveillance System in 2016, 9.3% of adults within the District of Columbia had a diabetes diagnosis. Overall, the measurement year (MY) 2016 District of Columbia MCO averages did not compare favorably to the national averages for the HEDIS® Comprehensive Diabetes Care performance measures. On five of seven measures, the MCOs performed below the national average benchmarks. Diabetes is a chronic condition, and eliminating risk factors such as smoking, overweight/obesity, physical inactivity, high blood pressure, high cholesterol, and high blood glucose is critical in managing the condition. In 2018, DHCF initiated the Comprehensive Diabetes Care PIP with the Medicaid managed care population and used MY 2017 results as the baseline assessment.

Maternal Health - The District of Columbia Department of Health Perinatal Health and Infant Mortality Report (April 5, 2018) published several relevant statistics based on 2015-2016 DC birth data:⁹

- Fifty-two percent (52%) of non-Hispanic black mothers entered prenatal care in the 1st trimester compared to 86% of non-Hispanic white mothers and 64% of Hispanic mothers.
- One (1) in 20 non-Hispanic black mothers did not initiate prenatal care, which was significantly higher than the percentage of non-Hispanic white and Hispanic mothers.

Some of these women may have high-risk pregnancies and conditions that can potentially be managed. DC Health has identified multiple core priorities to drive programmatic efforts. In addition to the potential positive effects on the mother's and newborn's health, prenatal care can also positively impact child health.

Overall, the MY 2017 District of Columbia MCO averages did not compare favorably to the national averages for the HEDIS® Prenatal and Postpartum Care performance measures. Both measures performed below the national average benchmarks.

To further drive improvement on the MCO PIPs, DHCF and the MCOs participate in multi-stakeholder QI collaboratives which typically includes representation from provider groups and with other governmental and community stakeholders. For 2020, DHCF is proposing a QI improvement collaborative for the Maternal Health PIP that will bring stakeholders together to identify and implement clinical and systematic interventions aimed at improving timeliness of prenatal, postpartum, and contraceptive care.

⁹ These statistics represent all DC residents who gave birth, not only those covered by DC Medicaid. For more information, please refer to the DC Department of Health Perinatal Health and Infant Mortality Report published on April 5, 2018.

ii. Incentivizing MCO Performance

DHCF has implemented an MCO pay-for-performance (P4P) program, which includes capitation payment withhold tied to MCO performance on select quality improvement performance measures. DHCF selected three outcomes-based measures that aim to reduce the following: 1) Plan All-Cause Readmissions, 2) Potentially Preventable Hospitalizations, and 3) Low Acuity Non-Emergent (LANE) ED Visits. DHCF chose three performance measures to incentivize the risk-based MCOs to maximize provision of case management and primary and preventive care in the least acute setting. The DQHO works closely with the MCOs to address barriers and implement effective interventions to improve the P4P measures. The results of the MCO P4P program are published biannually on DHCF's website.

Value Based Purchasing - DHCF is requiring MCOs to engage in value-based purchasing (VBP) arrangements or other alternative payment methodologies (APM) that link specific financial incentives to demonstrable improvement in health outcomes. MCOs must utilize payment arrangements with their network providers to reward performance excellence and performance improvement in targeted priority areas conducive to improved health outcomes and/or cost savings to the health system. VBP arrangements with providers include both FFS-based bonus arrangements and shared savings, shared risk, or capitated Alternative Payment Methods arrangements.

As of February 2018, all risk-based MCOs are operating VBP programs. DHCF aims to further align these programs across MCOs to achieve increased efficiencies for providers and maximize positive health outcomes for enrollees. DHCF is working closely with community partners to identify and prioritize social determinants of health that challenge the District's Medicaid population and how the agency can most effectively leverage this data to build person-centered VBP programs.

iii. Mayor's Commission on Healthcare Systems Transformation

The work of the District of Columbia Mayor's Commission on Healthcare Systems Transformation (the Commission) focused on alleviating systemic health care challenges in the District by developing recommendations that address the current stresses in the District's health care system. The Commission specifically targeted the following issues: improving access to primary, acute, and specialty care services, including behavioral health care; addressing health system capacity issues for inpatient, outpatient, pre-hospital and emergency room services; and promoting an equitable geographic distribution of acute care and specialty services in disproportionately-underserved communities east of the Anacostia river. The *Report and Recommendations of the Mayor's Commission on Healthcare systems Transformation* can be found here: <https://dmhhs.dc.gov/node/1409786>.

iv. Health Homes

DHCF launched its first Health Homes program, called My DC Health Home (MDCHH), in January 2016. To be eligible for MDCHH, beneficiaries must have a serious mental illness (SMI). In July 2017, DHCF launched its second Health Homes program, called My Health GPS (MHGPS), targeting beneficiaries with three or more chronic conditions. These programs provide critical case management and care coordination services to enrollees in the primary care setting. Health Home providers coordinate very closely with community partners to address unmet needs of enrollees. DHCF conducted an observational analysis on a cohort of participants pre- and post-enrollment in the MHGPS Program. The analysis illustrated promising results on preventable utilization, including: reduction in LANE ED visits as well as total ED cost, reduction in preventable inpatient admissions, and no growth in readmissions.

Starting in 2017, DHCF began reporting on the CMS Health Home Core Set of performance measures for MDCHH enrollees and will continue to track their progress on key quality metrics to improve their health outcomes.¹⁰ DHCF began reporting on the CMS Health Home Core Set for MHGPS enrollees in 2018.¹¹

B. Health Information Technology (HIT)

i. DC's Information Systems and Medicaid Data Warehouse

DHCF has created a unique, single source Medicaid Data Warehouse (MDW) that ensures timely access to claims and encounter data. DHCF migrated ten years of claims history from its MMIS into an enterprise data warehouse and is now able to create all CMS required reports and ad-hoc reports. The modernized data infrastructure and analytical tools allow for evaluation of MCO performance across financial and utilization metrics. In conjunction with the adoption of the MDW, DHCF has incorporated numerous analytics tools to augment the agency's reporting and analytics capabilities, to better serve the District Medicaid population.

ii. Health Information Technology Initiatives

DHCF's Health Care Reform and Innovation Administration (HCRIA) is charged with implementing the necessary Health Information Technology (HIT) to support the agency's quality improvement efforts across service delivery areas and programs. HCRIA is spearheading initiatives currently to develop multiple, sophisticated HIT tools, including an HIE platform through CRISP (the Chesapeake Regional Information System for our Patients); eCQM aligned population health reporting tool; a performance measurement tool that will be used by providers across programs, such as Health Homes, Nursing Facility Quality Improvement, and DHCF's FQHC P4P program. All these

¹⁰ Measurement year 2016 and 2017 data on the CMS Health Home Core Set of performance for MDCHH have been reported to CMS.

¹¹ Measurement year 2017 data on the CMS Health Home Core Set of performance for MHGPS was reported in 2018.

initiatives can help the MCOs enhance their quality improvement initiatives. For example, the electronic clinical quality measures (eCQM) tool creates the opportunity for MCOs to monitor performance measures using clinical data, thus creating a comprehensive picture of performance and holding providers accountable.

In addition, the Community Resource Information Exchange Technical Solution (CoRIE) Development Grant will fund District partners (e.g., DC PACT (public/private community partnership), DC Primary Care Association) to create a community resource inventory and referral system for capturing, reporting, measuring and sharing data on Social Determinants of Health. Finally, the SUD Demonstration Project Planning Grant will fund the District to design and build an infrastructure that enables structured data collection and communication with District behavioral health providers, as well as the development and implementation of consent management tools to facilitate appropriate exchange of 42 CFR Part 2 data.¹²

V. Delivery System Reforms

Behavioral Health System Redesign

The District of Columbia offers a broad array of behavioral health services, ranging from diagnosis and counseling to more intensive interventions for individuals with SMI, serious emotional disturbance (SED) or substance use disorder (SUD). However, key gaps in the Medicaid service array and complex and overlapping oversight have made it harder for the District to manage behavioral health services in a holistic way that is integrated with other medical treatment.

Providers and services are overseen by DHCF, Medicaid MCOs, and the District's Department of Behavioral Health, with some overlap in authority. In addition, other District agencies provide ancillary behavioral health services and touchpoints including through the school system, foster care and child protective services, and justice system, among others. This division of responsibility has sometimes resulted in service gaps, confusion about points of entry, and a disconnect between beneficiaries' physical and behavioral health care. In addition, the disparate Medicaid coverage of institutions for mental disease (IMD) services between the managed care and FFS programs unfairly disadvantage FFS beneficiaries.

In 2019, DHCF expanded the behavioral health network to include FQHCs, free-standing mental health clinics, physician groups, and clinical group practices to treat substance abuse and mental health disorders under the direction of a physician. The qualified practitioners were expanded to nurse practitioners, physician assistants, and other allied health professionals under the direction of a physician.

¹² For more information on the Demonstration Project to Increase Substance Use Provider Capacity, please visit: <https://dhcf.dc.gov/page/demonstration-project-increase-substance-use-provider-capacity>

The dramatic increase in opioid-related fatalities in recent years has exacerbated and deepened these challenges and catalyzed the District's interest in seeking new authorities to ensure Medicaid can more effectively support residents' needs. DHCF received CMS approval in November 2019 for a Section 1115 Medicaid Behavioral Health Transformation demonstration that seeks to strengthen the District's Medicaid behavioral health system through the addition of a broader array of services and providers designed to improve access to and transitions of care, including, coverage for short-term residential and inpatient services provided by IMDs for individuals with SMI and SUD, and complementary community-based services.¹³ To compliment the Behavioral Health Transformation Demonstration and the District of Columbia Opioid Response program activities, DHCF was awarded a \$4.6 million CMS planning grant to assess the growth in District Medicaid provider capacity to diagnose SUD and provide treatment and recovery services.¹⁴

Medicaid Program Reform

DHCF plans to move towards a fully managed Medicaid program by 2025. This move aims to transform the managed care program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.

Initially, DHCF will transition nearly 22,000 individuals currently in the Medicaid FFS program to the Medicaid managed care program, effective October 1, 2020. Health care costs for individuals with FFS coverage are typically four-to-five times greater than persons in managed care as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays. Today, these beneficiaries must manage their health care needs without assistance or care coordination. By joining the managed care program, this population will receive access to much needed care coordination, and as a result, improved health outcomes.

VI. Conclusion and Opportunities

Managed Care Performance

The care coordination challenges that plagued the District's three full-risk MCOs from 2014 through 2016 have been well documented – members' use of the emergency room for routine care, potentially avoidable hospital admissions and readmissions – and remain stubborn challenges. However, DHCF is seeing some improvement.

With CMS approval, DHCF implemented the MCO P4P program in 2017, which is funded through a two-percent withhold of each MCO's actuarially sound capitation payments. DHCF used data from the period April 1, 2015 through March 31, 2016 to set the initial baseline. MCOs must

¹³ For more information on the 1115 Waiver Initiative, please visit <https://dhcf.dc.gov/1115-waiver-initiative>.

¹⁴ For more information on the Demonstration Project to Increase Substance Use Provider Capacity, please visit: <https://dhcf.dc.gov/page/demonstration-project-increase-substance-use-provider-capacity>

meet minimum thresholds for improvement (i.e., reduction in rates of avoidable emergency and inpatient utilization) for all three performance measures in order to earn any portion of the withhold. For the most recent annual data period for 2018, the MCOs have spent approximately \$47 million on patient care that may have been avoided using more aggressive care coordination strategies. This is a notable reduction from the over \$53 million spent in year one of the program, which equates to roughly \$6 million in savings (this does not account for increases to outpatient costs with reductions in emergency and inpatient utilization). Most MCOs have exceeded the established targets for performance in quality initiatives, except for DHCF’s newest MCO entering the District in late 2017 (see Figure 1 and 2 below).

Figure 1: MCO Performance on P4P Measures FY2017 (Year 1 of P4P Program)

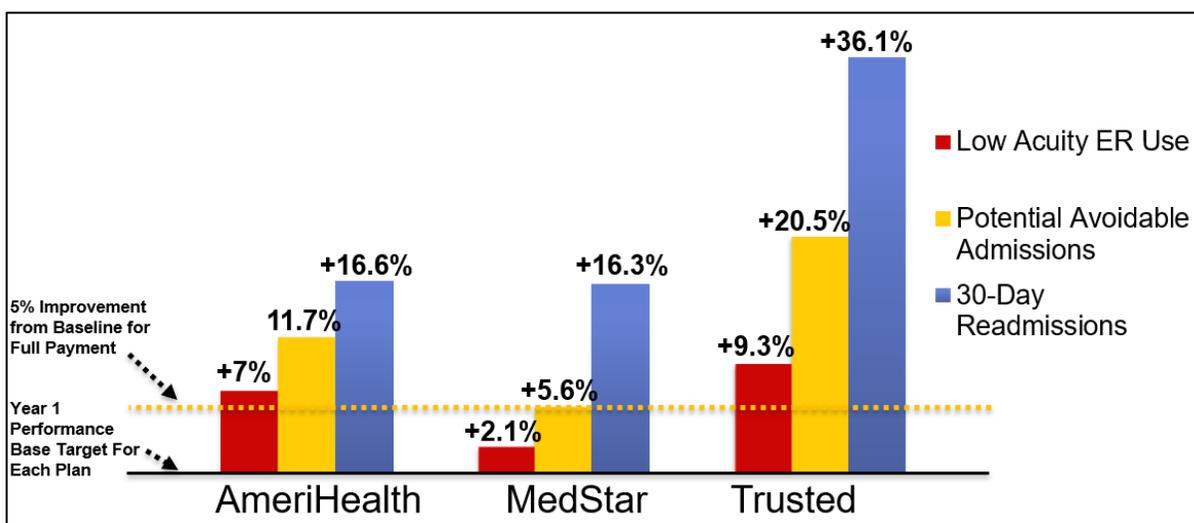
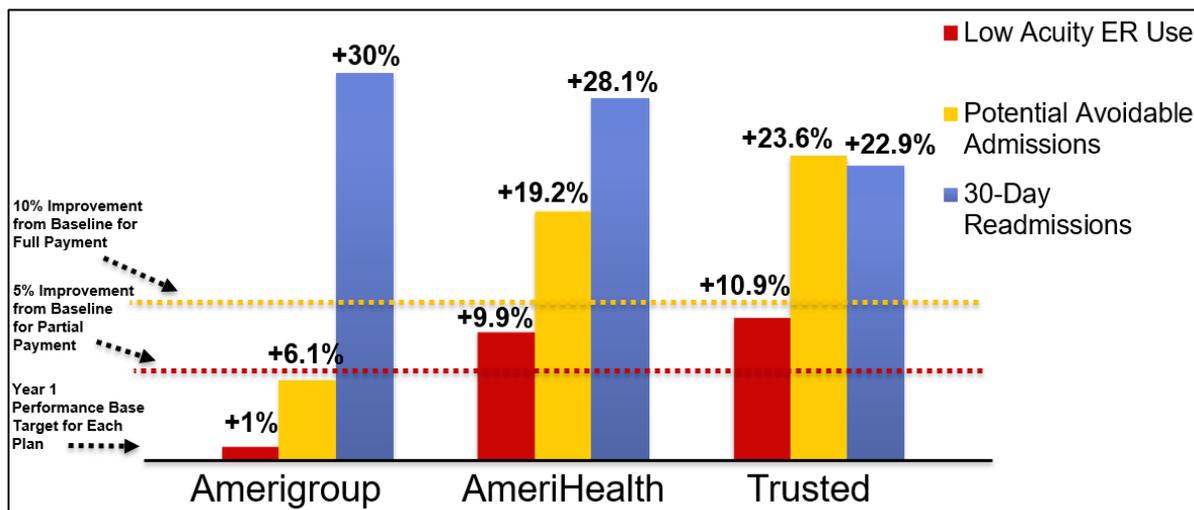


Figure 2: MCO Performance on P4P Measures FY2018 (Year 2 of P4P Program)



Future Medicaid quality improvement activities will consider the behavioral health and physical health needs of the FFS populations as they begin to transition into the managed care program over the next five years. These proposed changes, with the recent expansion of the District's HIE capabilities, should positively impact health outcomes for all beneficiaries as their care will be less fragmented.

Over the next few years, DHCF will work more closely with the MCOs to incorporate APMs into all provider contracts. Through the leadership of DQHO, DHCF will move toward achieving the triple aim in its managed care program by identifying additional areas for improvement and promoting best practices. The Medicaid system transformation will further augment the goals outlined in this quality strategy as the District strives to improve outcomes for all beneficiaries.

Appendix I: Selected Performance Measures

This Appendix highlights the MCO-reported quality measures that are tied to the DHCF's 10 quality strategy objectives. DHCF may refine the required measures to align to the District's priorities as needed.

Measure Name	Measure Description	Steward
Objective 1.1: Promote effective communication between patients and their care partners		
Rating of All Health Care	CAHPS survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care)	AHRQ
Rating of Personal Doctor	CAHPS survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of Personal Doctor)	AHRQ
Objective 1.2: Support appropriate case management and care coordination		
High Risk Beneficiaries Referred to a Health Home	Number of referrals and retention of enrollees in the health home program	DHCF
48 Hour Follow-up After Emergency Department Visit	The percentage of members who were contacted by the MCO within 48 hours after an emergency department visit.	DHCF
Objective 1.3: Address physical and behavioral health comorbidities		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA
High Blood Pressure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg Note: A single rate is reported and is the sum of all three groups.	NCQA
Objective 2.1: Improve management of pre-diabetes and diabetes		
Adult BMI Assessment	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA

Comprehensive Diabetes Care: HbA1c Poor Control (>9%)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	NCQA
Objective 3.1: Improve comprehensive behavioral health services		
Follow-up after Emergency Department Visit for Mental Illness Within 7/30 Days of the ED Visit	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness. Two rates are reported: <ul style="list-style-type: none"> ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). 	NCQA
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Within 30 Days of the ED Visit	Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: <ul style="list-style-type: none"> ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). 	NCQA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA
Objective 3.2: Improve maternal and child health		
Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	Assess children and young adults 12 months-19 years of age who had a visit with a primary care practitioner (PCP). The measure reports on four separate percentages: <ul style="list-style-type: none"> Children 12-24 months who had a visit with a PCP during the measurement year. Children 25 months-6 years who had a visit with a PCP during the measure year. Children 7-11 years who had a visit with a PCP during the measure year or the year prior to the measurement year. Adolescents 12-19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year. 	NCQA
Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.	NCQA
Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA

<p>Contraceptive Care: Postpartum and All Women</p>	<p>Among women ages 15 through 44 who had a live birth, the percentage that is provided:</p> <ol style="list-style-type: none"> 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. 	<p>OPA</p>
<p>Objective 3.3: Reduce health disparities</p>		
<p><i>Select measures in this Appendix are to be reported by select strata, including age, race, ethnicity, sex, primary language, and disability status and geography</i></p>		
<p>Objective 4.1: Incorporate pay for performance programs in all MCO contracts and Objective 4.2: Direct MCO payments for primary care enhancement and local hospital services</p>		
<p>Low Acuity Non-Emergent (LANE)</p>	<p>Percentage of avoidable, low-acuity non-emergent, emergency department visits.</p>	<p>DHCF</p>
<p>Potentially Preventable Hospitalizations</p>	<p>Percentage of inpatient admissions for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.</p>	<p>DHCF</p>
<p>Plan All-Cause Readmissions (PCR)</p>	<p>For patients ages 18-64, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 calendar days and the predicted probability of an acute readmission.</p>	<p>NCQA</p>

Appendix II: Department of Health Care Finance Informational Bulletin Concerning Compliance Actions in the Managed Care Program.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
441 4th Street Northwest, Suite 900 South
Washington, DC 20001

Department of Health Care Finance Informational Bulletin

DATE: November 13, 2019
FROM: Lisa Truitt
Director, Health Care Delivery Management Administration
SUBJECT: Compliance Actions in the Managed Care Program

The purpose of this Informational Bulletin is to outline the hierarchy of actions the Department of Health Care Finance (DHCF) may implement for non-compliance with and poor performance of contract requirements by a Medicaid managed care organization (MCO). This Informational Bulletin applies to all DHCF contracted Medicaid MCOs and the Child and Adolescent Supplemental Security Income Program (CASSIP) Contractor, hereinafter referred to as MCO.

The DHCF requires MCOs to take corrective action for occurrences of non-compliance or poor performance under the Medicaid managed care contract (Contract), including but not limited to instances where the DHCF determines the MCO's quality improvement efforts are inadequate or improved performance is necessary due to identified weaknesses within operations of the program. A variety of means will be utilized to assure compliance with the Contract, including issuance of compliance actions to achieve resolution of all outstanding requirements. Any MCO found non-compliant of its Contract may be eligible for a range of compliance and/or enforcement actions, in accordance with the following procedures.

Compliance Continuum

The DHCF may issue a compliance/enforcement action to an eligible MCO according to the following Compliance Continuum, in chronological order, as well as in order of increasing severity. Depending on the number of, severity of, or potential for harm to an enrollee and the MCO's instance(s) of non-compliance, DHCF may take initial action at any point on the following continuum:

Compliance Actions

1. ***Notice of Non-Compliance (NONC)*** – Issued by the DHCF, a NONC represents a formal acknowledgement of the instance of non-compliance. NONCs are used to document small or isolated problems.
2. ***Warning Letter*** – Issued by the DHCF, a Warning Letter is issued either when an organization has already received a NONC, yet the problem persists, or as a first offense for larger or more concerning problems. Unlike NONCs, these letters contain warning language

about the potential consequences to the MCO, should the non-compliant performance continue.

3. **Level 1 Corrective Action Plan (CAP)** – The DHCF may request the MCO to submit a Level 1 CAP outlining how the MCO will resolve each identified occurrence of non-compliance with specific deadlines. When a Level 1 CAP is requested, the DHCF shall initiate Enhanced Monitoring of the MCO until the CAP is resolved to the satisfaction of the DHCF.
4. **Level 2 CAP** – Issued by the Office of Contracting and Procurement (OCP), a Level 2 CAP is reserved for persistent problems or very serious concerns that require in-depth and continued monitoring by the DHCF. A Level 2 CAP requires the MCO to submit a step-by-step plan of action to achieve targeted outcomes for resolution of identified occurrences of non-compliance. For all Level 2 CAPs, the DHCF shall initiate Enhanced Monitoring of the MCO until the CAP is resolved to the satisfaction of the DHCF. MCOs are required to self-report all ongoing and closed Level 2 CAPs when applying to any new District procurement.

Enforcement Actions

5. **Intermediate Sanctions** – MCOs are required to report all Intermediate Sanctions when applying for a new District procurement and may prohibit the ability of an MCO to participate in District procurements. Issued by the OCP, Intermediate Sanctions may include the following, as outlined in the MCO contracts:
 - a. Civil money penalties;
 - b. Appointment of temporary management for Contractor;
 - c. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
 - d. Suspension of all new enrollment;
 - e. Suspension of payment for beneficiaries enrolled after the effective date of the sanction; and
 - f. Additional sanctions under District law that address areas of noncompliance.

Contract Actions

6. **Termination** – The DHCF, through the OCP, may ultimately terminate its contract with an MCO due to non-compliance and/or poor performance.

Other Considerations

The DHCF may choose to issue an action for each occurrence of non-compliance or include several occurrences of an MCO's non-compliance in a single action. A specific action will endure until:

- The MCO has demonstrated to the satisfaction of the DHCF, resolution of the occurrence(s) of non-compliance and implemented adequate measures to reasonably prevent future occurrences; OR
- The occurrence(s) of non-compliance is (are) not resolved to the satisfaction of the DHCF, and DHCF escalates the issue to a higher step on the Compliance Continuum.

The DHCF shall conduct a review of all compliance/enforcement actions issued to the MCO during the previous or current Contract period. At any time, DHCF may choose to publicly publish a compliance report of past performance by each contracted MCO.

For questions regarding this Informational Bulletin, contact Abby Kahn, Compliance Officer, DHCF Division of Quality and Health Outcomes at abigail.kahn@dc.gov or (202) 442-4650.

Appendix III: Requirements for the Quality Assurance and Performance Improvement (QAPI) Program

MCO QAPIs are reviewed during the pre-contract period, readiness review process and annually thereafter. MCOs are also required to provide an annual written evaluation of the impact and effectiveness of the QAPI program in a similar format to the QAPI submitted.

QAPIs must contain, at minimum, the following elements:

- Description of Quality Management (QM) Committee structure – must include:
 - Quality Improvement Manager
 - Key management staff
 - MCO network providers
- Designation of individuals/departments responsible for QAPI implementation – MCOs must designate a senior executive with appropriate authority and accountability to oversee QAPI implementation. The Chief Quality Officer is accountable for the administrative success of QAPI program activities. The Chief Medical Officer must have substantial involvement.
- Description of network provider participation in QAPI – MCOs must involve network providers in QAPI activities by including a requirement in provider contracts securing cooperation.
- Description of strategy for ensuring that all staff responsible for the QAPI program will remain current in the education, experience and training need for their positions.
- Integration of quality assurance with other management functions – To be effective, quality assurance must be integrated in all aspects of MCO management and operations. The QAPI must describe the process by which this integration will be achieved.
- Clinical practice guidelines – MCOs must develop or adopt practice guidelines consistent with current standards of care, as recommended by network practitioners. Include a description of how the MCO will:
 - Ensure guidelines are based on valid and reliable clinical evidence;
 - Provide guidelines to providers and members when requested;
 - Apply the guidelines to utilization management; member education; coverage of services; and any other appropriate areas.
- Quality and appropriateness of care – Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- Standards for service accessibility – MCOs must develop written standards for service accessibility.

- Utilization review procedures – Include mechanisms to detect overutilization and underutilization of services.
- Annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and evaluates the effectiveness of clinical and non-clinical initiatives. MCOs should conduct data analysis, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees.
- Performance Improvement Project (PIP) – MCOs are also required to conduct at least 2 PIPs each year in a priority topic area of DHCF's choosing. A description of how the MCO intends to address the areas of improvement must be included in the QAPI.
- Quality indicator measures – MCOs must at least annually collect and submit to DHCF performance measure data including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS specified Core Measures, EPSDT, Clinical and Non-clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events and all EQRO activities as part of its QAPI program.
- QAPI documentation methods – The QAPI must contain a description of the process by which all QAPI activities will be documented, including performance improvement studies, medical record audits, utilization reviews, etc.