District of Columbia
Department of Health Care Finance

Medicaid Managed Care

2020 Annual Technical Report

Qlarant

DHCF
Department of Health Care Finance

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Executive Summary

Introduction

The District of Columbia's (DC's) Department of Health Care Finance (DHCF) contracts with Qlarant, an external quality review organization (EQRO), to evaluate its Medicaid managed care program, DC Healthy Families. The managed care program has served Medicaid beneficiaries since 1998 and provides acute, primary, specialty, and specific behavioral health services to qualifying children and families, pregnant women, and children with special needs. Managed care plans (MCPs) contracted to provide these services include:

- AmeriHealth Caritas District of Columbia (ACDC)
- CareFirst Community Health District of Columbia (CFDC)
- Health Services for Children with Special Needs (HSCSN)
- MedStar Family Choice (MFC)[1]

As the District of Columbia EQRO, Qlarant evaluates MCP compliance with federal and DHCF-specific requirements by conducting multiple external quality review (EQR) activities including:

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

Qlarant conducted EQR activities throughout 2020 and evaluated MCP compliance and performance for measurement years (MYs) 2019 and 2020, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[2] This report summarizes results from all EQR activities and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs.

Key Findings

Key findings are summarized below for the DC Healthy Families Program. MCP-specific strengths, weaknesses, and recommendations are identified within the MCP Quality, Access, Timeliness Assessment section of the report. MCP findings correspond to performance related to the quality, accessibility, and timeliness of services provided to their enrollees.

Performance Improvement Project Validation. The MCPs conducted two PIPs each and reported results for MY 2019. For the Comprehensive Diabetes Care PIP, MCP PIP validation scores ranged from 69% to

[1] MFC is new to the DC Healthy Families program, effective October 1, 2020. MFC replaced Amerigroup District of Columbia (AGP), a previously contracted MCP, through a competitive procurement process.
[2] CMS EQRO Protocols

100%. MCPs reported their second remeasurement results, which were mixed. MCP weighted averages demonstrated improvement, compared to baseline performance, for three of seven measures. HSCSN performed poorly compared to other MCPs and should focus attention on implementing system-level interventions and conducting a comprehensive analysis to better understand performance and barriers. For the Maternal Health PIP, MCPs reported baseline performance. All MCPs developed methodologically sound PIPs and are expected to demonstrate improvement in their first remeasurement period. MCP PIP validation scores ranged from 95% to 100%.

Performance Measure Validation. Qlarant conducted two PMV audits during 2020. The first audit focused on validating PIP measure accuracy and the second audit evaluated the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures. MCP Information Systems Capabilities Assessments determined MCPs had appropriate systems in place to process accurate claims and encounters. The MCPs received overall PMV ratings ranging from 99% to 100% for the PIP measures and 93% to 100% for the EPSDT measures. All measures were assessed as "reportable."

Operational Systems Review. Qlarant conducted a comprehensive OSR in 2020. MCP scores ranged from 93% to 97%. All MCPs were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, most of which related to the Grievance and Appeal System standard. The 2020 OSR confirmed the MCPs did not address all 2019 CAPs, which is described in more detail within the Assessment of Previous Recommendations section of the report. Most notably, HSCSN did not adequately address a majority of its CAPs.

Network Adequacy Validation. MCPs have robust provider networks demonstrating at least 99% compliance with geographic and provider-to-enrollee requirements. During 2020, MCPs improved access to timely provider appointments. However, opportunity continues to exist to positively impact timely access as MCP performance ranged from 71% to 100%. ACDC and CFDC substantially improved the accuracy of their provider directories, while HSCSN's improvement was marginal. All MCPs should continue efforts to improve the reliability of provider directory content ensuring enrollees have access to accurate provider information. The 2020 assessments determined MCP compliance ranged from 35% to 60%.

Conclusion

DHCF requires MCPs to obtain and maintain National Committee for Quality Assurance (NCQA) accreditation, which validates their commitment to quality improvement.[3] MCPs should demonstrate this commitment by conducting improvement strategies to drive PIP measure outcomes in a positive direction. The Comprehensive Diabetes Care PIP is maturing and should demonstrate significant and sustained improvement before closure. Comprehensive barrier and data analyses should assist MCPs in understanding where to focus efforts. The MCPs are largely compliant with federal and DHCF managed care requirements. When deficiencies are identified, most MCPs respond quickly with corrective actions. MCPs have robust provider networks and made strides in improving timely access to provider appointments and should continue activities to improve provider directory accuracy. MCP program structures support quality monitoring and improvement activities to further enhance the quality, accessibility, and timeliness of health care. DHCF should continue to strive to improve health outcomes

[3] Accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

by encouraging MCPs to meet and exceed quality strategy goals and holding MCPs accountable for performance.

District of Columbia Managed Care Program

2020 Annual Technical Report

Introduction

Background

The District of Columbia's (DC's) Department of Health Care Finance (DHCF) aims to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for District of Columbia residents. To assist in meeting this goal, the District operates a Medicaid managed care program known as DC Healthy Families (DCHF) and provides free health insurance to District residents meeting specific income and eligibility requirements. Three Medicaid managed care organizations and one health plan providing health care services to Medicaid enrollees in the District's Child and Adolescent Supplemental Security Income Program (CASSIP) participate in the DC Healthy Families program.[1] Collectively, these entities are referred to as managed care plans (MCPs) to maintain uniformity. These MCPs, serving approximately 236,711 enrollees, include:

- AmeriHealth Caritas District of Columbia (ACDC)
- CareFirst Community Health District of Columbia (CFDC)
- Health Services for Children with Special Needs (HSCSN)
- MedStar Family Choice (MFC)

MFC is new to the DC Healthy Families program, effective October 1, 2020. MFC replaced Amerigroup District of Columbia (AGP), a previously contracted MCP, through a competitive procurement process.

DHCF continues to transform its managed care program into a more organized, accountable, and person-centered system to best support the District's Medicaid beneficiaries in managing and improving their health. DHCF understands the significance of quality and its impact on health outcomes and requires the MCPs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation.[2] NCQA evaluates the quality of health care plans provide their enrollees. Audits consist of an assessment of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).[3,4] Table 1 provides the NCQA accreditation status of each contracted MCP.

[1] Health Services for Children with Special Needs is the District's contractor for the CASSIP program. It serves supplemental security income eligible Medicaid enrollees age 0-26 years. It must comply with the MCP standards (or more stringent standards as required by its contract).
[2] HSCSN is additionally required to obtain and maintain NCQA accreditation in case management.
[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 1. MCP Accreditation Status

MCP	NCQA Accreditation	Accreditation/Distinction
ACDC	Accredited	Case Management Health Plan Multicultural Health Care
CFDC	Accredited	Case Management Health Plan
HSCSN	Accredited	Case Management
MFC*	-	-

*MFC is expected to obtain NCQA accreditation within 12 months of contract award.
AGP was accredited during its contract term.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires DHCF to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of the District's MCPs. To meet these requirements, DHCF contracts with Qlarant. As the EQRO, Qlarant evaluates each MCP's compliance with federal and DC-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. During 2020, Qlarant conducted the following EQR activities:

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

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report summarizes Qlarant's EQR findings based on MCP audits conducted during 2020. The report describes objectives, methodologies, results, and conclusions for each EQR activity. Qlarant identifies MCP strengths and weaknesses relating to quality, access, and timeliness of care provided to the managed care enrollees. The report also includes recommendations for improvement which, if acted upon, may positively impact enrollee outcomes and experiences.

Performance Improvement Projects

Objective

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

Methodology

DHCF required MCPs to conduct and report on two District-selected PIPs during 2020, Comprehensive Diabetes Care and Maternal Health. MCPs reported measurement year (MY) 2019 PIP-related activities, improvement strategies, and performance measure (PM) results in their 2020 reports. The MCPs submitted their reports to Qlarant in July 2020 after MY 2019 PIP measure rates were validated and finalized. PIP measures were audited as part of the PMV activity to provide confidence in PM rates. MCPs completed a data and barrier analysis and identified follow-up activities for each PIP submission. MCPs used Qlarant reporting tools and worksheets to report their PIPs. Qlarant provided MCP specific technical assistance, as requested.

Qlarant reviewed each PIP to assess the MCP's methodology and to perform an overall validation of PIP results. Qlarant completed these activities in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.[5,6] PIP validation activities included evaluating:

- Topic
- Aim Statement
- Identified Population
- Sampling Method
- Variables and Performance Measures
- Data Collection Procedures
- Data Analysis and Interpretation of Results
- Improvement Strategies (Interventions)
- Significant and Sustained Improvement

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

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

[5] CMS EQRO Protocols

[6] CMS released updated protocols in January 2020. Due to the timing of the release of the new protocol which includes assessing the early PIP planning and development process, Qlarant conducted the 2020 review and validation process using a blended approach which captured critical elements of the updated protocol, as well as the preceding protocol. This report reflects the critical reporting elements of the new protocol.

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

Results

PIP validation results for 2020 MCP-reported PIPs, including MY 2019 activities and PM results, are included in this report. Table 2 highlights fundamental elements of the two DHCF-selected PIPs. Key MCP improvement strategies and results for each PIP for the year under review follow the table.[8]

Table 2. MCP PIP Overview

2020 PIPs	DHCF Selected PIP 1	DHCF Selected PIP 2
Program	Medicaid	Medicaid
Topic	Comprehensive Diabetes Care	Maternal Health
Performance Measure(s), Measure Steward, & Population	*PMs: Comprehensive Diabetes Care –* 1. Hemoglobin A1c (HbA1c) Testing 2. HbA1c Poor Control (>9%) 3. HbA1c Control (<8%) 4. HbA1c Control (<7%) for a Selected Population 5. Eye Exam (Retinal) Performed 6. Medical Attention for Nephropathy 7. Blood Pressure Control (<140/90 mm Hg) Measure Steward: NCQA Population: Enrollees 18-75 years of age with type 1 and type 2 diabetes	*PMs: Prenatal and Postpartum Care –* 1. Timeliness of Prenatal Care 2. Postpartum Care Measure Steward: NCQA Population: Enrollees with live birth deliveries (PMs 1 and 2) *PMs: Contraceptive Care* 3. Postpartum Women* 4. All Women* Measure Steward: US Office of Population Affairs (OPA), collected as part of the CMS Child and Adult Core Sets Population: Enrollees ages 15-20 and 21-44 who had a live birth (PM 3), Enrollees ages 15-20 and 21-44 who are at risk of unintended pregnancy (PM 4)
Aim	Will implementation of targeted educational and outreach interventions improve performance in process and outcome measures for enrollees with diabetes during the measurement year?	Will implementation of system-level and targeted educational interventions increase prenatal, postpartum, and contraceptive care visits and services in women having live births and women at risk for pregnancy during the measurement year?
Phase	Remeasurement 2	Baseline

*Contraceptive Care sub-measures are reported by contraceptive care type, enrollee age, and days post-delivery, if applicable.

Comprehensive Diabetes Care PIP

ACDC Interventions

Enrollee-focused intervention(s):

- **Non-emergent medical transportation.** Allowed enrollees the ability to schedule convenient, immediate transportation for non-emergent medical needs.

[8] Only key improvement strategies are listed. Comprehensive intervention lists may not be included due to CMS's preference for a succinct report.

- **Medication refill reminder.** Monitored prescription refills and called enrollees to provide reminders to refill and offer assistance with transportation to the pharmacy or prescription delivery.
- **Metabolic Syndrome Wellness Circles.** Wellness circles consist of six sessions over a three-month period. Partnered with community organizations to offer enrollees with diabetes and/or hypertension access to wellness circles to better manage conditions and live healthier lives.

Provider-focused intervention(s):

- **Remote monitoring for blood glucose.** Provided opportunity for enrollees to complete "smart," remote testing and share real time results with their primary care provider (PCP) to facilitate monitoring between visits.

MCP-focused intervention(s):

- **Telemedicine program.** Provided alternative solution to offer services and education in enrollee homes. A certified medical assistant or nurse conducted screening and connected the enrollee with the provider through video telemedicine sessions.

ACDC PIP Measure Results

Table 3 displays ACDC's Comprehensive Diabetes Care PIP measure results and level of improvement.

Table 3. ACDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasure-ment Year MY 2019	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	83.58%	85.95%*	*	*
HbA1c Poor Control (>9%) ***(lower rate is better)***	42.34%	40.70%*	*	*
HbA1c Control (<8%)	50.18%	49.59%*	*	*
HbA1c Control (<7%) for a Selected Population	38.89%	38.93%*	*	*
Eye Exam (Retinal) Performed	57.30%	57.02%*	*	*
Medical Attention for Nephropathy	88.32%	86.57%*	*	*
Blood Pressure Control (<140/90 mm Hg)	54.20%	62.40%*	*	*

*Provider site restrictions related to the COVID-19 public health emergency resulted in an incomplete HEDIS hybrid audit for MY 2019. Following NCQA and DHCF guidance, the MCP elected to report validated rates from MY 2018 for MY 2019. As a result, the MCP level of improvement was not evaluated.

AGP Interventions

Enrollee-focused intervention(s):

- **Diabetes management program.** Provided diabetes education and case management support for low, medium, and high-risk enrollees.

- **Healthy meals.** Provided healthy meal options and education including services such as Weight Watchers, home meal delivery service, and healthy cooking classes to eligible enrollees.
- **Diabetes medication adherence outreach.** Conducted telephone outreach to noncompliant statin therapy enrollees. Provided assistance in overcoming barriers to medication compliance and access to a pharmacist consult.

Provider-focused intervention(s):

- **Gaps in care reporting.** Reviewed reports of enrollees with gaps in care with providers (one-on-one). Worked directly with provider offices to conduct outreach and schedule enrollees with gaps in care.

MCP-focused intervention(s):

- **Healthy rewards program.** Provided monetary incentives to enrollees completing critical preventive care screenings, allowing opportunity for provider and MCP early intervention.

AGP PIP Measure Results

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

Table 4. AGP Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2018•	Last Remeasure-ment Year MY 2019	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	86.37%	80.84%	No	-
HbA1c Poor Control (>9%) ***(lower rate is better)***	47.69%	51.28%	No	-
HbA1c Control (<8%)	41.85%	41.79%	No	-
HbA1c Control (<7%) for a Selected Population	29.02%^	^	^	^
Eye Exam (Retinal) Performed	35.52%	34.12%	No	-
Medical Attention for Nephropathy	89.78%	81.75%	No	-
Blood Pressure Control (<140/90 mm Hg)	44.77%	45.07%	Yes	No

• AGP's contract was effective October 2017. AGP had limited data and results until 2018; therefore, the MCP's baseline year was MY 2018.
^ AGP did not report a rate prior to MY 2019 for the HbA1c Control (<7%) measure; therefore, for this measure only, MY 2019 serves as the baseline year. The MCP level of improvement cannot be evaluated until a remeasurement rate is available.
- There was no improvement.

CFDC Interventions

Enrollee-focused interventions:

- **Face-to-face enrollee education.** Provided education at wellness and clinic days. Also partnered with community organizations and public radio to promote awareness of chronic conditions.

- **Healthy meal service.** Provided healthy meals to chronically ill enrollees with diabetes via home delivery.

Provider-focused interventions:

- **Provider education on diabetes measures.** Conducted provider meetings and shared information about how to better engage patients to address gaps in care.

MCP-focused interventions:

- **Integration of MCP staff into Emergency Departments (EDs)/Hospitals.** Stationed care coordinators in participating hospitals to meet enrollees utilizing the ED. Enrollees are educated on following up with their assigned provider and available social resources.
- **Homebased/telehealth visits.** Referred difficult-to-engage enrollees to homebased or telehealth programs. Nurse practitioner conducted assessments and provided a link to the enrollee's PCP.

CFDC PIP Measure Results

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

Table 5. CFDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasure-ment Year MY 2019	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	79.38%	77.19%	No	-
HbA1c Poor Control (>9%) ***(lower rate is better)***	52.55%	46.90%	Yes	No
HbA1c Control (<8%)	40.15%	45.44%	Yes	No
HbA1c Control (<7%) for a Selected Population	29.69%	33.48%	Yes	No
Eye Exam (Retinal) Performed	35.58%	36.13%	Yes	No
Medical Attention for Nephropathy	83.76%	77.55%	No	-
Blood Pressure Control (<140/90 mm Hg)	27.55%	46.53%	Yes	Yes

- There was no improvement.

HSCSN Interventions

Enrollee-focused interventions:

- None.

Provider-focused interventions:

- **Diabetes education for providers.** Hosted an educational session including a review of diabetes clinical practice guidelines and required patient exams.

MCP-focused interventions:

- **Diabetes clinical practice guidelines.** Adopted and implemented diabetes-specific clinical practice guidelines to address enrollee needs.*
- **Diabetes assessment tool.** Revised the diabetes assessment tool and captured additional questions related to enrollee cultural and communication barriers. These barriers are addressed in the enrollee's care coordination plan.*
- **Diabetes care content training.** Completed annual educational session on diabetes to assist care managers in understanding diabetes management and complications and the importance of care coordination.

*HSCSN did not sufficiently update its interventions in the 2020 PIP submission. Interventions identified were documented as planned interventions with expectations to complete them in 2019.

HSCSN PIP Measure Results

Table 6 displays HSCSN's Comprehensive Diabetes Care PIP measure results and level of improvement.

Table 6. HSCSN Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasure-ment Year MY 2019	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	93.10%<	90.63%	No	-
HbA1c Poor Control (>9%) ***(lower rate is better)***	65.52%<	65.63%	No	-
HbA1c Control (<8%)	31.03%<	31.25%	Yes	No
HbA1c Control (<7%) for a Selected Population	30.77%<	31.03%<	Yes	No
Eye Exam (Retinal) Performed	62.07%<	46.88%	No	-
Medical Attention for Nephropathy	79.31%<	65.63%	No	-
Blood Pressure Control (<140/90 mm Hg)	72.41%<	56.25%	No	-

<Denominator is less than 30. Caution is advised when interpreting results.
- There was no improvement.

MCP Annual Rates for the Comprehensive Diabetes Care PIP Measures

Figures 1-7 display MCP annual performance rates for the Comprehensive Diabetes Care PIP measures for MYs 2017-2019. AGP did not have reportable rates until MY 2018. Figures also include MCP weighted averages.

Figure 1. HbA1c Testing

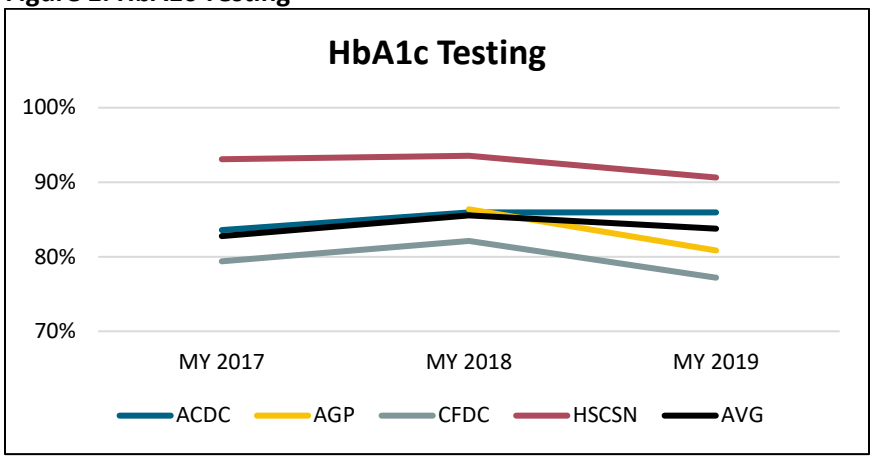


Figure 2. HbA1c Poor Control (>9%) (*lower rate is better*)

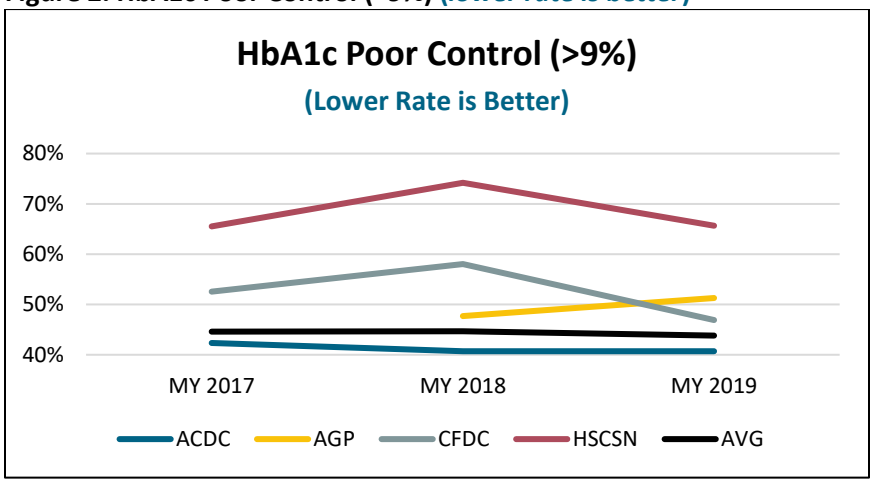


Figure 3. HbA1c Control (<8%)

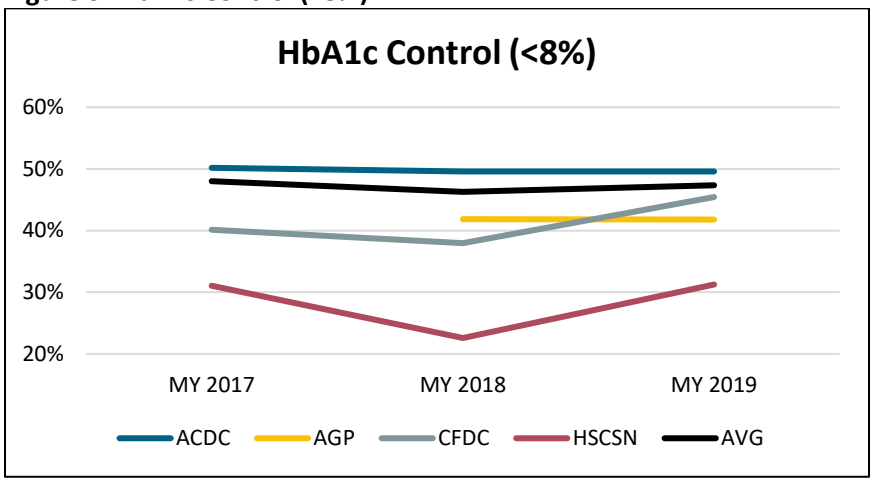
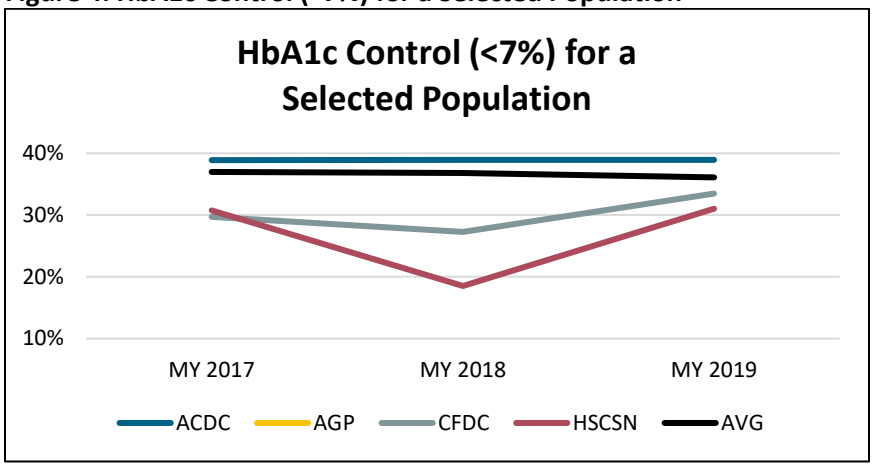


Figure 4. HbA1c Control (<7%) for a Selected Population



Trended results are not available for AGP. The MCP reported performance for the first time for MY 2019 (29.02%).

Figure 5. Eye Exam (Retinal) Performed

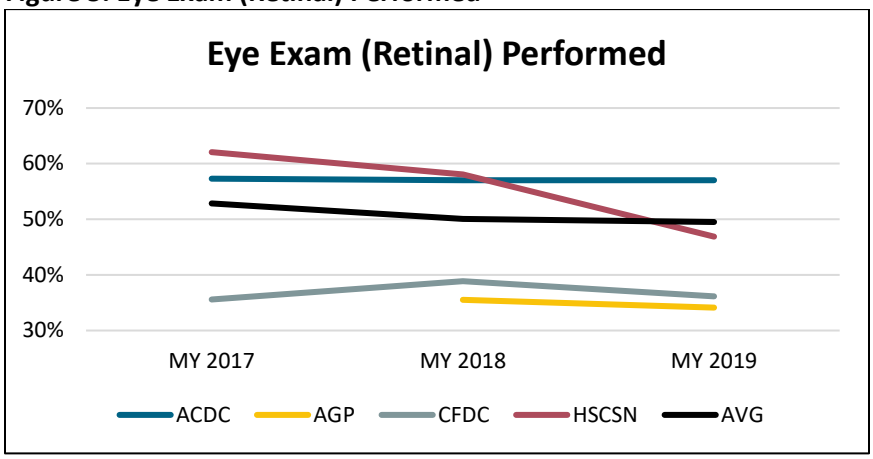


Figure 6. Medical Attention for Nephropathy

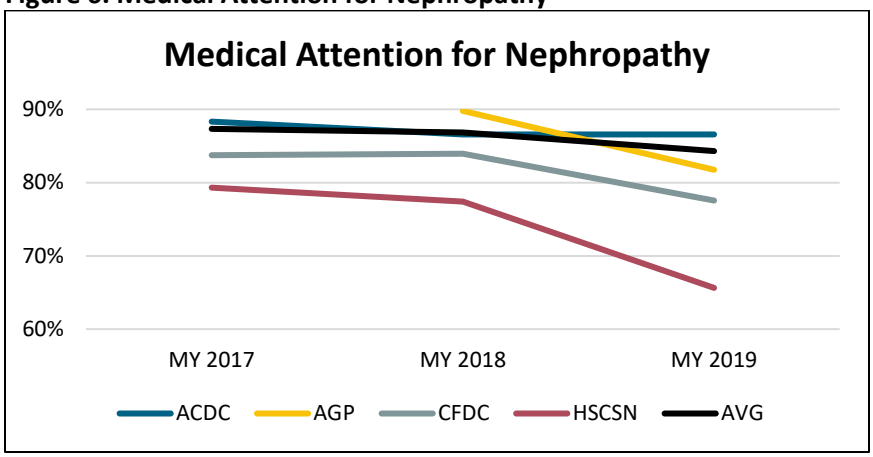
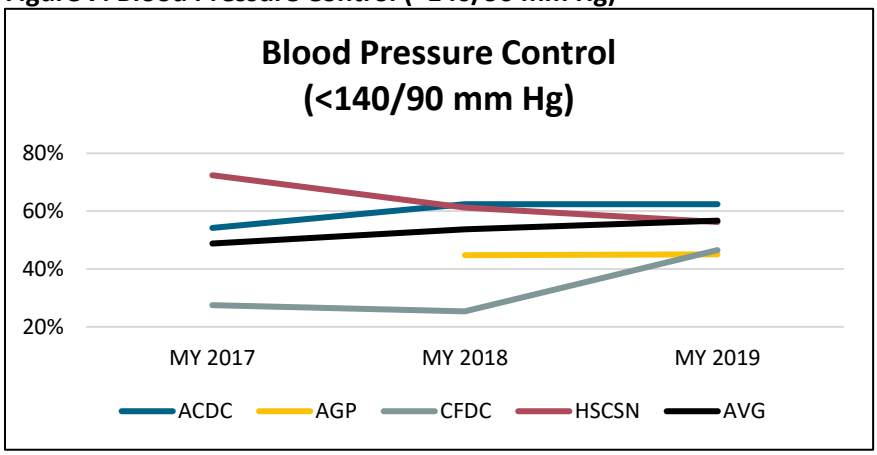


Figure 7. Blood Pressure Control (<140/90 mm Hg)



MCP PIP Validation Results

Table 7 displays each MCP's validation results, including scoring and confidence level, for the 2020 (MY 2019) Comprehensive Diabetes Care PIP. Performance ranges from 69% (HSCSN) to 100% (ACDC and CFDC).

Table 7. MCP Validation Results for the Comprehensive Diabetes Care PIP

2020 (MY 2019)	ACDC	AGP	CFDC	HSCSN	MCP Average
Validation Score	100%	97%	100%	69%	92%
Confidence Level	**High Confidence**	**High Confidence**	**High Confidence**	**Low Confidence**	**Moderate Confidence**

Maternal Health PIP

MCP Interventions

MY 2019 served as the baseline year for the Maternal Health PIP. Interventions are not required during the baseline period; therefore, this report does not include a summary of enrollee, provider, and MCP-specific interventions for the PIP. Interventions will be included in the next annual report.

ACDC PIP Measure Results

Table 8 displays ACDC's Maternal Health PIP measure results. Only baseline results are available.

Table 8. ACDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasure-ment Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.67%	NA	NA	NA
Postpartum Care	79.08%	NA	NA	NA

Performance Measure	Baseline Year MY 2019	Last Remeasure-ment Year	Improvement	Statistically Significant Improvement
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	10.26%	NA	NA	NA
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	48.08%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	3.85%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	25.64%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	13.32%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	41.29%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	3.59%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	14.66%	NA	NA	NA
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	27.56%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception	5.13%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception	27.74%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception	4.56%	NA	NA	NA

NA – Not Applicable – Only baseline results are available.

AGP PIP Measure Results

Table 9 displays AGP's Maternal Health PIP measure results. Only baseline results are available.

Table 9. AGP Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasure-ment Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	70.32%	NA	NA	NA
Postpartum Care	62.53%	NA	NA	NA
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	0%<	NA	NA	NA
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	37.93%<	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	0%<	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	17.24%<	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	11.23%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	31.85%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	4.96%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	12.01%	NA	NA	NA
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	25.04%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception	4.16%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception	18.72%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception	2.97%	NA	NA	NA

NA – Not Applicable – Only baseline results are available.
<Denominator is less than 30. Caution is advised when interpreting results.

CFDC PIP Measure Results

Table 10 displays CFDC's Maternal Health PIP measure results. Only baseline results are available.

Table 10. CFDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasure-ment Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	65.81%	NA	NA	NA
Postpartum Care	69.49%	NA	NA	NA
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	20.00%	NA	NA	NA
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	46.67%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	6.67%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	23.33%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	14.35%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	34.72%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	1.39%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	7.87%	NA	NA	NA
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	23.42%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception	5.62%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception	16.94%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception	1.93%	NA	NA	NA

NA – Not Applicable – Only baseline results are available.

HSCSN PIP Measure Results

Table 11 displays HSCSN's Maternal Health PIP measure results. Only baseline results are available.

Table 11. HSCSN Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasure-ment Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.86%	NA	NA	NA
Postpartum Care	60.34%	NA	NA	NA
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	11.11%<	NA	NA	NA
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	50.00%<	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	0%<	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	27.78%<	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	8.33%<	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	33.33%<	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	0%<	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	0%<	NA	NA	NA
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	27.96%	NA	NA	NA
Age 15-20 – Long-Acting Reversible Method of Contraception	3.76%	NA	NA	NA
Age 21-44 – Most/Moderately Effective Method of Contraception	32.74%	NA	NA	NA
Age 21-44 – Long-Acting Reversible Method of Contraception	6.28%	NA	NA	NA

NA – Not Applicable – Only baseline results are available.
<Denominator is less than 30. Caution is advised when interpreting results.

MCP Annual Rates for the Maternal Health PIP Measures

Graphics trending MCP PIP measure annual rates are not displayed as remeasurement results are not available until the next annual reporting period. Tables 14-15, under PMV results, details MCP comparative performance and weighted averages for each measure for MY 2019.

MCP PIP Validation Results

Table 12 displays each MCP's validation results, including scoring and confidence level, for the 2020 (MY 2019) Maternal Health PIP. Performance ranges from 95% (HSCSN) to 100% (ACDC and CFDC).

Table 12. MCP Validation Results for the Maternal Health PIP

2020 (MY 2019)	ACDC	AGP	CFDC	HSCSN	MCP Average
Validation Score	100%	96%	100%	95%	98%
Confidence Level	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖

Conclusion

Summary conclusions for the Comprehensive Diabetes Care and Maternal Health PIPs are below. Specific MCP strengths, weaknesses, and recommendations are included in the MCP Quality, Access, Timeliness Assessment section, in Tables 24-28, later in the report.

Comprehensive Diabetes Care PIP

- ACDC, CFDC, and HSCSN reported their second remeasurement rates for the Comprehensive Diabetes Care measures. AGP reported its first remeasurement rates.
- ACDC elected to report validated rates from MY 2018 based on an incomplete HEDIS hybrid audit for MY 2019 (due to provider site restrictions related to the COVID-19 public health emergency). NCQA and DHCF permitted this reporting decision.
- All MCPs had enrollee, provider, and MCP interventions in place during MY 2019, with one exception: HSCSN did not report enrollee-focused interventions.
- Negative trends (consecutive annual decline in performance) were demonstrated in the MCP weighted averages for the HbA1c Control (<7%) for a Selected Population, Eye Exam (Retinal) Performed, and Medical Attention for Nephropathy measures.
- A positive trend (consecutive annual improvement in performance) was demonstrated in the MCP weighted average for the Blood Pressure Control (<140/90 mm Hg) measure.
- ACDC, AGP, and CFDC received high confidence ratings for their Comprehensive Diabetes PIP. There was low confidence in HSCSN's PIP.

Maternal Health PIP

- MY 2019 served as the baseline year for the Maternal Health PIP; therefore, no comparison results are available.
- Overall, MCPs developed methodologically sound PIPs.
- All MCPs received high confidence ratings for the Maternal Health PIP.

Performance Measure Validation

Objective

DHCF uses PMs to monitor performance of individual MCPs at a point in time, track performance over time, and compare performance among MCPs. The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCP and determines the extent to which the MCP followed specifications for calculating and reporting the measures. The accuracy and reliability of the reported rates is essential to ascertaining whether the MCP's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows DHCF to have confidence in MCP PM results.

Methodology

Qlarant validated District-selected PMs including MY 2019 PIP measures and fiscal year (FY) 2020 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) measures.[9] Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.[10]

The validation process was interactive and concurrent to the MCP calculating the PMs. Validation activities occurred before, during, and after an onsite visit to the MCP and included two principle components:[11]

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

Essential PMV activities included a(n):

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

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

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

[9] District of Columbia FY 2020: October 1, 2019 through September 30, 2020.
[10] CMS EQRO Protocols
[11] The MCP onsite PMV review activities were conducted via virtual desk audit due to the COVID-19 public health emergency.

- Information submitted as part of the follow-up items requested after the onsite visit

Qlarant conducted onsite PMV review activities in May 2020 for the PIP PMV and in October 2020 for EPSDT PMV. MCP onsite PMV review activities were conducted via virtual desk audit due to the COVID-19 public health emergency. After the MCPs reported final measure rates and Qlarant approved them for each audit, Qlarant reported findings for the following audit elements including: documentation, denominator, numerator, sampling (if applicable), and reporting. Audit element descriptions are provided below.

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

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

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

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

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

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

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

Results

PIP Performance Measures

All MCPs had appropriate systems in place to process accurate claims and encounters. Table 13 includes 2020 MCP PMV results based on the calculation of MY 2019 PIP measures. Compliance with each PMV element is reported by MCP and MCP average.

Table 13. PIP PMV Results

Element	ACDC	AGP	CFDC	HSCSN	MCP Average
Documentation	100%	98%	98%	98%	99%
Denominator	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	100%	100%
Sampling	100%	100%	100%	100%	100%
Reporting	100%	100%	100%	100%	100%
Overall Rating	100%	99%	99%	99%	99%
Reporting Designation	R	R	R	R	R¨
Level of Confidence	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖

R – Reportable; measures were compliant with DHCF specifications
¨ All MCPs received a "reportable" designation

Table 14 displays MCP MY 2019 PM rates and reports each PM's data collection methodology.

Table 14. PIP Performance Measure Results

Performance Measure	Data Collection Method+	ACDC	AGP	CFDC	HSCSN
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	Hybrid	85.95%*	80.84%	77.19%	90.63%
HbA1c Poor Control (>9%) ***(lower rate is better)***	Hybrid	40.70%*	51.28%	46.90%	65.63%
HbA1c Control (<8%)	Hybrid	49.59%*	41.79%	45.44%	31.25%
HbA1c Control (<7%) for a Selected Population	Hybrid	38.93%*	29.02%	33.48%	31.03%<
Eye Exam (Retinal) Performed	Hybrid	57.02%*	34.12%	36.13%	46.88%
Medical Attention for Nephropathy	Hybrid	86.57%*	81.75%	77.55%	65.63%
Blood Pressure Control (<140/90 mm Hg)	Hybrid	62.40%*	45.07%	46.53%	56.25%
Maternal Health					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	Hybrid	84.67%	70.32%	65.81%	75.86%
Postpartum Care	Hybrid	79.08%	62.53%	69.49%	60.34%
Contraceptive Care for Postpartum Women					
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	Administrative	10.26%	0%<	20.00%	11.11%<
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	Administrative	48.08%	37.93%<	46.67%	50.00%<
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	Administrative	3.85%	0%<	6.67%	0%<
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	Administrative	25.64%	17.24%<	23.33%	27.78%<

Performance Measure	Data Collection Method+	ACDC	AGP	CFDC	HSCSN
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	Administrative	13.32%	11.23%	14.35%	8.33%<
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	Administrative	41.29%	31.85%	34.72%	33.33%<
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	Administrative	3.59%	4.96%	1.39%	0%<
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	Administrative	14.66%	12.01%	7.87%	0%<
Contraceptive Care for All Women					
Age 15-20 – Most/Moderately Effective Method of Contraception	Administrative	27.56%	25.04%	23.42%	27.96%
Age 15-20 – Long-Acting Reversible Method of Contraception	Administrative	5.13%	4.16%	5.62%	3.76%
Age 21-44 – Most/Moderately Effective Method of Contraception	Administrative	27.74%	18.72%	16.94%	32.74%
Age 21-44 – Long-Acting Reversible Method of Contraception	Administrative	4.56%	2.97%	1.93%	6.28%

+ Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data.
* Provider site restrictions related to the COVID-19 public health emergency resulted in an incomplete HEDIS hybrid audit for MY 2019. Following NCQA and DHCF guidance, the MCP elected to report validated rates from MY 2018.
< Denominator is less than 30. Caution is advised when interpreting results.

Table 15 details the MY 2019 MCP weighted average for each PM and compares performance to national benchmarks. The table includes the aggregate eligible population and numerator for each PM.

Table 15. MCP Performance Measure Rates for MY 2019

Performance Measure	Eligible Population	Numerator	MCP Average	Benchmark Comparison*
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	7,258	6,080	83.77%	♦
HbA1c Poor Control (>9%) ***(lower rate is better)***	7,258	3,180	43.81%	♦
HbA1c Control (<8%)	7,258	3,437	47.35%	♦
HbA1c Control (<7%) for a Selected Population	6,183	2,232	36.10%	♦♦
Eye Exam (Retinal) Performed	7,258	3,593	49.51%	♦
Medical Attention for Nephropathy	7,258	6,119	84.30%	♦
Blood Pressure Control (<140/90 mm Hg)	7,258	4,116	56.71%	♦
Maternal Health				
Timeliness of Prenatal Care	2,802	2,243	80.04%	♦
Postpartum Care	2,802	2,094	74.74%	♦

Performance Measure	Eligible Population	Numerator	MCP Average	Benchmark Comparison*
Contraceptive Care for Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	233	24	10.30%	♦♦♦
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	233	109	46.78%	♦♦
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	233	8	3.43%	♦♦
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	233	57	24.46%	♦♦♦
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	2,185	284	13.00%	♦♦
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	2,185	850	38.90%	♦♦
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	2,185	78	3.57%	♦♦♦
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	2,185	292	13.36%	♦♦
Contraceptive Care for All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	7,724	2,062	26.70%	♦
Age 15-20 – Long-Acting Reversible Method of Contraception	7,724	383	4.96%	♦♦
Age 21-44 – Most/Moderately Effective Method of Contraception	32,209	7,711	23.94%	^
Age 21-44 – Long-Acting Reversible Method of Contraception	32,209	1,220	3.79%	^

* Comprehensive Diabetes Care and Timeliness of Prenatal Care and Postpartum Care benchmark sources: Quality Compass 2020 (MY 2019 data) National Medicaid Average for health maintenance organizations (HMOs). Contraceptive Care benchmark sources include Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, October 2020 and Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart, October 2020.

^ Benchmark is not available.

♦ The DC MCP Average is below the National Average.

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

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

EPSDT Performance Measures

Qlarant completed a comprehensive EPSDT PMV audit for ACDC, CFDC, and HSCSN. All MCPs had appropriate systems in place to process accurate claims and encounters. Qlarant conducted a readiness review assessment for MFC and found evidence the MCP will be ready to calculate rates for the next reporting period. The MCP's start date of October 1, 2020 did not permit opportunity to report rates for FY 2020.

Table 16 includes 2020 MCP PMV results based on the calculation of FY 2020 EPSDT measures. Compliance with each PMV element is reported by MCP.

Table 16. EPSDT PMV Results

Element	ACDC	CFDC	HSCSN	MCP Average
Documentation	96%	100%	96%	97%
Denominator	100%	100%	100%	100%
Numerator	80%	100%	92%	91%
Sampling	NA	NA	NA	NA
Reporting	100%	100%	100%	100%
Overall Rating	93%	100%	96%	96%
Reporting Designation	R	R	R	R¨
Level of Confidence	**Moderate Confidence** 	**High Confidence** 	**High Confidence** 	**High Confidence** 

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

Table 17 reports FY 2020 EPSDT measure results for each MCP.

Table 17. EPSDT Performance Measure Results

Performance Measure	ACDC	CFDC	HSCSN
Total Individuals Eligible for EPSDT for 90 Continuous Days	56,051	13,023	4,340
Average Period of Eligibility	0.92	0.87	0.96
Expected Number of Screenings	68,172	15,167	4,644
Total Screens Received	46,168	9,256	3,529
Screening Ratio	0.68	0.61	0.76
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	52,732	11,673	4,193
Total Eligibles Receiving at Least One Initial or Periodic Screen	31,226	6,309	2,732
Participation Ratio	0.59	0.54	0.65
Total Eligibles Referred for Corrective Treatment	12,518	1,869	2,606
Total Eligibles Receiving Any Dental Service From a Dentist	26,515	5,367	2,302
Total Eligibles Receiving Preventive Dental Service From a Dentist	22,978	4,427	2,042
Total Eligibles Who Received Dental Treatment Services From a Dentist	10,041	1,694	771
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	2,289	521	163
Total Eligibles Receiving Diagnostic Dental Services	24,713	5,147	2,253
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	3,251	838	142
Total Eligibles Receiving Any Dental or Oral Health Service	25,395	4,997	2,135
Total Number of Screening Blood Lead Tests	3,899	902	168

Table 18 displays key FY 2020 EPSDT measure results including screen, participation, and preventive dental service ratios. The table also reports the MCP weighted average for each key measure.[12]

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

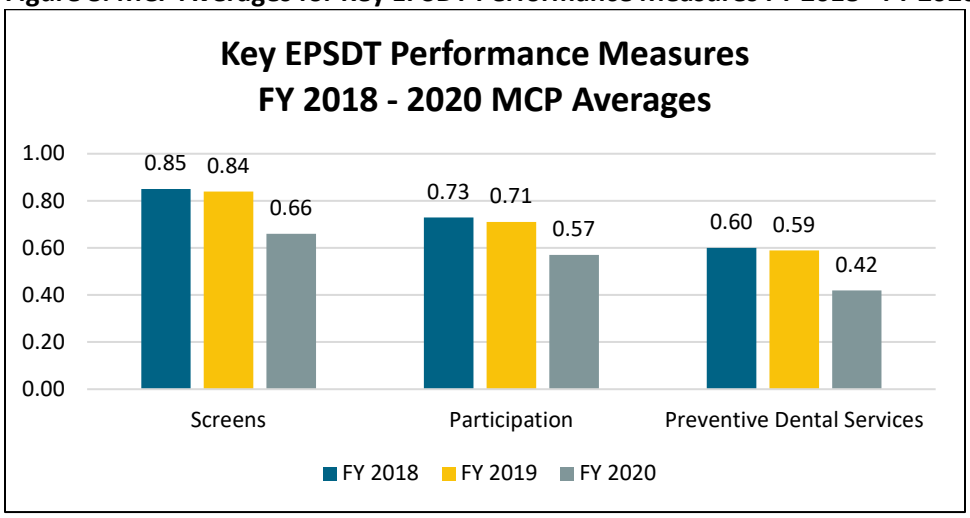
Table 18. FY 2020 Key EPSDT Performance Measure Results

Key EPSDT Performance Measures	ACDC	CFDC	HSCSN	MCP Average*
EPSDT Screening Ratio	0.68	0.61	0.76	0.66
EPSDT Participation Ratio	0.59	0.54	0.65	0.57
EPSDT Preventive Dental Services Ratio	0.44	0.38	0.49	0.42

*The MCP averages were calculated using unaudited rates from AGP.

Figure 8 displays key EPSDT measure results over the last three years, FY 2018 - FY 2020.[13]

Figure 8. MCP Averages for Key EPSDT Performance Measures FY 2018 - FY 2020



Conclusion

Aggregate summary conclusions for the PMV activities are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 24-28 within the MCP Quality, Access, Timeliness Assessment section.

[12] MCP weighted averages were calculated using audited rates from ACDC, CFDC, and HSCSN and unaudited rates from AGP. While AGP's contract ended September 30, 2020, the MCP was required to report EPSDT rates.
[13] The FY 2020 MCP averages were calculated using unaudited rates from AGP.

PIP PMV

- ACDC received an overall rating of 100%, while all other MCPs received an overall rating of 99%. The MCP average overall rating was 99%.
- All MCPs received high confidence ratings for the PIP PMV.
- Analysis of MY 2019 MCP weighted averages demonstrates 53% of measures with available benchmarks (10 of 19) met or exceeded national average benchmarks. The following measures met or exceeded the 75th percentile benchmarks:
    - Contraceptive Care for Postpartum Women:
        - Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days
        - Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days
        - Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days
- All but one Comprehensive Diabetes Care MCP weighted average compared unfavorably to national average benchmarks. Only the HbA1c Control (<7%) for a Selected Population measure met or exceeded the national average.

EPSDT PMV

- ACDC received an overall rating of 93%, indicating moderate confidence in EPSDT PMV results, while CFDC and HSCSN received high confidence scores of 100% and 96%, respectively.
- Key MCP weighted average EPSDT measure results for FY 2020 are lower than the previous two years. Lower Screening, Participation, and Preventive Dental Services Ratios are likely due to the COVID-19 public health emergency.
- Qlarant conducted a readiness review assessment for MFC and concluded the MCP will be ready to calculate and report rates for the FY 2021 reporting period.

Operational Systems Review

Objective

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

Methodology

Qlarant conducted a comprehensive review of applicable CFR standards for the 2020 OSR. Qlarant completed review activities in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations*.[14] The OSR process was interactive with the MCP. Review activities occurred before, during, and after an onsite visit to the MCP. Pre-onsite visit activities included evaluating policies, reports, meeting minutes, and other supporting documents shared by the MCP. Onsite visit activities focused on MCP staff interviews, process demonstrations, and record

[14] CMS EQRO Protocols

reviews. Post-onsite visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

For the 2020 OSR, onsite visit activities occurred during October for ACDC, CFDC, and HSCSN. MFC's onsite visit activities occurred during December 2020 due to MFC's operational start date of October 1, 2020. Qlarant conducted virtual onsite audits due to the COVID-19 public health emergency. The 2020 OSR focused on compliance demonstrated during MY 2020.

CFR standards (42 CFR §438) reviewed include:

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

Standards are comprised of elements and components, all of which are individually reviewed and scored. Qlarant uses the following scale when evaluating compliance for each element and/or component:

- Met - the MCP meets *both* requirements:
  - Documentation and data sources provide evidence of compliance with regulatory requirements and
  - Staff are able to describe processes consistent with documentation
- Partially met - the MCP meets *either* requirement:
  - Documentation is present, but staff are unable to articulate processes or show evidence of implementation during interviews or
  - Staff are able to describe and verify existence of processes, but documentation is incomplete or inconsistent with practice
- Not met - the MCP meets *both* requirements:
  - Documentation and data sources are not present or do not provide evidence of compliance with regulatory requirement and
  - Staff are unable to describe and/or verify existence of processes required to demonstrate compliance with regulatory requirements
- Not Applicable - the requirement does not apply during the review period

Based on scores, Qlarant assigns a compliance rating or level of confidence. Compliance ratings include:

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

Results

Table 19 displays 2020 MCP OSR results by standard and total. A level of confidence in each MCP's compliance is assigned based on the overall weighted score. The table also includes MCP averages.

Table 19. 2020 MCP OSR Results

2020 OSR	ACDC	CFDC	HSCSN	MFC	MCP Average
Information Requirements	97%	100%	98%	89%	96%
Disenrollment Requirements and Limitations*	BS	BS	BS	BS	BS
Enrollee Rights and Protections*	94%	100%	89%	89%	93%
MCO Standards	96%	100%	95%	96%	97%
Quality Assessment and Performance Improvement Program	100%	100%	93%	100%	98%
Grievance and Appeal System	98%	90%	88%	90%	92%
Overall Weighted Score	97%	96%	93%	93%	95%
Confidence Level	**High Confidence**	**High Confidence**	**Moderate Confidence**	**Moderate Confidence**	**High Confidence**

*New standards for 2020, including Subpart B: §438.56 Disenrollment Requirements and Limitations and Subpart C: §438.102 Provider – Enrollee Communications and §438.114 Emergency and Poststabilization Services are not included in the scoring.
BS – Baseline Standard. The entire Disenrollment Requirements and Limitations standard was reviewed as baseline. While it was not scored, the MCPs received feedback on their level of compliance with the standard.

MCPs are expected to demonstrate 100% compliance with all OSR standards. MCPs demonstrating less than 100% must develop a corrective action plan (CAP) to address each element or component found to not exhibit full compliance. Results of the 2020 OSR reveal all MCPs must develop CAPs. Figure 9 illustrates MCP CAPs required by standard. While baseline standards were excluded from scoring, MCPs are required to develop CAPs for them if they were not able to demonstrate compliance during the baseline review.

Figure 9. MCP OSR Elements/Components by Standard Requiring CAPs

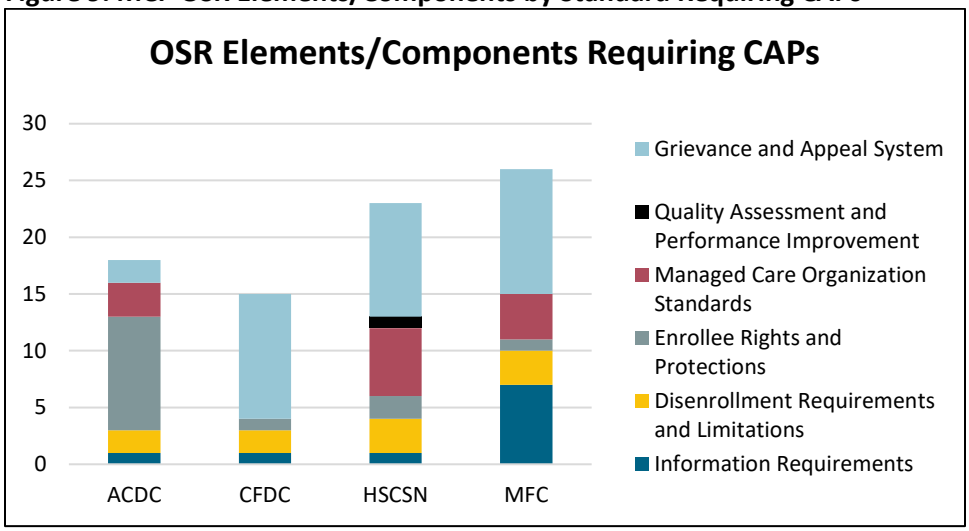


Table 20 details annual MCP results and MCP averages by standard from 2018 - 2020.

Table 20. 2018 - 2020 MCP OSR Results by Standard

2020 OSR Standards	Year	ACDC	CFDC	HSCSN	MFC	MCP Average*
Information Requirements	2018	95%	90%	90%	NA	93%
	2019	98%	100%	98%	NA	98%
	2020	97%	100%	98%	89%	96%
Disenrollment Requirements and Limitations	2018	-	-	-	-	-
	2019	-	-	-	-	-
	2020	BS	BS	BS	BS	BS
Enrollee Rights and Protections	2018	100%	100%	100%	NA	100%
	2019	100%	100%	100%	NA	100%
	2020	94%	100%	89%	89%	93%
MCO Standards	2018	98%	93%	92%	NA	95%
	2019	99%	100%	99%	NA	99%
	2020	96%	100%	95%	96%	97%
Quality Assessment and Performance Improvement Program	2018	100%	86%	86%	NA	93%
	2019	100%	100%	93%	NA	96%
	2020	100%	100%	93%	100%	98%
Grievance and Appeal System	2018	95%	88%	89%	NA	92%
	2019	96%	82%	84%	NA	89%
	2020	98%	90%	88%	90%	92%
Overall Weighted Score	2018	97%	91%	90%	NA	94%
	2019	98%	94%	93%	NA	95%
	2020	97%	96%	93%	93%	95%

* The 2018 and 2019 MCP averages were calculated using ACDC, AGP, CFDC, and HSCSN scores. The 2020 MCP average was calculated using ACDC, CFDC, HSCSN, and MFC scores.
BS - Baseline Standard: the standard was reviewed as baseline and not scored.

Conclusion

Aggregate summary conclusions for the OSR activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 24-28 within the MCP Quality, Access, Timeliness Assessment section.

- The MCPs received overall weighted scores from 93% (HSCSN and MFC) to 97% (ACDC) for the 2020 OSR. The MCP average was 95% (high confidence), which is consistent with 2019 results and one percentage point higher than 2018 results.
- The MCPs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its Medicaid enrollees. MCP specific strengths, weaknesses, and recommendations are detailed in the MCP Quality, Access, Timeliness Assessment section.
- All MCPs are required to develop CAPs based on 2020 OSR results. Results of MCP 2019 OSR CAPs are included in the Assessment of Previous Recommendations section.

Network Adequacy Validation

Objective

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

Methodology

Qlarant conducted a comprehensive assessment of each MCP's provider network using standards established by DHCF. Qlarant:

- Compared MCP geographic access reports to time and distance standards
- Assessed MCP provider access and availability compliance with requirements
- Validated the accuracy of each MCP's online provider directory

An abbreviated summary of DHCF standards is provided below.

DHCF MCP Provider Network Standards

Mileage and travel. Care must be available within five (5) miles or no more than thirty (30) minutes travel time (from an enrollee's residence).
Network composition. All enrollees shall have at least two (2) age-appropriate PCPs available meeting mileage and travel standards.
Provider-to-enrollee ratios. At least one (1) PCP for every five hundred (500) enrollees, at least one (1) pediatric PCP for every five hundred (500) child and adolescent enrollees, and at least one (1) dentist for every seven hundred fifty (750) child and adolescent enrollees.
24-hour urgent care appointment. Services must be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.
30-day routine care appointment. Adult enrollees should obtain routine and well health assessments within thirty (30) days. Pediatric enrollees should obtain EPSDT screening examinations within (thirty) 30 days.

Qlarant evaluated MCP geographic access during the 2020 OSR. Qlarant reviewed reports submitted by each MCP which reported their compliance with DHCF time and distance standards, as well as provider-to-enrollee ratios. An evaluation of compliance was completed.

Qlarant requested and received current electronic provider directory data from each MCP for PCPs (serving adults and children) and dental providers. Adult PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 21 years of age or older. Specialties included family medicine, internal medicine, adult medicine, general medicine, family nurse practitioner, or geriatrics. Pediatric PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 20 years of age or younger. Specialties included family medicine, pediatrics, adolescent medicine, general medicine, or family nurse practitioner. Dental providers were defined as providers offering appointments for routine dental services, such as cleanings and fillings, to any enrollee. Specialties included general dentistry or pediatric dentistry.

Qlarant randomly selected providers to survey and assess compliance with DHCF standards. Surveys were conducted throughout 2020 using Qlarant-developed tools and experienced surveyors following scripts. A maximum of three telephone call attempts were made for each provider during normal business hours, except for the noon hour when offices typically close for lunch. Surveys were considered successful if the surveyor was able to reach the intended provider/practice and complete the survey.

For 2020 telephone surveys, Qlarant moved from a combination of secret shopper and traditional surveys, as previously conducted, to traditional surveys only to reduce burden on providers.[15] Qlarant also modified appointment availability assessments from provider to practice level for a more accurate representation of access to care. These methodological changes should be considered when interpreting 2020 results compared to previous annual results.

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

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

- Provider was with the practice contacted
- Provider offered the desired primary care or dental services, depending on the type of call
- Provider accepted the listed (participating) MCP
- Response to provider accepting new patients matched the online provider directory
- Practice name matched the online provider directory
- Address matched the online provider directory
- Telephone number matched the online provider directory
- Able to locate provider in online provider directory

Results of three of four MCPs are reported due to AGP's contract termination and MFC's late entry during 2020. Results are reported for ACDC, CFDC, and HSCSN.

Results

Provider Geographic Access

ACDC's and CFDC's geographic access reports suggest robust provider networks where at least 99% (ACDC) and 100% (CFDC) of all enrollees have access to 2 PCPs and 1 dental provider within 5 miles or 30 minutes. At least 99% (ACDC) and 100% (CFDC) of all enrollees have access to specialty providers within 30 minutes. Based on the information provided in the geographic access reports, ACDC and CFDC appeared to meet provider-ratio requirements for adult and pediatric PCPs and dental providers.

HSCSN's geographic access reports also indicate a robust provider network where 100% of enrollees have access to 2 PCPs and at least 1 dental and obstetrics/gynecology provider within 5 miles. HSCSN's reports demonstrate 98% of enrollees have access to behavioral health providers and other specialty providers within five miles. Based on information provided in the geographic access reports, HSCSN appeared to meet the provider-ratio requirement for dental providers.

Provider Appointment Access and Availability

Qlarant surveyed adult and pediatric PCPs and dental providers during 2020. Table 21 displays results of key provider access and availability measures for each MCP and the MCP weighted average.

Table 21. 2020 MCP Key Provider Access and Availability Measure Results

2020 Access and Availability	ACDC	CFDC	HSCSN	MCP AVG
Successful contact with provider	71%	68%	56%	65%
Provider accepts the listed MCP	96%	91%	97%	92%
Provider accepts new patients	100%	94%	94%	96%

Figures 10-11 illustrate MY 2020 adult and pediatric PCP compliance with routine and urgent appointment standards. Survey results indicate adults had better access to routine care while children had better access to urgent care.

Figure 10. 2020 MCP Adult PCP Appointment Compliance

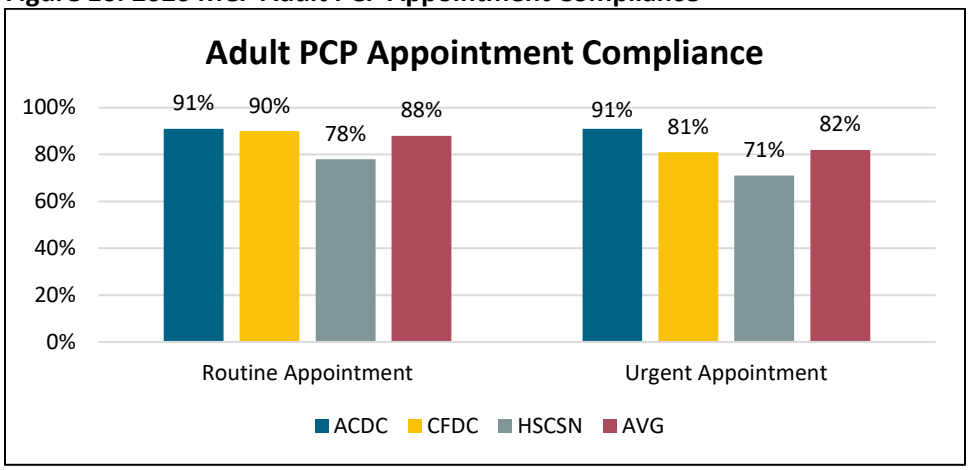
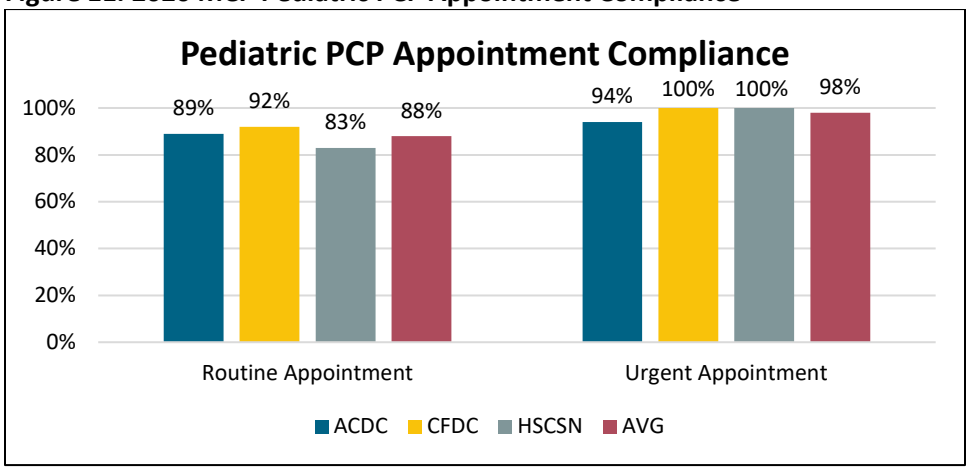


Figure 11. 2020 MCP Pediatric PCP Appointment Compliance



Figures 12-13 include MCP weighted averages trended from 2018 - 2020. Notably, substantial improvement was observed in obtaining timely urgent care for adults.

Figure 12. 2018 - 2020 MCP Average Adult PCP Appointment Compliance

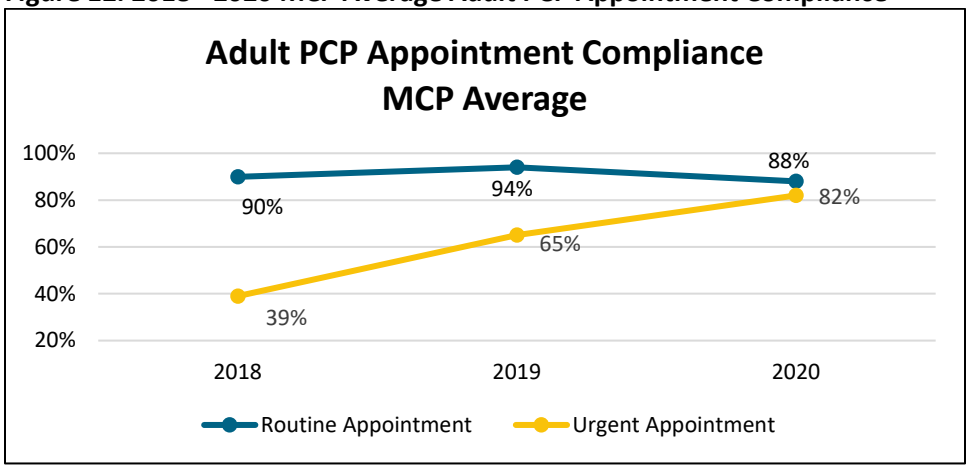


Figure 13. 2018 - 2020 MCP Average Pediatric PCP Appointment Compliance

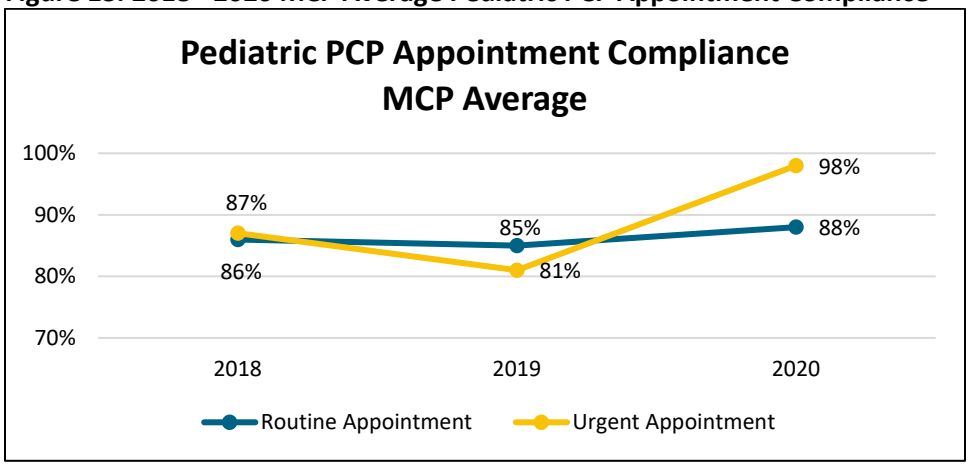


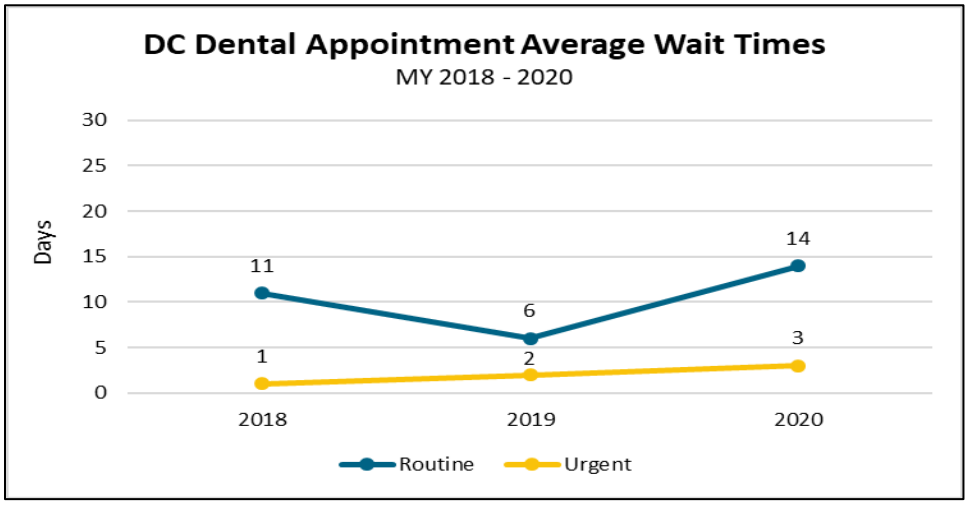
Table 22 details MCP dental provider survey results for routine and urgent appointment requests in 2020. DHCF does not have timeliness standards for dental providers.

Table 22. 2020 MCP Dental Appointment Wait Times for Routine and Urgent Care

2020 Dental Appointments	ACDC	CFDC	HSCSN	MCP AVG
Routine Care Appointment				
Wait Days Average	19	15	9	14
Wait Days Range	0 - 134	0 - 69	0 - 28	0 - 134
Urgent Care Appointment				
Wait Days Average	2	5	3	3
Wait Days Range	0 - 14	0 - 69	0 - 23	0 - 69

Figure 14 displays MCP average number of days to obtain routine and urgent dental appointments for 2018 - 2020.

Figure 14. 2018 - 2020 MCP Average Number of Days for Routine and Urgent Dental Appointments



Provider Directory Accuracy

Figure 15 provides 2020 MCP overall accuracy of provider directory validation results compared to the MCP average of 49%.

Figure 15. 2020 MCP Overall Accuracy of Provider Directory

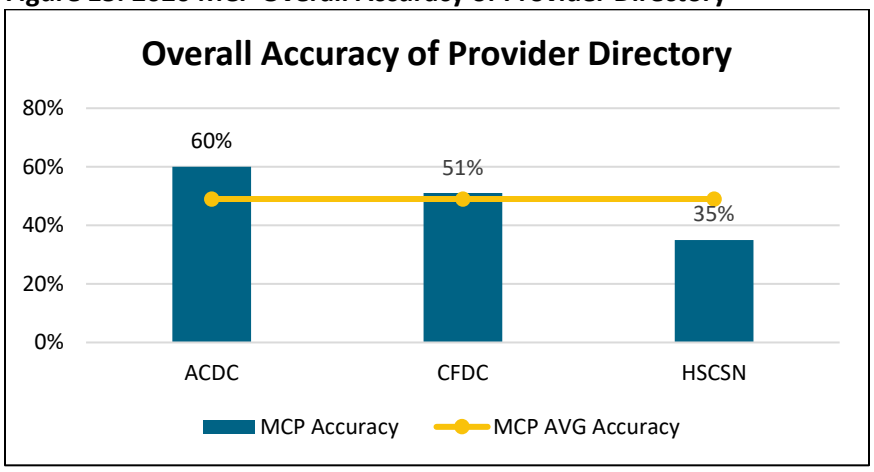
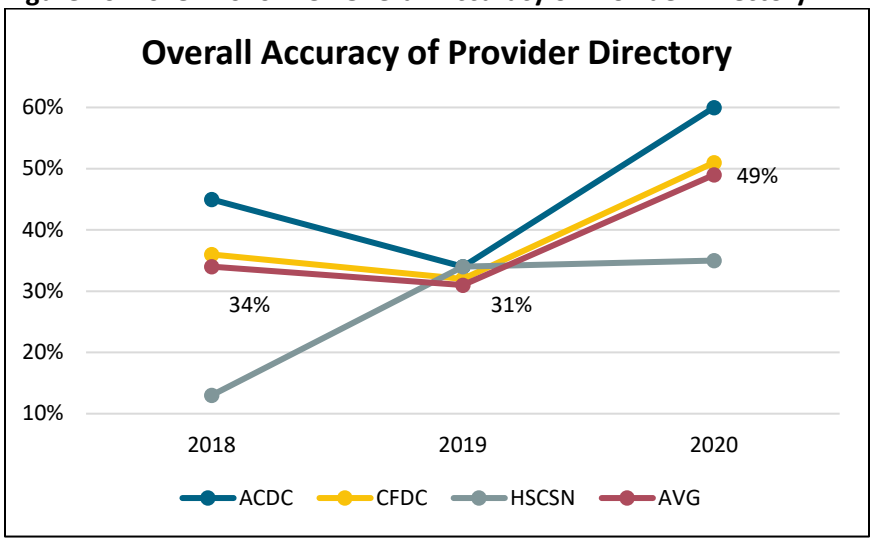


Figure 16 illustrates overall provider directory accuracy compared to MCP weighted averages trended from 2018 – 2020.

Figure 16. 2018 - 2020 MCP Overall Accuracy of Provider Directory



Data labels (34%, 31%, and 49%) refer to the MCP average.

Conclusion

Aggregate summary conclusions for the NAV activities are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 24-28 within the MCP Quality, Access, Timeliness Assessment section.

- MCPs have robust provider networks with at least 99% of enrollees having access to 2 PCPs and 1 dental provider within 5 miles or 30 minutes.
- MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 71% to 100% for 2020. MCP averages reveal the following timely access compliance ratings: 88% for adults accessing routine care, 82% for adults accessing urgent care, 88% for children accessing routine care, and 98% for children accessing urgent care.
- Adult access to urgent care, on average, increased annually from 2018 - 2020.
- The MCP average number of days to obtain a dental appointment for routine care has fluctuated since 2018; however, it has remained within 14 days. Urgent care appointment wait times increased by one day each year to three days in 2020.
- Overall accuracy of MCP online provider directories ranged from 35% (HSCSN) to 60% (ACDC) for 2020. The MCP average was 49%.
- The overall accuracy of provider directory MCP average increased 18 percentage points from 2019 to 2020.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

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

Quality, Access, and Timeliness Definitions

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

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

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

Tables 24-27 highlight strengths and weaknesses for each MCP. Identified strengths and weaknesses correspond to the quality, access, and/or timeliness of services delivered to MCP enrollees. Only applicable domains for each strength or weakness are identified with a (⮝) or (⮟) indicating a positive or negative impact as described below. Where appropriate, weaknesses include recommendations.

⮝ The MCP strength identified positively impacts the quality, access, and/or timeliness.

- The MCP weakness identified negatively impacts the quality, access, and/or timeliness.

ACDC

Table 24. ACDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
▲	▲	▲	**Strength.** ACDC received a score of 100% (high confidence). The assessment did not include an evaluation of performance improvement due to the MCP reporting MY 2018 rates for MY 2019. The COVID-19 public health emergency limited the MCP's ability to collect medical records needed for MY 2019 reporting.
Maternal Health PIP			
▲	▲	▲	**Strength.** ACDC received a score of 100% (high confidence). The MCP's PIP was methodologically sound.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
▲	▲	▲	**Strength.** ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
▼			**Weakness.** ACDC received a score of 93% (moderate confidence). While ACDC passed the medical record over-read, 24% of records were deemed invalid and not reviewed due to date of birth errors. This negatively impacted the documentation and numerator elements of the PMV audit. **Recommendation.** ACDC should enhance its enrollment data validation process to ensure accurate dates of birth are captured in its information system.
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
▲	▲	▲	**Strength.** ACDC received a score of 97% in the Information Requirements standard contributing to the MCP's overall high confidence score.
▼	▼		**Weakness.** ACDC did not take action to address Provider Directory inaccuracies. **Recommendation.** ACDC should develop a process to address errors identified in the Provider Directory. A tracking log may assist in documenting errors identified and dates corrections are made.
Disenrollment Requirements and Limitations			
	▼		**Weakness.** ACDC did not fully communicate disenrollment information within the Enrollee Handbook. **Recommendation**. ACDC should revise the Enrollee Handbook to inform the enrollee of disenrollment causes and the process to request disenrollment.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Enrollee Rights and Protections			
▼			**Weakness.** ACDC's Enrollee Rights and Responsibilities Policy did not address all new requirements. **Recommendation**. ACDC should revise its Enrollee Rights and Responsibilities Policy to reflect all requirements (§438.102).
▼	▼	▼	**Weakness.** ACDC did not have a policy addressing emergency and poststabilization services. **Recommendation**. ACDC should develop an emergency and poststabilization policy to address requirements (§438.114).
MCO Standards			
▲	▲	▲	**Strength.** ACDC received a score of 96% in the MCO Standard, which contributed to the MCP's overall high confidence score.
	▼	▼	**Weakness.** ACDC did not conduct a network provider survey during its 12-month contract period. **Recommendation**. ACDC should conduct an access to care survey at least once during the MCP contract year.
▼	▼		**Weakness.** ACDC did not provide evidence of follow up with providers who failed to meet network adequacy standards. **Recommendation.** ACDC should complete corrective actions with providers failing to meet network adequacy standards consistent with its policy.
▼			**Weakness.** ACDC failed to consistently demonstrate providing notice to providers for covered outpatient drug authorization decisions within 24 hours. **Recommendation.** ACDC should consistently comply with the requirement of completing provider notification of outpatient drug preauthorization request outcomes, by telephone or other telecommunication device, within 24 hours of receipt of request.
Quality Assessment and Performance Improvement Program			
▲			**Strength.** ACDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality.
Grievance and Appeal System			
▲	▲	▲	**Strength.** ACDC received a score of 98% in the Grievance and Appeal System standard contributing to the MCP's overall high confidence score.
		▼	**Weakness.** ACDC's Provider Manual and Enrollee Handbook did not identify the correct 90-day timeframe permitted for standard grievance resolution. **Recommendation.** ACDC should correct its Provider Manual and Enrollee Handbook to correctly reflect the 90-day grievance resolution timeframe.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
▼			**Weakness.** An ACDC appeal resolution letter, reviewed as part of a record review, included an error which resulted in communicating inaccurate information to an enrollee. **Recommendation.** ACDC should ensure enrollee resolution letters are consistent with results documented in the enrollee record. The MCP may consider implementing quality checks in the resolution-letter process.
NETWORK ADEQUACY VALIDATION			
	▲		**Strength.** ACDC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	▲	▲	**Strength.** ACDC received compliance ratings exceeding 90% for timely access to adult routine and urgent appointments and pediatric urgent appointments.
	▼	▼	**Weakness.** ACDC received a score of 89% for timely access to pediatric routine appointments. **Recommendation.** ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	▼		**Weakness.** ACDC received a score of 60% for overall provider directory accuracy. **Recommendation.** ACDC should make provider directory accuracy a priority and update information routinely.

AGP

Table 25. AGP Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
▲	▲	▲	**Strength.** AGP received a score of 97% (high confidence). Note: Due to AGP's contract start date of October 2017, the MCP only had one year of remeasurement compared to two years for all other MCPs. Therefore, sustained improvement was not evaluated.
▼	▼	▼	**Weakness.** AGP did not demonstrate statistically significant improvement in any measures. **Recommendation.** AGP should conduct a more in-depth analysis to understand effectiveness of interventions and make adjustments accordingly. AGP should consider developing additional interventions to address access-related barriers to care.
Maternal Health PIP			
▲	▲	▲	**Strength.** AGP received a score of 96% (high confidence). Overall, the MCP developed a methodologically sound PIP.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
⮟			**Weakness.** AGP reported errors in PM rates. **Recommendation.** AGP should add a validation step to its reporting process to ensure accurate rates are submitted.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
⮝	⮝	⮝	**Strength.** AGP received a score of 99% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
⮟			**Weakness.** AGP had data entry errors in its final rate worksheet and had to resubmit rates. **Recommendation.** AGP should introduce a validation step as part of the final rate submission process to eliminate reporting errors.
EPSDT Performance Measures			
Results are not available. DHCF ended its contract with AGP prior to the FY 2020 EPSDT PMV audit.			
OPERATIONAL SYSTEMS REVIEW			
Results are not available. DHCF ended its contract with AGP prior to the 2020 OSR.			
NETWORK ADEQUACY VALIDATION			
Results are not available. DHCF ended its contract with AGP prior to the conclusion of the 2020 NAV.			

CFDC

Table 26. CFDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
⮝	⮝	⮝	**Strength.** CFDC received a score of 100% (high confidence). The MCP demonstrated sustained improvement in the Eye Exam (Retinal) Performed measure and statistically significant improvement in the Blood Pressure Control (<140/90 mm Hg) measure.
Maternal Health PIP			
⮝	⮝	⮝	**Strength.** CFDC received a score of 100% (high confidence). The MCP developed a sound PIP meeting all requirements.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
⮝	⮝	⮝	**Strength.** CFDC received a score of 99% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
⮟			**Weakness.** CFDC had data entry errors in its final rate worksheet and had to resubmit rates. **Recommendation.** CFDC should introduce a validation step as part of the final rate submission process to eliminate errors. Final PIP and PMV measure rates should be consistent.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
EPSDT Performance Measures			
▲	▲	▲	**Strength.** CFDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
▲	▲	▲	**Strength.** CFDC received a score of 100% in the Information Requirements standard, which contributed to the MCP's overall high confidence score.
		▼	**Weakness.** CFDC's Enrollee Handbook incorrectly identified a 90-day filing timeframe for a grievance. This error was based on using an Enrollee Handbook template provided by DHCF. CFDC's OSR score for this component was not negatively impacted due to this error as the MCP previously communicated the correct unlimited timeframe to DHCF. **Recommendation.** CFDC should revise the Enrollee Handbook to reflect the unlimited timeframe for filing a grievance.
Disenrollment Requirements and Limitations			
▼			**Weakness.** CFDC did not communicate the disenrollment process within the Enrollee Handbook. **Recommendation**. CFDC should revise the Enrollee Handbook to inform the enrollee of the disenrollment process, including contact information and a telephone number.
▼	▼		**Weakness.** CFDC did not outline the availability of the grievance process in its Disenrollment Causes and Processes Policy. **Recommendation**. CFDC should revise its Disenrollment Causes and Processes Policy and include grievance procedures as they relate to enrollee disenrollment.
Enrollee Rights and Protections			
▲	▲	▲	**Strength.** CFDC received a score of 100% in the Enrollee Rights and Protections standard, which contributed to the MCP's overall high confidence score.
▼			**Weakness.** CFDC's Emergency Department and Post-Stabilization Care Policy omitted reference to DHCF (part of new requirement). **Recommendation.** CFDC should amend its Emergency Department and Post-Stabilization Care Policy and state it will not deny emergency services based on emergency room provider failure to notify DHCF.
MCO Standards			
▲	▲	▲	**Strength.** CFDC received a score of 100% in the MCO Standard meeting all federal and DHCF-established requirements.
Quality Assessment and Performance Improvement Program			
▲			**Strength.** CFDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. CFDC demonstrated a commitment to quality.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Grievance and Appeal System			
⮟	⮟	⮟	**Weakness.** A record review demonstrated CFDC did not consistently follow policy in acknowledging appeals, providing timely grievance and appeal resolution notice, making reasonable effort to give the enrollee prompt notice of an appeal resolution extension, and using and sending the correct appeal resolution letter template and notice attachments. **Recommendation**. CFDC should ensure compliance in acknowledging appeals, resolving grievances and appeals, and providing notice according to policies. CFDC should consider implementing a quality check in its resolution and notification process.
⮟			**Weakness.** CFDC did not specify the parties to an appeal in its Enrollee Appeals Policy (even though revisions were approved during the 2019 CAP process). **Recommendation.** CFDC should revise its Enrollee Appeals Policy to identify parties of an appeal as specified in §438.406 (b)(6)(i)(ii).
⮟			**Weakness.** CFDC's Provider Manual incorrectly asserted enrollees have the right to request a fair hearing from DHCF at any point during the appeal process. **Recommendation.** CFDC should correct its Provider Manual and state enrollees must exhaust CFDC's one level appeal process before requesting a District fair hearing.
		⮟	**Weakness.** CFDC's Provider Manual identified an incorrect timeframe to authorize or provide services previously denied and subsequently approved. **Recommendation.** CFDC should amend its Provider Manual and state the MCP must authorize or provide services no later than 72 hours from the date it receives notice reversing a determination (rather than two business days).
NETWORK ADEQUACY VALIDATION			
	⮝		**Strength.** CFDC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	⮝	⮝	**Strength.** CFDC received compliance ratings of at least 90% for timely access to adult routine appointments and pediatric routine and urgent appointments.
	⮟	⮟	**Weakness.** CFDC received a score of 81% for timely access to adult urgent appointments. **Recommendation.** CFDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	⮟		**Weakness.** CFDC received a score of 51% for overall provider directory accuracy. **Recommendation.** CFDC should make provider directory accuracy a priority and update information routinely.

HSCSN

Table 27. HSCSN Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
▼	▼	▼	**Weakness.** HSCSN received a score of 69% (low confidence). The MCP did not properly document its interventions or conduct an adequate data analysis. The MCP did not achieve sustained or statistically significant improvement in any measures. **Recommendation**. HSCSN should document and/or update its interventions annually. The MCP should conduct a thorough analysis including reporting statistical significance testing and effectiveness of interventions. Understanding intervention effectiveness and barriers, and making adjustments accordingly, should assist the MCP in achieving improvement.
Maternal Health PIP			
▲	▲	▲	**Strength.** HSCSN received a score of 95% (high confidence) and provided a sound methodology.
▼			**Weakness.** HSCSN reported an error in one of the PM rates. **Recommendation.** HSCSN should add a validation step to its reporting process to ensure accurate rate submissions.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
▲	▲	▲	**Strength.** HSCSN received a score of 99% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
▼			**Weakness.** HSCSN had data entry errors/discrepancies in reporting final PIP measure and PIP PMV measure rates and had to resubmit rates. **Recommendation.** HSCSN should introduce a validation step as part of the final rate submission process. This should eliminate errors and ensure consistency in reporting PIP measure and PIP PMV measure rates.
EPSDT Performance Measures			
▲	▲	▲	**Strength.** HSCSN received a score of 96% (high confidence). All EPSDT measure rates were deemed “reportable.”
▼			**Weakness.** HSCSN reported duplicate and triplicate numerator events and had errors in its source code. The MCP had to correct and resubmit program documentation multiple times before obtaining approval. **Recommendation.** HSCSN should review and update source code annually and include quality checks to ensure accurate numerator events.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
▲	▲	▲	**Strength.** HSCSN received a score of 98% in the Information Requirements standard. Most enrollee materials met requirements.
		▼	**Weakness.** HSCSN reported its downloadable portable document format (PDF) provider directory, which it uses for its paper provider directory, is updated annually. This timeline is not compliant. **Recommendation:** HSCSN should ensure its downloadable PDF provider directory is updated no later than 30 calendar days after receiving updated information.
Disenrollment Requirements and Limitations			
▼			**Weakness.** HSCSN included an incorrect CFR reference in its Change in Enrollee Status/Disenrollment Policy. **Recommendation.** HSCSN should amend its Change in Enrollee Status/Disenrollment Policy to correctly reference §438.702(a)(4) rather than to §438.702(a)(3).
		▼	**Weakness.** HSCSN's Change in Enrollee Status/Disenrollment Policy does not consider a disenrollment approved should the MCP or DHCF fail to make a timely determination. **Recommendation.** HSCSN should revise its Enrollee Status/Disenrollment Policy to address the requirement: If the MCP or DHCF fails to make a disenrollment determination within the timely limit, the disenrollment is considered approved.
		▼	**Weakness.** HSCSN's Enrollee Status/Disenrollment Policy included an incorrect time period related to reenrollment. **Recommendation.** HSCSN should amend its Enrollee Status/Disenrollment Policy to reflect the requirement that it will automatically reenroll a beneficiary who lost eligibility for a period of two months or less (not three months or less as specified in the policy).
Enrollee Rights and Protections			
▼			**Weakness.** HSCSN's Enrollee Rights and Responsibilities Policy did not reference compliance with Federal and State laws as specified in §438.100(d). **Recommendation.** HSCSN should revise its Enrollee Rights and Responsibilities Policy and confirm compliance with Federal and State laws as required in §438.100(d).
▼			**Weakness.** HSCSN's Enrollee Rights and Responsibilities Policy did not specify it will not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient. **Recommendation.** HSCSN should revise its Enrollee Rights and Responsibilities Policy and state it will not prohibit or restrict a provider from advising or advocating on behalf of an enrollee consistent with §438.102(a)(1)(i)(ii)(iii)(iv).

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MCO Standards			
▲	▲	▲	**Strength.** HSCSN received a score of 95% in the MCO Standard.
	▼	▼	**Weakness.** HSCSN's access and availability related policies and Provider Manual did not reflect accurate and/or complete access requirements. **Recommendation.** HSCSN should amend relevant access and availability policies (to capture initial appointment timeframes for PCP and EPSDT visits) and the Provider Manual (to assert the provider offers hours of operation that are no less than those for commercial or fee for service enrollees).
	▼	▼	**Weakness.** HSCSN did not provide evidence of provider surveys for all provider types specified by the MCP contract, nor did it provide evidence of corrective actions for providers failing to meet standards. **Recommendation.** HSCSN should conduct monitoring of all provider types (adult and pediatric PCP, specialist, dental, obstetrics, and mental/behavioral health) for compliance with appointment standards and after-hours accessibility. HSCSN should require corrective action when providers fail to meet access standards. Qlarant recommends HSCSN develop a process for monthly monitoring of corrective action plans and resurveying providers to ensure compliance with HSCSN-established requirements.
▼			**Weakness.** HSCSN did not provide evidence of an annual review for its utilization management review criteria. **Recommendation.** HSCSN should ensure its utilization management review criteria is reviewed and approved by its Quality Council (or other relevant medical oversight body) at least annually.
▼		▼	**Weakness.** HSCSN did not follow its Vendor Oversight Policy by conducting annual audits of each delegate, nor did it ensure quarterly performance reporting to its Vender Oversight Committee. **Recommendation.** HSCSN should conduct annual vendor audits and complete quarterly performance reporting as required by its Vendor Oversight Policy.
Quality Assessment and Performance Improvement Program			
▼			**Weakness.** HSCSN did not provide evidence of consistent subcommittee quarterly reporting to the Quality Management Oversight Committee (QMOC). **Recommendation.** HSCSN should ensure consistent, quarterly subcommittee reporting to the QMOC. This also includes reporting of under and overutilization of services.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Grievance and Appeal System			
➘		➘	**Weakness.** A record review demonstrated HSCSN did not consistently follow policy providing timely notice of adverse determinations and timely acknowledgement or resolution notice of appeals. The review also demonstrated HSCSN did not use the date of oral inquiries for seeking an appeal as the date of initial appeal receipt, nor did the MCP demonstrate a reasonable attempt to provide oral notice of a denial to provide expedited appeal resolution. **Recommendation**. HSCSN should ensure compliance in providing timely notice of adverse determinations, acknowledgement of appeals, and resolution notice of appeals. HSCSN should use the date of oral inquiries seeking an appeal as the initial appeal receipt date and provide reasonable attempts to communicate denial of expedited appeal resolution. These requirements are consistent with HSCSN policies.
	➘	➘	**Weakness.** HSCSN's Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy did not specify the MCP informs the enrollee of limited time available to present evidence and testimony and make legal and factual arguments prior to standard or extended appeal resolution. **Recommendation.** HSCSN should amend its Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy to state the MCP informs the enrollee of limited time available to present evidence and testimony and make legal and factual arguments prior to standard or extended appeal resolution.
		➘	**Weakness.** HSCSN's Provider Manual did not include a grievance-resolution timeframe. **Recommendation.** HSCSN should update its Provider Manual and specify a 90-day grievance resolution notification timeframe.
➘		➘	**Weakness.** HSCSN did not consistently report grievance and appeal data to committees including the QMOC. **Recommendation.** HSCSN should specify in its grievance and appeal policies the quality committee structure and frequency of reporting grievance and appeal data, compliance results, opportunity for improvement through tracking and trending, and resultant action plans. Reporting at the subcommittee and QMOC level should occur at least quarterly.
		➘	**Weakness.** HSCSN's Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy requires the MCP to authorize or provide disputed services no later than two business days after reversal or notification of reversal from the District. **Recommendation.** HSCSN should amend its Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy to correctly specify the MCP must authorize or provide disputed services no later than 72 hours from the date it receives notice reversing the determination.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
NETWORK ADEQUACY VALIDATION			
	▲		**Strength.** HSCSN provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	▲	▲	**Strength.** HSCSN received a compliance rating of 100% for timely access to pediatric urgent appointments.
	▼	▼	**Weakness.** HSCSN received compliance ratings ranging from 71%-83% for timely access to adult routine and urgent appointments and pediatric routine appointments. **Recommendation.** HSCSN should follow up with noncompliant providers and provide education and require corrective actions, as necessary.
	▼		**Weakness.** HSCSN received a score of 35% for overall provider directory accuracy. **Recommendation.** HSCSN should make provider directory accuracy a priority and update information routinely.

MFC

Table 28. MFC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
Results are not available. MFC's contract was effective October 1, 2020.			
Maternal Health PIP			
Results are not available. MFC's contract was effective October 1, 2020.			
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
Results are not available. MFC's contract was effective October 1, 2020.			
EPSDT Performance Measures			
▲			**Strength.** A readiness review of MFC's information systems determined the MCP should be ready to calculate and report EPSDT results for the next reporting period.
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
▼			**Weakness.** MFC's Enrollee Materials Policy stated the Enrollee Handbook will include cost sharing, if any. DHCF prohibits cost sharing. **Recommendation:** MFC should revise its Enrollee Materials Policy and state it does not impose cost sharing.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
			Weakness. MFC's Enrollee Handbook specified incorrect requirements for timely filing of a grievance, appeal, and fair hearing. **Recommendation:** MFC should correct its Enrollee Handbook and state grievances may be filed at any time (not within 90 days of incident). Appeals should be filed within 60 days from the date on the adverse benefit determination notice (not the date the notice is mailed). Fair hearings should be requested within 120 days from the date on the appeal resolution (not the date the notice is mailed).
			**Weakness.** MFC's Enrollee Materials Policy did not specify the Provider Directory is available in paper form, upon request. **Recommendation:** MFC should revise its Enrollee Materials Policy and state the Provider Directory is available in paper form, upon request.
			**Weakness.** MFC's Provider Directory did not include behavioral health providers. **Recommendation.** MFC should update its web-based and paper copy provider directories and include behavioral health providers.
			**Weakness.** MFC did not have a machine-readable provider directory or formulary drug list available on its website. **Recommendation.** MFC should post a machine-readable provider directory and formulary drug list on its website.
Disenrollment Requirements and Limitations			
			**Weakness.** MFC did not communicate the disenrollment process, for cause and without cause, within the Enrollee Handbook. **Recommendation**. MFC should revise the Enrollee Handbook to inform the enrollee of the disenrollment process and include contact information and a telephone number.
			**Weakness.** MFC's Disenrollment of Enrollees Policy did not include the enrollee moving out of the MCP's service area as a cause for disenrollment. **Recommendation.** MFC should amend its Disenrollment of Enrollees Policy and include the disenrollment for cause reason of moving out of the MCP's service area.
Enrollee Rights and Protections			
			**Weakness.** HSCSN did not provide evidence of ensuring each enrollee is free to exercise his or her right, and exercising those rights does not adversely affect the way the MCP and its network providers or State agency treats the enrollee. **Recommendation.** HSCSN should state enrollees are free to exercise their rights and enrollees exercising their rights do not adversely affect the way MFC, its network providers, or DHCF treats the enrollees.
MCO Standards			
			**Strength.** MFC received a score of 96% in the MCO Standard demonstrating compliance with most requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
➘	➘		**Weakness.** MFC's Geographical Access and Adequacy of Provider Network Policy did not include requirements to submit documentation to the State. **Recommendation.** MFC should revise its Geographical Access and Adequacy of Provider Network Policy and specify when it submits documentation to DHCF including: at the time it enters into a contract with the District, on an annual basis, at any time there has been a significant change, or enrollment of a new population.
		➘	**Weakness.** MFC did not identify a timeframe for conducting health risk assessments within its Health Risk Assessment for New Enrollees Policy. **Recommendation.** MFC should specify the MCP will conduct health risk assessments within 90 days of enrollment within its Health Risk Assessment for New Enrollees Policy.
➘			**Weakness.** MFC's Utilization Management Criteria Policy did not assert the MCP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. **Recommendation.** MFC should update its Utilization Management Criteria Policy and explicitly state it will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.
➘	➘		**Weakness.** MFC's delegation agreements did not include all required components. **Recommendation.** MFC should update its delegation agreements and specify inspection and audit parameters including requirements of §438.230(c)(3)(i)(ii)(iii)(iv).
Quality Assessment and Performance Improvement Program			
➚			**Strength.** MFC received a score of 100% in the Quality Assessment and Performance Improvement Program Standard.
Grievance and Appeal System			
		➘	**Weakness.** MFC did not address the deemed exhaustion of appeal process in its Enrollee Appeals Policy. **Recommendation**. MFC should revise its Enrollee Appeals Policy and assert if the MCP fails to adhere to the notice and timing requirements, the enrollee is deemed to have exhausted the MCP's appeal process and may initiate a State fair hearing.
➘			**Weakness.** MFC's Enrollee Grievances, Complaints, and Inquiries Policy included multiple grievance categories and procedures for each, including exceptions for sending written acknowledgements. **Recommendation.** MFC should revise its Enrollee Grievances, Complaints, and Inquiries Policy to eliminate exceptions for sending written acknowledgments. There are no separate categories of grievances per the MCP contract.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
		✓	**Weakness.** MFC's Enrollee Appeals Policy did not require the MCP to inform enrollees of the limited time available to present evidence and testimony and make legal and factual arguments for standard and extended appeals. **Recommendation.** MFC should amend its Enrollee Appeals Policy to inform enrollees of their limited time to present evidence and testimony and make legal and factual arguments for standard and extended appeals.
✓		✓	**Weakness.** MFC has multiple categories of grievances, which is inconsistent with federal regulations and the MCP contract. The Provider Manual provides an incorrect grievance-resolution timeframe. **Recommendation.** MFC should revise its Enrollee Grievances, Complaints, and Inquiries policy and specify one grievance category with a 90-day resolution timeframe. MFC should revise its Provider Manual and reflect the 90-day resolution timeframe.
		✓	**Weakness.** MFC's Provider Manual communicated incorrect appeal resolution-notice timeframes. **Recommendation.** MFC should amend its Provider Manual and specify written resolution notice is provided to the enrollee within 30 calendar days (not 30 days plus 2 days).
		✓	**Weakness.** MFC's Enrollee Handbook and Provider Manual did not accurately reflect expedited resolution of appeals timelines. **Recommendation.** MFC should update its Enrollee Handbook and Provider Manual to include expedited resolution notice within 72 hours (not 3 calendar days).
✓	✓		**Weakness.** MFC's Enrollee Grievances, Complaints, and Inquiries Policy did not address grievance resolution consistent with §438.10. **Recommendation.** MFC should revise its Enrollee Grievances, Complaints, and Inquiries Policy and require the MCP comply with grievance resolution consistent with §438.10 and specify the requirements.
✓	✓		**Weakness.** MFC's Enrollee Appeals Policy specified its appeal resolution notice is compliant with §438.10, but does not explain the requirements. **Recommendation.** MFC should amend its Enrollee Appeals Policy and explain §438.10 requirements.
✓			**Weakness.** MFC's Provider Manual did not explain the MCP will not take any punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal. **Recommendation.** MFC should state, within the Provider Manual, the MCP will not take any punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
		⮟	**Weakness.** MFC did not specify in its Enrollee Appeals Policy, the enrollee requirement to timely file an appeal when continuing benefits during the appeal process. **Recommendation.** MFC should update its Enrollee Appeals Policy to include the requirement, for continuation of benefits, the enrollee must timely file an appeal.
⮟			**Weakness.** MFC's Enrollee Appeal and Fair Hearing Process policies did not include the enrollee withdrawing the request for a State fair hearing as a reason for discontinuing benefits. **Recommendation.** MFC should revise its Enrollee Appeal and Fair Hearing Process policies and assert the enrollee withdrawing the request for a fair hearing as a reason for discontinuing benefits.
NETWORK ADEQUACY VALIDATION			
Results are not available. MFC's contract was effective October 1, 2020.			

Assessment of Previous Recommendations

Qlarant assessed MCP compliance in addressing previous annual recommendations.[16] MCPs were expected to remedy 2019 deficiencies and demonstrate full compliance. Qlarant evaluated corrective actions during the course of conducting 2020 EQR activities. MCPs not addressing deficiencies are at risk of not being compliant with their contracts. Assessment outcomes are illustrated in Figures 17-20. MCP specific 2019 recommendations and follow-up 2020 assessments are summarized in Tables 29-32. Green and red arrow symbols specify results:

- ⮝ The MCP adequately addressed the recommendation.
- ⮟ The MCP did not adequately address the recommendation.

ACDC

ACDC complied with 7 of 10 recommendations, demonstrating a 70% compliance rating.

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

Figure 17. Assessment Outcome for ACDC 2019 Recommendations

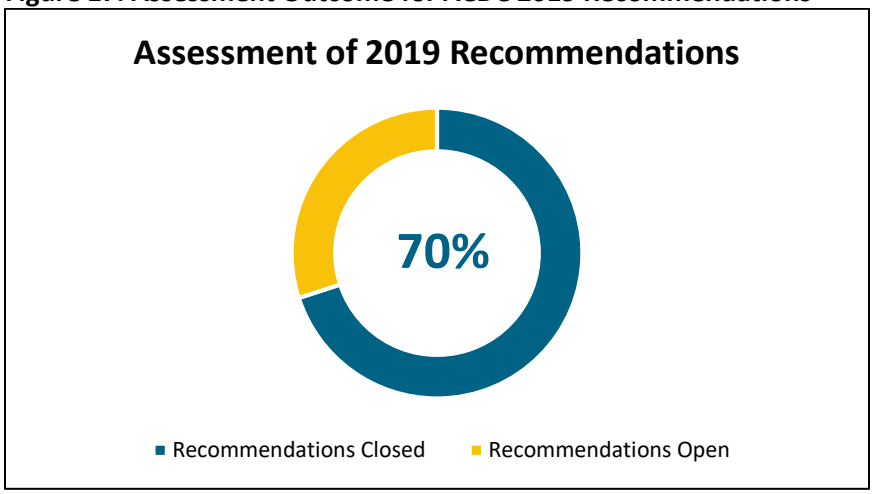


Table 29. Assessment of ACDC's Previous Annual Recommendations

2019 Recommendations	2020 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
ACDC achieved a score of 100%.	Not applicable.
Maternal Health PIP	
ACDC achieved a score of 100%.	Not applicable.
Performance Measure Validation	
PIP Performance Measures	
ACDC achieved a score of 100%.	Not applicable.
EPSDT Performance Measures	
ACDC should enhance enrollee information quality checks between information systems and medical records to reduce data discrepancies and record disqualification.	⮟ ACDC did not sufficiently address the 2019 recommendation as 24% of records were deemed invalid and not reviewed due to date of birth errors. The recommendation remains in place for 2020.
ACDC should enhance training and oversight of the medical record review process to improve accuracy of results.	⮝ ACDC improved the accuracy of its medical record review. Qlarant's medical record over-read resulted in 100% agreement with ACDC's numerator positive assessment.
Operational Systems Review	
Information Requirements	
ACDC should update PDF versions of the provider directories to identify all providers, including specialists and behavioral health providers, who are accepting new enrollees as patients.	⮝ ACDC updated PDF versions of the provider directories as recommended.
Enrollee Rights and Protections	
ACDC achieved a score of 100%.	Not applicable.
MCO Standards	
ACDC should take and provide evidence of corrective action when network providers fail to comply with timely access standards.	⮟ ACDC did not sufficiently address the 2019 recommendation and it remains in place for 2020.
Quality Assessment and Performance Improvement Program	
ACDC achieved a score of 100%.	Not applicable.

2019 Recommendations	2020 Assessment
Grievance and Appeal System	
ACDC should revise its authorization decision related policy and state if the service authorization decision is not reached within the timeframe specified, it constitutes a denial and is thus an adverse benefit determination.	ACDC updated its authorization decision related policy as recommended.
ACDC should revise its grievance policy to include the requirement that individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision making or a subordinate of any such individual.	ACDC updated its grievance policy as recommended.
ACDC should amend relevant policies to include the requirement that anyone participating in appeal decision making will take into account all comments, documents, and records submitted by the enrollee (or representative) without regard to whether such information was submitted or considered in the initial adverse benefit determination.	ACDC updated relevant policies as recommended.
ACDC should revise its Provider Manual to eliminate any reference of cost recovery for continued services if the fair hearing decision is adverse to the enrollee. DHCF prohibits cost recovery.	ACDC updated its Provider Manual as recommended.
Network Adequacy Validation	
ACDC should educate and work with its provider network to improve compliance in obtaining urgent appointments with pediatric PCPs in a timely manner (67% compliance in 2019).	ACDC adequately improved compliance in obtaining urgent appointments with pediatric PCPs in a timely manner (94% in 2020).
ACDC should improve overall accuracy of its provider directory (34% in 2019).	While ACDC demonstrated significant improvement in 2020 (60%), an opportunity for improvement remains and the recommendation continues.

AGP

AGP complied with 7 of 7 recommendations that were assessed, demonstrating a 100% compliance rating. Not all EQR activities were completed for AGP during 2020 due to their contract termination.

Figure 18. Assessment Outcome for AGP 2019 Recommendations

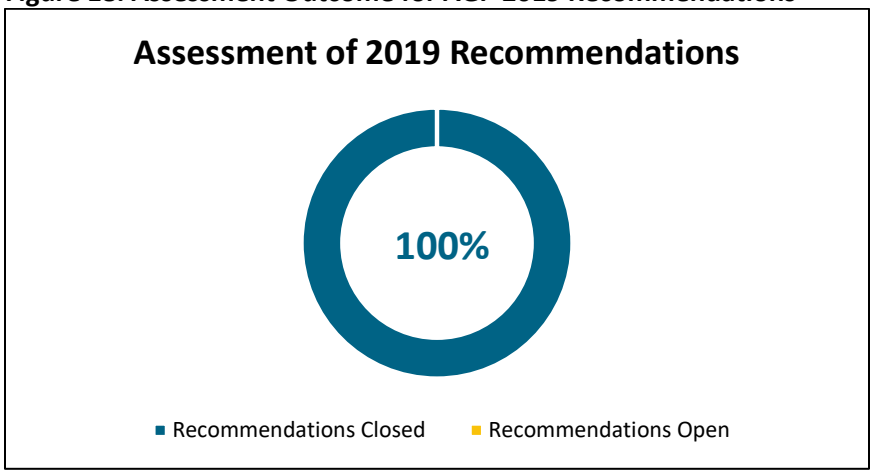


Table 30. Assessment of AGP's Previous Annual Recommendations

2019 Recommendation	2020 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
AGP should provide MCP-specific data to support the project rationale.	⮝ AGP provided MCP-specific data to support the project rationale.
AGP should conduct sampling and a medical record review for the Comprehensive Diabetes Care HbA1c <7 for Select Population measure.	⮝ AGP conducted sampling and completed a medical record review for the HbA1c <7 for Select Population measure.
AGP should ensure the population included is consistent with requirements.	⮝ AGP included the appropriate population consistent with requirements.
Maternal Health PIP	
AGP should provide MCP-specific data to support the project rationale.	⮝ AGP provided MCP-specific data to support the project rationale.
AGP should ensure the population included is consistent with requirements.	⮝ AGP included the appropriate population consistent with requirements.
Performance Measure Validation	
PIP Performance Measures	
AGP should conduct sampling and a medical record review for the Comprehensive Diabetes Care HbA1c <7 for Select Population measure.	⮝ AGP conducted sampling and completed a medical record review for the HbA1c <7 for Select Population measure.
AGP should ensure the population included is consistent with requirements.	⮝ AGP included the appropriate population consistent with requirements.
EPSDT Performance Measures	
DHCF terminated its contract with AGP on 9/30/2020. A 2020 EPSDT PMV audit was not conducted for AGP.	
Operational Systems Review	
DHCF terminated its contract with AGP on 9/30/2020. A 2020 OSR was not conducted for AGP.	
Network Adequacy Validation	
DHCF terminated its contract with AGP on 9/30/2020. A 2020 NAV was not fully completed for AGP.	

CFDC

CFDC complied with 12 of 16 recommendations, demonstrating a 75% compliance rating.

Figure 19. Assessment Outcome for CFDC 2019 Recommendations

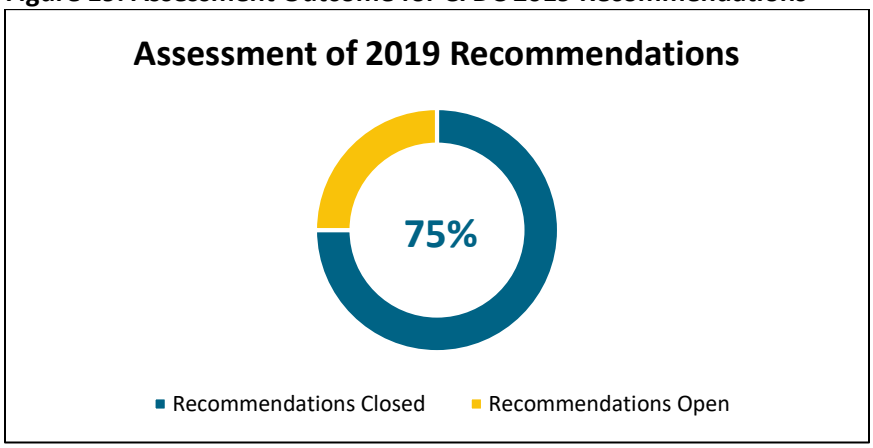


Table 31. Assessment of CFDC's Previous Annual Recommendations

2019 Recommendations	2020 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
CFDC should consider implementing evidence-based interventions suggesting tests of change will likely lead to desired improvement to achieve statistically significant improvement in at least one measure.	CFDC initiated interventions leading to statistically significant improvement in the Blood Pressure Control (<140/90 mm Hg) measure.
Maternal Health PIP	
CFDC achieved a score of 100%.	Not applicable.
Performance Measure Validation	
PIP Performance Measures	
CFDC achieved a score of 100%.	Not applicable.
EPSDT Performance Measures	
CFDC achieved a score of 100%.	Not applicable.
Operational Systems Review	
Information Requirements	
CFDC achieved a score of 100%.	Not applicable.
Enrollee Rights and Protections	
CFDC achieved a score of 100%.	Not applicable.
MCO Standards	
CFDC achieved a score of 100%.	Not applicable.
Quality Assessment and Performance Improvement Program	
CFDC achieved a score of 100%.	Not applicable.

2019 Recommendations	2020 Assessment
Grievance and Appeal System	
CFDC should amend applicable policies and state the requirement that the MCP must provide the enrollee with written notice of termination, suspension, or reduction of a previously authorized Medicaid-covered service, at least 10 days before the date of action.	⮝ CFDC updated its policies as recommended.
CFDC should revise its grievance policy to include the requirement for individuals making decisions on grievances are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. Individuals making decisions should have the appropriate clinical expertise in treating the enrollee's condition or disease.	⮝ CFDC updated its grievance policy as recommended.
CFDC should revise its grievance and appeals policies to include the requirement for ensuring individuals who make decisions on grievances and appeals are individuals who take into account all comments, documents, and records submitted by the enrollee (or representative) without regard to whether such information was submitted or considered in the initial adverse benefit determination.	⮝ CFDC updated its grievance and appeals policies as recommended.
CFDC should revise its appeals policy to include informing enrollees of limited time available for presenting evidence and allegations of fact or law, in person as well as in writing, for standard resolutions and extensions.	⮝ CFDC updated its appeal policy as recommended.
CFDC should update its appeals policy to specify parties to the appeal including the enrollee and his/her representative or legal representative of a deceased enrollee's estate.	⮟ CFDC did not update its appeal policy as recommended.
CFDC should revise its appeals policy to require written notice to the enrollee of any timeframe extension, not at the request of the enrollee, to occur within two calendar days, not two business days.	⮝ CFDC updated its appeals policy as recommended.
CFDC should revise its appeals policy to include the requirement for providing written notification of appeal resolution to the enrollee in a format and language that, at a minimum, meet the standards described at §438.10.	⮝ CFDC updated its appeals policy as recommended.
CFDC should include in its appeals policy the required parties to the District fair hearing.	⮝ CFDC updated its appeals policy as recommended.

2019 Recommendations	2020 Assessment
CFDC should include a statement in the Provider Manual informing providers the MCP will not take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.	⮝ CFDC updated its Provider Manual as recommended.
CFDC should revise its appeals policy and include the requirement for demonstrating reasonable effort to give the enrollee prompt oral notice of a decision to deny a request for an expedited resolution of an appeal followed by written notice within two calendar days including the right to file a grievance.	⮝ CFDC updated its appeals policy as recommended.
CFDC should include in its appeals policy the full list of requirements for continuation of benefits as specified in §438.420(b)(1)(2)(3)(4). Benefits reinstated should continue until action occurs consistent with §438.420(c)(1)(2)(3).	⮝ CFDC updated its appeals policy as recommended.
CFDC should revise its Provider Manual to state if the MCP or District Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	⮟ CFDC updated one of two Provider Manual sections correctly. CFDC must ensure all sections reflect accurate timeframe requirements.
CFDC should revise its appeals policy to include the requirement for payment by the MCP or District of disputed services furnished while an appeal is pending if the MCP or District Hearing Officer reverses a decision to deny authorization of services.	⮝ CFDC updated its appeals policy as recommended.
Network Adequacy Validation	
CFDC should educate and work with its provider network to improve compliance in obtaining routine and urgent appointments with adult and pediatric PCPs in a timely manner (compliance in 2019: adult routine 83%, adult urgent 33%, pediatric routine and urgent 83%).	⮟ CFDC improved compliance in obtaining timely appointments. Routine and urgent appointments with adult PCPs: 90% and 81%, respectively. Routine and urgent appointments with pediatric PCPs: 92% and 100%, respectively. An opportunity to continue to improve urgent appointment timeliness with adult PCPs remains.
CFDC should improve overall accuracy of its provider directory (32% in 2019).	⮟ While CFDC demonstrated significant improvement in 2020 (51%), an opportunity for improvement remains and the recommendation continues.

HSCSN

HSCSN complied with 11 of 24 recommendations, demonstrating a 46% compliance rating.

Figure 20. Assessment Outcome for HSCSN 2019 Recommendations

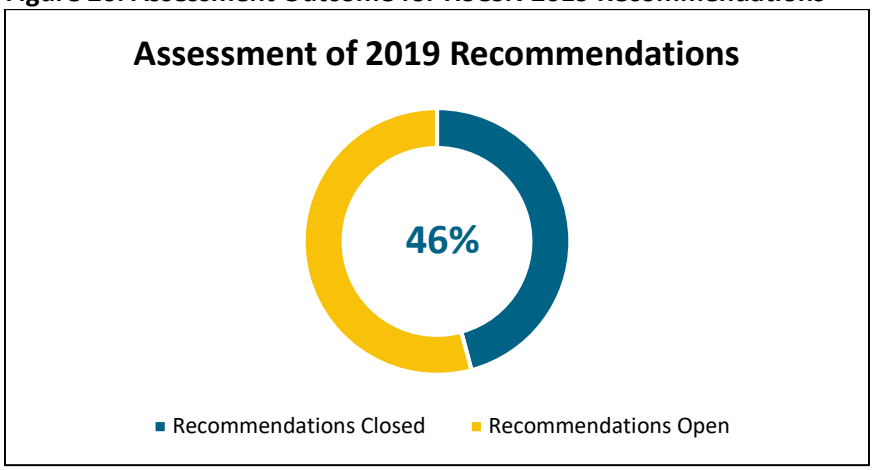


Table 32. Assessment of HSCSN's Previous Annual Recommendations

2019 Recommendations	2020 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
HSCSN should provide MCP-specific data to support the project rationale.	⮝ HSCSN provided MCP-specific data to support the project rationale.
HSCSN should implement interventions addressing barriers. Interventions should be robust and achieve statistically significant improvement.	⮟ HSCSN did not sufficiently address the 2019 recommendation. Interventions were not properly reported and the recommendation continues in 2020. Statistically significant improvement was not achieved.
HSCSN should conduct a complete data analysis including describing results of statistical significance testing and evaluating intervention effectiveness. Results should be reported accurately.	⮟ HSCSN did not sufficiently address the 2019 recommendation. One measure was omitted from analysis and HSCSN did not report statistical significance results. Intervention effectiveness was based on subjective impressions, rather than objective data.
Maternal Health PIP	
HSCSN achieved a score of 100%.	Not applicable.
Performance Measure Validation	
PIP Performance Measures	
HSCSN achieved a score of 100%.	Not applicable.
EPSDT Performance Measures	
HSCSN achieved a score of 100%.	Not applicable.
Operational Systems Review	
Information Requirements	
HSCSN should post a machine-readable drug formulary on its website.	⮝ HSCSN posted a machine-readable drug formulary on its website.

2019 Recommendations	2020 Assessment
Enrollee Rights and Protections	
HSCSN achieved a score of 100%.	Not applicable.
MCO Standards	
HSCSN should monitor provider compliance with network adequacy standards for timely appointments and provide evidence of such monitoring.	⮟ HSCSN did not sufficiently address the 2019 recommendation. The recommendation remains in place for 2020.
Quality Assessment and Performance Improvement Program	
HSCSN should conduct PM monitoring consistent with what is identified in its Quality Assessment and Performance Improvement Plan and report results to the Quality Management and Outcomes Committee quarterly.	⮟ HSCSN did not fully implement its corrective action plan and an opportunity for improvement continues in 2020.
Grievance and Appeal System	
HSCSN should ensure all relevant policies consistently reflect the requirement for exhausting HSCSN's appeal process before requesting a District fair hearing and provide this information in the adverse benefit determination notice.	⮝ HSCSN updated relevant policies as recommended.
HSCSN should revise all relevant policies to include instructions on how to request continuation of benefits in the adverse benefit determination notice.	⮝ HSCSN updated relevant policies as recommended.
HSCSN should amend relevant policies and state it must provide notice of termination, suspension, or reduction of a previously authorized Medicaid-covered service, at least 10 days before the date of action.	⮝ HSCSN updated relevant policies as recommended.
HSCSN should revise relevant policies to consistently reflect the regulatory timeframe for providing notice of standard authorization decisions—not to exceed 14 calendar days following receipt of the request for service.	⮟ HSCSN did not fully implement its corrective action. HSCSN's authorization policy continues to have a timeframe error.
HSCSN should revise the appeal policy to specify the requirement for sending the enrollee a written acknowledgement of an appeal within two business days of receipt. Additionally, HSCSN should demonstrate compliance with this requirement.	⮟ HSCSN revised its appeal policy as recommended. However, the MCP did not consistently demonstrate compliance based on record review results.
HSCSN should revise its appeal policy to include the requirement to inform the requestor of the limited time available for presenting evidence and testimony and make legal and factual arguments in the case of a standard or extended appeal.	⮟ HSCSN did not fully implement its corrective action plan and an opportunity for improvement continues in 2020.
HSCSN should demonstrate it resolves all standard appeals within the required 30 calendar day timeframe.	⮟ HSCSN did not consistently demonstrate compliance with resolving standard appeals according to the 30-calendar-day timeframe. The opportunity for improvement continues in 2020.

2019 Recommendations	2020 Assessment
HSCSN should revise its Enrollee Handbook and correct the expedited appeal resolution and notice timeframe from three calendar days to 72 hours.	⮝ HSCSN updated the Enrollee Handbook as recommended.
HSCSN should revise its appeal policy to include the requirement for providing written notification in a format and language that meets the requirements of §438.10.	⮝ HSCSN updated its appeal policy as recommended.
HSCSN should revise its appeal policy to address the requirement to include in the appeal resolution notice how to make a request for continuation of benefits. Reference to continuation of benefits during an appeal must also include fair hearings.	⮝ HSCSN updated its appeal policy as recommended.
HSCSN should amend its appeal policy and specify parties to the District fair hearing: HSCSN and the enrollee and his/her representative or the representative of a deceased enrollee's estate.	⮝ HSCSN updated its appeal policy as recommended.
HSCSN should demonstrate the Provider Manual has been finalized and distributed to providers with updated and accurate enrollee grievance and appeal information.	⮟ HSCSN did not fully implement its corrective action plan and an opportunity for improvement continues in 2020. HSCSN should update the Provider Manual and include the grievance resolution timeframe.
HSCSN should revise its appeal policy and include a requirement to review information obtained from appeal records as part of the MCP's ongoing monitoring and quality improvement activities.	⮟ HSCSN did not fully implement its corrective action plan. Meeting minutes did not provide evidence of grievance and appeal trend discussions or opportunities for improvement. This recommendation remains in place for 2020.
HSCSN should revise its appeal policy to address the requirement to make appeal records available to CMS upon request.	⮝ HSCSN updated its appeal policy as recommended.
HSCSN should revise its appeal policy to include the additional requirement for continuation of benefits until the District Fair Hearing Officer issues a hearing decision adverse to the enrollee.	⮝ HSCSN updated its appeal policy as recommended.
HSCSN should amend its appeal policy to require the MCP to authorize or provide disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date the MCP receives notice reversing the determination and in cases involving an expedited appeal, within 24 hours of the reversal.	⮟ HSCSN did not fully implement its corrective action plan and include accurate timeframes in the appeal policy. This recommendation remains in place for 2020.
Network Adequacy Validation	
HSCSN should educate and work with its provider network to improve compliance in obtaining urgent appointments with adult PCPs and routine appointments with pediatric PCPs (2019 results: adult urgent 60%, pediatric routine 67%).	⮟ While HSCSN improved compliance in obtaining timely appointments in 2020, the MCP continues to have an opportunity for improvement: urgent appointments with adult PCPs (71%) and routine appointments with adult PCPs (78%) pediatric PCPs (83%).

2019 Recommendations	2020 Assessment
HSCSN should improve overall accuracy of its provider directory (34% in 2019).	✓ HSCSN demonstrated marginal improvement in 2020 (34% to 35%). An opportunity for improvement remains and the recommendation continues.

State Recommendations

DHCF continuously strives to improve the health and well-being of the District of Columbia residents. DHCF's mission focuses on improving health outcomes by providing access to comprehensive, cost-effective, and quality health care services. To provide a means for achieving this mission, DHCF developed a Medicaid Managed Care Quality Strategy.[17] Table 33 identifies quality strategy goals, using the Institute for Healthcare Improvement Triple Aim framework.

Table 33. DHCF Quality Strategy Goals

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

DHCF evaluates MCP progress in meeting quality strategy goals through:

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

Qlarant's EQR results assist DHCF in each of these evaluation mechanisms. Qlarant's findings report MCP performance and compliance. Recommendations are made to provide clear guidance on actions the MCPs should take to improve outcomes and operations. These actions, if implemented, may assist the MCPs in meeting quality strategy goals. In addition to providing MCP-specific guidance, Qlarant offers DHCF the following recommendations, which should positively impact the quality, accessibility, and timeliness of services provided to enrollees:

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

- Continue efforts to move all Medicaid beneficiaries into a fully managed care environment to provide a more organized, accountable, and person-centered system.
- Identify specific targets or benchmarks for DHCF-selected measures linked to quality strategy objectives.[18] Specific performance goals may encourage MCPs in driving performance improvement strategies resulting in improved outcomes.
- Hold MCPs more accountable for not addressing opportunities for improvement. As identified in the Assessment of Previous Recommendations section:
    - ACDC successfully addressed 80% of previous annual recommendations
    - CFDC successfully addressed 75% of previous annual recommendations
    - HSCSN successfully addressed 46% of previous annual recommendations
- Continue to work with community partners to address social determinants of health. Encourage MCPs to screen and provide referrals for social needs. Addressing social determinants of health is critical for improving health and reducing disparities in health and health care.
- Continue to use performance improvement initiatives to achieve better health outcomes including pay-for-performance. Promote MCP use of value-based purchasing or other methodologies linking payment to desired outcomes.
- Encourage and promote use of telehealth during the COVID-19 public health emergency and beyond. AHRQ reported clinical outcomes with telehealth are as good as or better than usual care and telehealth improves intermediate outcomes and satisfaction. Evidence of benefit is concentrated in specific areas:[19]
    - Monitoring patients with chronic conditions
    - Communicating and counseling patients with chronic conditions
    - Providing psychotherapy as part of behavioral health
- Put the MCP Quality Rating System/Consumer Report Card on hold until meaningful comparative results are available. Changes in contracted MCPs create barriers in reporting fair and balanced assessments.
- Require MCPs to identify improvement strategies for measures not meeting national Medicaid average benchmarks. Qlarant reports MCP HEDIS and CAHPS survey performance compared to benchmarks in Appendix 1 and Appendix 2. In summary, the MCP weighted averages performed lower than the national-average benchmarks in 65% of HEDIS measures and 85% of CAHPS survey measures. Results are illustrated in Figures 21-22.

[18] Selected performance measures are identified in Appendix I of the Medicaid Managed Care Quality Strategy
[19] Evidence Base for Telehealth

Figure 21. MY 2019 HEDIS MCP Average Performance Compared to Benchmarks

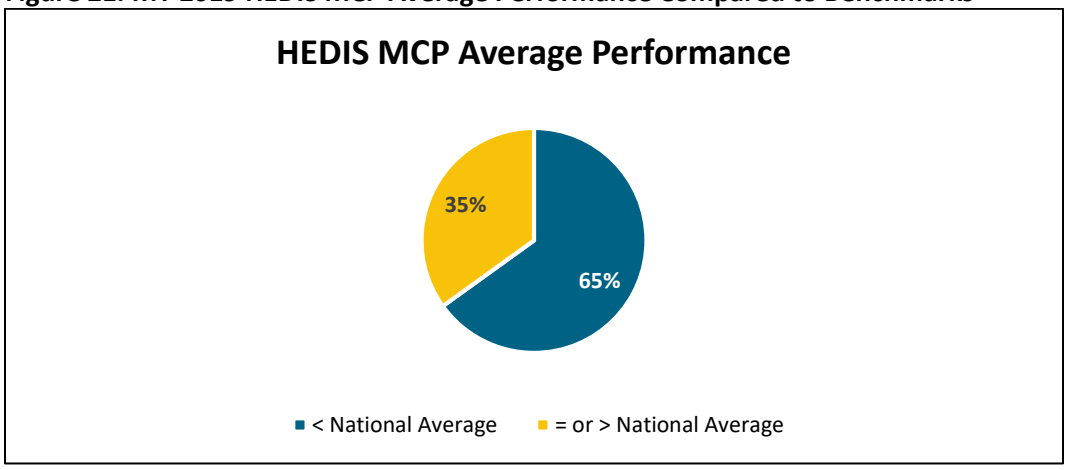
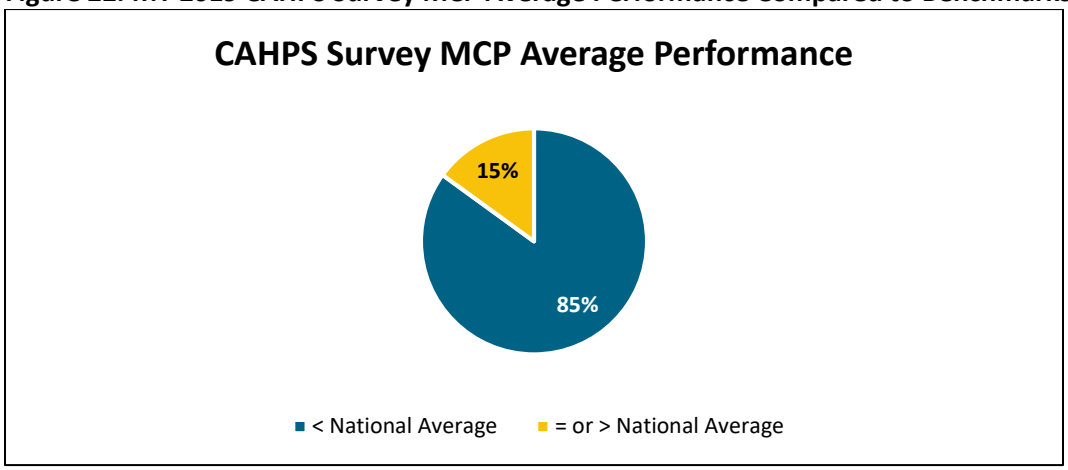


Figure 22. MY 2019 CAHPS Survey MCP Average Performance Compared to Benchmarks



Conclusion

As DC's contracted EQRO, Qlarant evaluated the DC Healthy Families managed care program to assess compliance with federal and DC-specific requirements. Review and validation activities occurred over the course of 2020 and assessed MY 2019 and MY 2020 performance, as applicable. Qlarant evaluated each participating MCP and found:

- For the Comprehensive Diabetes Care PIP, MCPs reported their second remeasurement. Analysis of the MCP weighted averages concluded:
  - Improvement in three measures when comparing the latest measurement results to baseline performance: HbA1c Testing, HbA1c Poor Control (>9%) (lower rate is better), and Blood Pressure Control (<140/90 mm Hg)
  - Positive consecutive annual improvement in the Blood Pressure Control (<140/90 mm Hg) measure
- Consider discontinuing two measures from the Comprehensive Diabetes Care PIP due to NCQA retirement: HbA1c Control (<7% for a Selected Population) and Medical Attention for Nephropathy. MCPs are no longer required to report them to NCQA. Eliminating the PMs from the PIP affords the MCPs more opportunity to focus efforts on the remaining five measures.

- For the Maternal Health PIP, MCPs reported baseline performance. All MCPs developed methodologically sound PIPs.
- All MCPs had appropriate systems in place to process accurate claims and encounters. All MCPs received "reportable" designations for the calculation of measures for both the PIP and EPSDT measures.
- MCPs had operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. The overall 2020 weighted OSR score was 95%, consistent with the 2019 score. All MCPs were required to complete CAPs.
- MCPs have robust provider networks demonstrating at least 99% compliance with geographic and provider-to-enrollee requirements. MCPs improved access to timely provider appointments, but opportunity exists to continue to positively impact timely access. MCPs should also improve the accuracy of their provider directories.
- All MCPs demonstrated strengths and weaknesses in the areas of quality, access, and timeliness. MCPs should address specific recommendations made to improve performance in these areas.
- ACDC and CFDC addressed most of their previous annual recommendations, while HSCSN addressed less than 50% of their recommendations.
- DHCF continues to strive to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services. DHCF updated its Medicaid Managed Care Quality Strategy and developed realistic, achievable goals to:
    - Ensure access to quality, whole-person care
    - Improve management of chronic conditions
    - Improve population health
    - Ensure high-value, appropriate care
- DHCF is targeting goals by implementing strategies to achieve better care, healthier enrollees, and more value. MCPs made strides in meeting some objectives, but there continues to be opportunity for improvement.
- MCPs adapted during the COVID-19 public health emergency and worked to ensure enrollee access to care. Increased access to telehealth helped address barriers to care.

Appendix A1

HEDIS® 2020 – Measurement Year (MY 2019)

The HEDIS performance measure tables include 2020 (MY 2019) results. Results for each MCP and the District MCP Weighted Averages are displayed. Each MCP average is also compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The District Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The District Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦ ♦
The District Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦ ♦ ♦

Effectiveness of Care Domain

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	36.19	41.35	NA	19.64	35.70	♦
Adult BMI Assessment	90.75	73.72	62.53	87.84	85.64	♦
Antidepressant Medication Management - Effective Acute Phase Treatment	48.28	37.79	NA	53.66	46.75	♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	31.46	24.43	NA	33.45	30.23	♦
Appropriate Testing for Pharyngitis (3-17 Yrs)*	86.68	84.95	NA	45.37	80.91	♦ ♦
Appropriate Testing for Pharyngitis (18-64 Yrs)*	71.25	67.05	NA	43.57	66.98	♦ ♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Appropriate Testing for Pharyngitis (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Appropriate Testing for Pharyngitis (Total)	79.30	75.31	NA	44.52	74.11	♦
Appropriate Treatment for Upper Respiratory Infection (3 months-17 Yrs)*	97.78	97.56	100.00	97.69	97.82	♦ ♦ ♦
Appropriate Treatment for Upper Respiratory Infection (18-64 Yrs)*	83.20	88.35	100.00	83.00	84.48	♦ ♦ ♦
Appropriate Treatment for Upper Respiratory Infection (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Appropriate Treatment for Upper Respiratory Infection (Total)	93.53	94.56	100.00	93.56	93.94	♦ ♦ ♦
Asthma Medication Ratio (5-11 Yrs)	49.75	48.86	NA	61.87	51.19	♦
Asthma Medication Ratio (12-18 Yrs)	48.99	57.89	NA	47.06	50.47	♦
Asthma Medication Ratio (19-50 Yrs)	47.67	52.97	NA	46.21	48.37	♦
Asthma Medication Ratio (51-64 Yrs)	55.14	61.11	NA	61.82	56.89	♦ ♦
Asthma Medication Ratio (Total)	49.68	53.68	61.76	54.38	50.93	♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 months-17 Yrs)*	94.33	93.17	100.00	93.92	94.21	♦ ♦ ♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64 Yrs)*	51.42	64.79	NA	57.06	55.63	♦ ♦ ♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	76.53	80.09	100.00	76.45	77.66	♦ ♦ ♦
Breast Cancer Screening	58.82	39.81	NA	39.43	51.27	♦
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	NA	**NC**

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Cervical Cancer Screening	65.45	37.96	60.17	49.64	56.55	♦
Childhood Immunization Status - Combination 2	69.10	28.95	79.35	61.31	58.58	♦
Childhood Immunization Status - Combination 3	65.94	27.98	78.26	58.88	56.11	♦
Childhood Immunization Status - Combination 4	65.69	27.98	77.17	58.64	55.90	♦
Childhood Immunization Status - Combination 5	51.09	23.11	58.70	55.96	45.61	♦
Childhood Immunization Status - Combination 6	36.74	17.27	55.43	38.93	33.03	♦
Childhood Immunization Status - Combination 7	50.85	23.11	58.70	55.72	45.43	♦
Childhood Immunization Status - Combination 8	36.74	17.27	55.43	38.69	32.99	♦
Childhood Immunization Status - Combination 9	32.60	15.33	43.48	37.23	29.66	♦
Childhood Immunization Status - Combination 10	32.60	15.33	43.48	36.98	29.61	♦
Childhood Immunization Status - DTaP	71.78	53.04	83.70	66.42	66.73	♦
Childhood Immunization Status - Hepatitis A	84.18	74.94	94.57	82.48	81.97	♦
Childhood Immunization Status - Hepatitis B	84.67	39.90	89.13	74.94	72.59	♦
Childhood Immunization Status - HiB	84.18	45.99	93.48	76.16	74.05	♦
Childhood Immunization Status - Influenza	41.12	26.28	60.87	45.99	39.00	♦
Childhood Immunization Status - IPV	84.43	65.21	91.30	76.16	78.63	♦
Childhood Immunization Status - MMR	85.16	72.51	95.65	80.54	81.63	♦
Childhood Immunization Status - Pneumococcal Conjugate	72.99	52.80	85.87	65.45	67.23	♦
Childhood Immunization Status - Rotavirus	60.10	46.72	64.13	67.40	58.38	♦
Childhood Immunization Status - VZV	84.91	72.51	95.65	80.29	81.44	♦
Chlamydia Screening in Women (16-20 Yrs)	80.74	83.00	78.18	61.44	79.09	♦♦♦
Chlamydia Screening in Women (21-24 Yrs)	80.79	77.17	74.71	71.76	78.98	♦♦♦
Chlamydia Screening in Women (Total)	80.76	79.84	76.85	66.25	79.04	♦♦♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	62.40	45.07	56.25	46.53	56.71	♦
Comprehensive Diabetes Care - Eye Exams	57.02	34.12	46.88	36.13	49.50	♦
Comprehensive Diabetes Care - HbA1c Testing	85.95	80.84	90.63	77.19	83.77	♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	38.93	29.02	NA	33.48	36.10	♦ ♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	49.59	41.79	31.25	45.44	47.35	♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) ***(Lower is Better)***	40.70	51.28	65.63	46.90	43.81	♦
Comprehensive Diabetes Care - Medical Attention for Nephropathy	86.57	81.75	65.63	77.55	84.30	♦
Controlling High Blood Pressure	53.77	38.44	36.67	47.69	49.66	♦
Diabetes Monitoring for People with Diabetes and Schizophrenia	65.22	NA	NA	NA	56.63	♦
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	77.52	77.78	81.25	54.73	75.10	♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (18+ Yrs)	NA	2.22	NA	2.57	2.34	♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (Total)	NA	2.19	NA	2.56	2.32	♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (18+ Yrs)	NA	4.19	NA	2.89	3.57	♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (Total)	NA	4.14	NA	2.88	3.54	♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (6-17 Yrs)	42.18	43.18	0.00	NA	34.07	♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (18-64 Yrs)	24.07	24.76	NA	15.48	21.77	♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (Total)	31.40	30.20	0.00	21.43	26.60	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (6-17 Yrs)	56.46	56.82	0.00	NA	45.93	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (18-64 Yrs)	35.65	37.14	NA	22.62	32.30	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (Total)	44.08	42.95	0.00	31.25	37.65	♦
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (13-17 Yrs)*	NA	NA	NA	NA	NA	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (18-64 Yrs)*	NA	17.20	NA	20.77	18.53	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (Total)*	NA	17.20	NA	20.77	18.53	**NC**

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (13-17 Yrs)*	NA	NA	NA	NA	NA	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (18-64 Yrs)*	NA	31.54	NA	37.70	33.84	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (Total)*	NA	31.54	NA	37.70	33.84	**NC**
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (6-17 Yrs)	42.86	6.67	32.43	33.33	34.20	♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (18-64 Yrs)	47.76	21.65	2.94	28.86	35.95	♦ ♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (Total)	46.59	19.40	18.31	29.67	35.56	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (6-17 Yrs)	65.58	28.89	62.16	48.48	56.88	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (18-64 Yrs)	65.45	31.50	17.65	37.58	49.95	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NA	**NC**
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (Total)	65.48	31.10	40.85	39.56	51.50	♦
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.32	43.48	NA	33.33	40.56	♦
Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	54.84	NA	NA	NA	56.76	♦ ♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Immunizations for Adolescents - Combination 1	84.43	75.91	88.07	77.66	82.24	♦ ♦
Immunizations for Adolescents - Combination 2	56.69	42.34	66.97	46.45	53.43	♦ ♦ ♦
Immunizations for Adolescents - HPV	59.85	45.01	72.94	49.24	56.64	♦ ♦ ♦
Immunizations for Adolescents - Meningococcal	86.37	77.62	89.45	80.20	84.17	♦ ♦
Immunizations for Adolescents - Tdap/Td	87.59	79.56	92.20	80.71	85.54	♦
Lead Screening in Children	81.02	72.26	87.23	77.86	78.56	♦ ♦
Medication Management for People With Asthma - Medication Compliance 50% (5-11 Yrs)	53.62	51.30	NA	43.31	51.97	**NC**
Medication Management for People With Asthma - Medication Compliance 50% (12-18 Yrs)	53.27	60.32	NA	35.71	52.77	**NC**
Medication Management for People With Asthma - Medication Compliance 50% (19-50 Yrs)	59.47	60.62	NA	50.00	58.44	**NC**
Medication Management for People With Asthma - Medication Compliance 50% (51-64 Yrs)	74.30	67.65	NA	59.09	71.46	**NC**
Medication Management for People With Asthma - Medication Compliance 50% (Total)	58.18	58.43	48.39	46.67	56.87	**NC**
Medication Management for People With Asthma - Medication Compliance 75% (5-11 Yrs)	27.30	24.68	NA	18.90	25.64	♦
Medication Management for People With Asthma - Medication Compliance 75% (12-18 Yrs)	27.99	39.68	NA	11.90	28.44	♦
Medication Management for People With Asthma - Medication Compliance 75% (19-50 Yrs)	33.77	38.13	NA	24.51	33.33	♦
Medication Management for People With Asthma - Medication Compliance 75% (51-64 Yrs)	48.94	48.53	NA	34.09	47.22	♦
Medication Management for People With Asthma - Medication Compliance 75% (Total)	32.41	35.28	22.58	21.90	31.61	♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11 Yrs)*	46.15	NA	NA	NA	36.00	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17 Yrs)*	58.00	NA	NA	NA	49.32	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)*	52.81	NA	NA	NA	43.90	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11 Yrs)*	38.46	NA	NA	NA	30.00	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17 Yrs)*	36.00	NA	NA	NA	34.25	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)*	37.08	NA	NA	NA	32.52	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11 Yrs)*	38.46	NA	NA	NA	30.00	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17 Yrs)	34.00	NA	NA	NA	31.51	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	35.96	NA	NA	NA	30.89	♦
Non-Recommended Cervical Cancer Screening in Adolescent Females ***(Lower is Better)***	0.30	0.36	0.27	0.41	0.32	♦ ♦ ♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Persistence of Beta-Blocker Treatment after a Heart Attack	76.47	NA	NA	NA	68.97	♦
Pharmacotherapy for Opioid Use Disorder (16-64 Yrs)*	19.70	25.93	NA	23.81	22.13	**NC**
Pharmacotherapy for Opioid Use Disorder (65+ Yrs)*	NA	NA	NA	NA	NA	**NC**
Pharmacotherapy for Opioid Use Disorder (Total)*	19.60	25.69	NA	23.81	22.00	**NC**
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.97	91.95	NA	75.68	87.67	♦ ♦
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	72.20	71.26	NA	54.05	70.14	♦ ♦
Risk of Continued Opioid Use >= 15 Days (18-64 Yrs) ***(Lower is Better)***	4.19	1.54	NA	4.14	3.59	♦ ♦ ♦
Risk of Continued Opioid Use >= 15 Days (65 Yrs) ***(Lower is Better)***	NA	NA	NA	NA	NA	**NC**
Risk of Continued Opioid Use >= 15 Days (Total) ***(Lower is Better)***	4.19	1.54	NA	4.14	3.59	♦ ♦ ♦
Risk of Continued Opioid Use >= 30 Days (18-64 Yrs) ***(Lower is Better)***	2.09	0.98	NA	1.53	1.78	♦ ♦ ♦
Risk of Continued Opioid Use >= 30 Days (65 Yrs) ***(Lower is Better)***	NA	NA	NA	NA	NA	**NC**
Risk of Continued Opioid Use >= 30 Days (Total) ***(Lower is Better)***	2.09	0.98	NA	1.53	1.78	♦ ♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	78.69	73.17	NA	71.79	76.24	♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	70.97	NA	NA	NA	69.68	♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	74.80	74.55	NA	66.07	73.39	♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	68.75	60.00	NA	NA	62.99	♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	64.77	NA	NA	NA	62.96	♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	66.85	56.10	NA	51.35	62.98	♦
Statin Therapy for Patients With Diabetes - Received Statin Therapy	66.84	59.43	NA	58.91	64.18	♦ ♦
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	61.47	57.62	NA	44.67	58.64	♦
Use of Imaging Studies for Low Back Pain	86.74	89.31	87.18	90.32	87.79	♦ ♦ ♦
Use of Opioids at High Dosage ***(Lower is Better)***	1.97	3.56	NA	2.50	2.23	♦ ♦ ♦
Use of Opioids From Multiple Providers - Multiple Pharmacies ***(Lower is Better)***	9.76	4.23	NA	5.30	8.66	♦
Use of Opioids From Multiple Providers - Multiple Prescribers ***(Lower is Better)***	31.21	31.15	NA	31.82	31.25	♦
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies ***(Lower is Better)***	7.27	3.46	NA	5.30	6.59	♦
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	32.49	NA	NA	23.26	30.83	♦ ♦

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (3-11 Yrs)	91.70	54.64	71.63	75.42	81.37	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (12-17 Yrs)	88.81	60.42	58.67	73.68	80.36	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	90.75	56.03	65.45	74.94	80.98	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Yrs)	84.12	37.09	68.37	56.90	70.48	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Yrs)	79.85	45.83	56.12	64.04	70.99	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	82.73	39.20	62.53	58.88	70.60	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Yrs)	80.51	36.75	62.33	54.88	67.60	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Yrs)	76.12	43.75	56.63	66.67	68.58	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	79.08	38.44	59.61	58.15	67.91	♦ ♦

* – New Measure introduced in MY 2019
NA – Not Applicable (Small denominator < 30)
NC – No Comparison was made due to no District average rates or benchmark

Access and Availability Domain

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Adults' Access to Preventive/ Ambulatory Health Services (20-44 Yrs)	71.25	51.76	85.04	46.84	62.11	♦
Adults' Access to Preventive/ Ambulatory Health Services (45-64 Yrs)	78.91	59.86	NA	58.29	70.60	♦
Adults' Access to Preventive/ Ambulatory Health Services (65+ Yrs)	86.00	NA	NA	NA	75.27	♦
Adults' Access to Preventive/ Ambulatory Health Services (Total)	73.73	54.31	85.04	50.26	64.77	♦
Annual Dental Visit (2-3 Yrs)	64.08	61.47	53.50	52.80	61.28	♦ ♦ ♦
Annual Dental Visit (4-6 Yrs)	76.97	67.53	63.13	63.52	72.14	♦ ♦
Annual Dental Visit (7-10 Yrs)	75.89	63.26	64.17	65.14	71.50	♦ ♦
Annual Dental Visit (11-14 Yrs)	74.58	61.61	67.02	64.03	70.65	♦ ♦
Annual Dental Visit (15-18 Yrs)	68.89	52.84	60.87	55.79	64.30	♦ ♦ ♦
Annual Dental Visit (19-20 Yrs)	50.82	38.23	55.53	40.78	47.95	♦ ♦ ♦
Annual Dental Visit (Total)	71.39	60.64	62.32	60.15	67.32	♦ ♦ ♦
Children and Adolescents' Access to PCP (12-24 Months)	93.99	87.73	96.30	88.56	92.28	♦
Children and Adolescents' Access to PCP (25 Months-6 Yrs)	84.51	75.04	93.62	76.06	81.23	♦
Children and Adolescents' Access To PCP (7-11 Yrs)	92.21	81.74	97.36	87.45	89.99	♦
Children and Adolescents' Access to PCP (12-19 Yrs)	91.27	81.69	97.16	85.17	89.47	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+ Yrs)	NA	48.65	NA	34.61	43.05	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	NA	48.65	NA	34.61	43.05	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+ Yrs)	NA	66.48	NA	54.55	61.84	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	NA	66.12	NA	54.55	61.64	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+ Yrs)	NA	40.59	NA	32.04	37.36	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment – Initiation of AOD – Other Drug Abuse or Dependence (Total)	NA	40.66	NA	32.07	37.41	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+ Yrs)	NA	44.24	NA	33.04	39.83	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	NA	44.20	NA	33.04	39.82	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+ Yrs)	NA	5.55	NA	3.34	4.67	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	NA	5.55	NA	3.34	4.67	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+ Yrs)	NA	24.73	NA	22.31	23.68	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	NA	24.59	NA	22.31	23.61	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+ Yrs)	NA	4.30	NA	1.94	3.39	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	NA	4.21	NA	2.32	3.48	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17 Yrs)	NA	NA	NA	NA	NA	**NC**
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+ Yrs)	NA	7.73	NA	5.29	6.75	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	NA	7.63	NA	5.45	6.76	♦
Prenatal and Postpartum Care - Timeliness of Prenatal Care	84.67	70.32	75.86	65.81	80.04	♦
Prenatal and Postpartum Care - Postpartum Care	79.08	62.53	60.34	69.49	74.74	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11 Yrs)*	36.73	NA	NA	NA	33.85	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Yrs)	52.73	NA	NA	NA	47.30	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	45.19	NA	NA	NA	41.01	♦

* – New Measure introduced in MY 2019
NA – Not Applicable (Small denominator < 30)
NC – No Comparison was made due to no District average rates or benchmarks

Utilization Domain

HEDIS Performance Measures	ACDC %	AGP %	HSCSN %	THP %	MCO Average %	Comparison to Benchmarks
Adolescent Well-Care Visits	69.34	49.39	77.38	57.18	65.09	♦ ♦ ♦
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	75.43	70.75	81.98	67.15	73.22	♦
Well-Child Visits in the First 15 Months of Life (0 visits)	3.41	5.60	1.79	5.11	4.03	♦ ♦ ♦
Well-Child Visits in the First 15 Months of Life (1 visit)	2.92	4.14	0.00	3.41	3.15	♦ ♦ ♦
Well-Child Visits in the First 15 Months of Life (2 visits)	3.89	7.54	3.57	3.89	4.49	♦ ♦ ♦
Well-Child Visits in the First 15 Months of Life (3 visits)	5.35	11.19	1.79	4.87	6.18	♦ ♦ ♦
Well-Child Visits in the First 15 Months of Life (4 visits)	12.90	11.68	3.57	9.98	12.03	♦ ♦ ♦
Well-Child Visits in the First 15 Months of Life (5 visits)	14.36	11.44	5.36	14.11	13.66	♦
Well-Child Visits in the First 15 Months of Life (6 or more visits)	57.18	48.42	83.93	58.64	56.48	♦

Appendix A2

CAHPS® 2020 – Measurement Year (MY 2019)

The CAHPS® survey measure tables include 2020 (MY 2019) results. Results for each MCP and the District MCP Averages are displayed. Each MCP average is also compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The District Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The District Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦ ♦
The District Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦ ♦ ♦

Adult CAHPS Measures

Adult CAHPS Survey Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Getting Care Quickly Composite (Always+Usually)	75.42	NA	76.35	69.30	73.69	♦
Getting Needed Care Composite (Always+Usually)	77.07	NA	80.63	70.38	76.03	♦
How Well Doctors Communicate Composite (Always+Usually)	90.94	NA	93.41	91.36	91.90	♦
Customer Service Composite (Always+Usually)	86.47	NA	87.40	87.79	87.22	♦
Coordination of Care Composite (Always+Usually)	NA	NA	NA	NA	NA	**NC**
Rating of All Health Care (8+9+10)	75.42	NA	78.35	73.37	75.71	♦

Adult CAHPS Survey Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Rating of Personal Doctor (8+9+10)	81.11	NA	86.07	83.16	83.45	♦
Rating of Specialist Seen Most often (8+9+10)	NA	NA	NA	NA	NA	**NC**
Rating of Health Plan (8+9+10)	77.39	NA	79.17	75.35	77.30	♦
Flu measure - Had flu shot or spray in the nose since July 1, 2019	43.58	NA	43.20	35.79	40.86	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	82.64	NA	NA	76.35	79.50	♦ ♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	58.33	NA	NA	49.25	53.79	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	44.06	NA	NA	48.00	46.03	♦

NA – Responses <100, too small to calculate a reliable rate
NC – No Comparison was made due to no District average rates or benchmarks

Child CAHPS for General Population (GP)

Child CAHPS Survey Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Child Survey - General Population: Getting Care Quickly Composite (Always+Usually)	NA	NA	87.93	72.38	80.16	♦
Child Survey - General Population: Getting Needed Care Composite (Always+Usually)	NA	NA	83.93	68.99	76.46	♦
Child Survey - General Population: How Well Doctors Communicate Composite (Always+Usually)	NA	NA	94.74	89.32	92.03	♦
Child Survey - General Population: Customer Service Composite (Always+Usually)	NA	NA	86.14	80.71	83.43	♦
Child Survey - General Population: Coordination of Care Composite (Always+Usually)	NA	NA	89.70	NA	89.70	♦ ♦ ♦
Child Survey - General Population: Rating of All Health Care (8+9+10)	NA	NA	87.68	84.19	85.94	♦
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	90.83	NA	92.44	92.16	91.81	♦ ♦
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	NA	NA	84.83	NA	84.83	♦
Child Survey - General Population: Rating of Health Plan (8+9+10)	88.00	NA	84.38	81.30	84.56	♦

NA – Responses <100, too small to calculate a reliable rate
NC – No Comparison was made due to no District average rates or benchmarks

Child CAHPS for Children with Chronic Conditions (CCC) Optional Reporting for MCPs

Child CAHPS Survey Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Child Survey - CCC Population: Access to Prescription Medicines (Always+Usually)	NA	NA	87.80	NA	87.80	♦
Child Survey - CCC Population: Access to Specialized Services Composite (Always+Usually)	NA	NA	66.62	NA	66.62	♦
Child Survey - CCC Population: Coordination of Care for Children with Chronic Conditions Composite	NA	NA	79.63	NA	79.63	♦ ♦ ♦
Child Survey - CCC Population: Family Centered Care: Getting Needed Information (Always+Usually)	NA	NA	90.29	NA	90.29	♦
Child Survey - CCC Population: Family Centered Care: Personal Doctor who Knows Child Composite	NA	NA	94.56	NA	94.56	♦ ♦ ♦
Child Survey - CCC Population: Getting Care Quickly Composite (Always+Usually)	NA	NR	87.93	NR	NR	**NC**
Child Survey - CCC Population: Getting Needed Care Composite (Always+Usually)	NA	NR	83.93	NR	NR	**NC**
Child Survey - CCC Population: How Well Doctors Communicate Composite (Always+Usually)	NA	NR	94.74	NR	NR	**NC**
Child Survey - CCC Population: Customer Service Composite (Always+Usually)	NA	NR	NR	NR	NR	**NC**
Child Survey - CCC Population: Coordination of Care Composite (Always+Usually)	NA	NR	NR	NR	NR	**NC**
Child Survey - CCC Population: Shared Decision Making Composite (Always+Usually)	NR	NR	NR	NR	NR	**NC**

Child CAHPS Survey Measures	ACDC %	AGP %	HSCSN %	CFDC %	MCP Average %	Comparison to Benchmarks
Child Survey - CCC Population: Health Promotion and Education Composite (Always+Usually)	NR	NR	NR	NR	NR	**NC**
Child Survey - CCC Population: Rating of All Health Care* (8+9+10)	NA	NR	NR	NR	NR	**NC**
Child Survey - CCC Population: Rating of Personal Doctor (8+9+10)	90.20	NR	NR	NR	90.20	♦ ♦
Child Survey - CCC Population: Rating of Specialist Seen Most Often (8+9+10)	NA	NR	NR	NR	NR	**NC**
Child Survey - CCC Population: Rating of Health Plan (8+9+10)	87.22	NR	NR	NR	87.22	♦ ♦

NA – Responses <100, too small to calculate a reliable rate
NC – No Comparison was made due to no District average rates or benchmarks
NR – Not Reported