District of Columbia
Department of Health Care Finance

District of Columbia Medicaid Managed Care

2021 Annual Technical Report

Qlarant

DHCF Department of Health Care Finance

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Executive Summary

Introduction

The District of Columbia (DC) Department of Health Care Finance (DHCF) aims to improve the health and well-being of DC residents by providing access to comprehensive, cost-effective, and quality health care services through multiple Medicaid managed care programs. These programs, which serve more than 252,000 enrollees, include DC Healthy Families Program (DCHFP), Child and Adolescent Supplemental Security Income Program (CASSIP), and District Dual Choice Program (DDCP). Table ES-1 highlights these programs and the contracted managed care plans (MCPs) providing associated services.

Table.ES-1. DC Managed Care Programs

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

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

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

This report summarizes results from all EQR activities conducted throughout 2021 for DCHFP and CASSIP, and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. The evaluation assessed MCP compliance and performance for measurement years (MYs) 2020 and 2021, as applicable. Qlarant did not evaluate the DDCP due to its February 1, 2022 contract start date. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[1]

Key Findings

Key finding summaries, for participating MCPs, are below. 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 performance measure results for MY 2020. For the Comprehensive Diabetes Care PIP, MCP PIP validation scores ranged from 80% to 95%. MCPs reported their third remeasurement results, which based on MCP averages, compared unfavorably to baseline performance. This decline in performance was likely influenced by the COVID-19 public health emergency. Only CFDC demonstrated high confidence in its PIP and reported statistically significant improvement in one measure, Blood Pressure Control (<140/90 mm Hg). For the Maternal Health PIP, MCPs reported their first remeasurement results. ACDC, CFDC, and HSCSN achieved a high confidence rating in their PIPs, while MFC's PIP resulted in a low confidence rating. MCP PIP validation scores ranged from 54% to 96%. All MCPs reporting remeasurement results demonstrated improvement in the Timeliness of Prenatal Care measure, with CFDC demonstrating statistically significant improvement.[2]

Performance Measure Validation. Qlarant conducted two PMV audits during 2021. The first audit focused on validating the accuracy of reported PIP measures and the second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures. Information Systems Capabilities Assessments determined MCPs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. The MCPs received overall PMV ratings of 100% for the PIP measures and 95% to 100% for the EPSDT measures. All measures were assessed as "reportable."

Operational Systems Review. Qlarant conducted a comprehensive OSR in 2021. MCP scores ranged from 96% to 99%. 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. All MCPs demonstrated improvement compared to the 2020 OSR.

Network Adequacy Validation. MCPs have robust provider networks demonstrating at least 99% compliance with geographic and provider-to-enrollee requirements. During 2021, MCP access to timely provider appointments was generally lower, with improvement in the MCP average for adult routine appointments only. Performance was likely influenced by the COVID-19 public health emergency.

[1] CMS EQRO Protocols
[2] MFC did not report rates due to its October 1, 2020 contract start date. The MCP's PIP submissions were evaluated as proposals and focused on PIP structure and methodology.

Opportunity exists to improve timely access as MCP performance ranged from 39% to 100%. Provider Directory accuracy remains an area requiring improvement. All MCPs should continue efforts to improve the reliability of provider directory content ensuring enrollees have access to accurate provider information. The 2021 assessments determined MCP compliance ranged from 43% to 51%.

Encounter Data Validation. A medical record review concluded an overall high level of encounter data accuracy, meaning medical record documentation supported the encounters' associated diagnosis and procedure codes. MCP performance ranged from 88% to 98%, with an average of 95%, which exceeded the DHCF established target of 90% for the first year of review. Insufficient medical record documentation most frequently contributed to noncompliance.

Conclusion

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

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

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

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

District of Columbia Managed Care Programs

2021 Annual Technical Report

Introduction

Background

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

DC Healthy Families Program (DCHFP). DCHFP, established in 1994, provides acute, primary, specialty, and certain behavioral health services to qualifying children, families, and pregnant women through three risk-based managed care organizations (MCOs). Current MCOs include AmeriHealth Caritas District of Columbia (ACDC), CareFirst Community Health Plan District of Columbia (CFDC), and MedStar Family Choice (MFC). The DCHFP serves approximately 235,000 enrollees.

Child and Adolescent Supplemental Security Income Program (CASSIP). CASSIP, organized as a Medicaid demonstration program in 1996, provides acute, primary, specialty, and behavioral health services to qualifying children and youth with special health care needs who receive supplemental security income. Enrollment into the single, prepaid benefit plan, Health Services for Children with Special Needs (HSCSN), is voluntary. The CASSIP serves approximately 5,000 enrollees.

District Dual Choice Program (DDCP).[1] DDCP, newly established in 2022, integrates care for dual eligible beneficiaries through a single program, which aims to improve Medicare and Medicaid benefit coordination. The DDCP includes a dual eligible special needs plan (D-SNP), in which enrollment is voluntary. The D-SNP provides Medicare and Medicaid services, including long term services and supports and behavioral health services. UnitedHealthcare (UHC) is the single D-SNP providing these services and serves approximately 12,071 enrollees.

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

DHCF continues to transform its managed care program into a more organized, accountable, and person-centered system to best support the District's managed care enrollees in managing and improving their health. DHCF understands the significance of quality and its impact on health outcomes and requires the DCHFP MCPs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation.[2] The CASSIP MCP must attain and maintain NCQA accreditation for Case Management. NCQA evaluates the quality of health care plans provided to their enrollees. Audits consist of an

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

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 MCP NCQA accreditation status and other descriptive information.[5]

Table 1. MCP NCQA Accreditation Status

MCP	NCQA Health Plan Accreditation	Program or Distinction
ACDC	Accredited	Case Management, Multicultural Health Care, Electronic Clinical Data
CFDC	Accredited	Case Management, Electronic Clinical Data
HSCSN	Not Required*	Case Management
MFC	Interim	Case Management

*HSCSN is required to maintain a Case Management Accreditation.

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

Case Management Program. This program evaluates clinicians and practices that use teamwork and technology to deliver coordinated and patient-centered primary care.

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

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

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires DHCF to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of the District's MCPs. To meet these requirements, DHCF contracts with Qlarant. As the EQRO, Qlarant evaluates each MCP's compliance with federal and DC-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. During 2021, 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)
- Encounter Data Validation (EDV)

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[5] https://reportcards.ncqa.org/health-plans, status: February 15, 2022

MCPs. This Annual Technical Report summarizes Qlarant's EQR findings based on MCP audits conducted during 2021, which focused on the established programs, DCHFP and CASSIP; the DDCP, which includes the D-SNP, commenced operations on February 1, 2022. 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 in accordance with 42 CFR §438.330(d). PIPs use a systematic approach to quality improvement and can be effective tools to assist MCPs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCP used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation assess the MCP level of improvement and provides DHCF and other stakeholders a level of confidence in results.

Methodology

DHCF required MCPs to conduct and report on two District-selected PIPs during 2021, Comprehensive Diabetes Care and Maternal Health.

Description of Data Obtained. MCPs documented measurement year (MY) 2020 PIP-related activities, improvement strategies, and measured results in their 2021 reports. The MCPs submitted their reports, which included one submission per PIP topic, to Qlarant in July 2021 and used validated performance measure results in their submissions. MCPs completed a data and barrier analysis and identified follow-up activities in each PIP submission. MCPs used Qlarant reporting tools and worksheets to report their PIPs. Qlarant provided MCP-specific technical assistance, as requested.

Technical Methods of Data Collection and Analysis. MCPs submitted a narrative report and calculations worksheet for each PIP. Qlarant reviewed PIP submissions to assess the MCP's PIP 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*.[6] PIP validation includes the following nine steps:

1. **Review the selected PIP topic.** Qlarant determines if the PIP topic targets an opportunity for improvement and is relevant to the MCP's population.
2. **Review the PIP aim statement.** Qlarant evaluates the adequacy of the PIP aim statement, which should frame the project and define the improvement strategy, population, and time period.
3. **Review the identified PIP population.** Qlarant determines whether the MCP identifies the PIP population in relation to the aim statement.

[6] CMS EQRO Protocols

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

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

Results

PIP validation results for 2021 MCP-reported PIPs, including MY 2020 activities and performance measure (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.

[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).

Table 2. MCP PIP Overview

2021 PIPs	DHCF Selected PIP 1	DHCF Selected PIP 2
Program	DCHFP, CASSIP	DCHFP, CASSIP
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. Eye Exam (Retinal) Performed 5. 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 3	Remeasurement 1

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

Key MCP improvement strategies and results for each PIP for the year under review are identified below.

Comprehensive Diabetes Care PIP

ACDC Interventions

ACDC completed numerous targeted enrollee, provider, and MCP interventions. Key interventions include:

- **Telemedicine program.** Completed home visits and launched video teleconferencing sessions to connect providers and enrollees. The program also provided point-of-care testing, medication management, and pharmacy follow-up.
- **Refill reminder and outreach program.** Generated a report every two weeks to identify all enrollees whose diabetes medication refill expired within the past 7 days and those about to expire within the next 14 days. The Rapid Response Outreach Team then completed outreach calls to enrollees to remind them of their refill and ask if they needed transportation to the pharmacy or would like to have their prescription refill delivered.

- **Non-emergent medical transportation.** Provided enrollees with convenient, immediate transportation for their non-emergent medical needs through the Lyft service.
- **Remote blood glucose monitoring.** Provided enrollees a technology-based solution that recorded and shared results with the provider between visits and provided direct feedback to the enrollee via a text message or email.
- **Prepared meal delivery program.** Provided nutritionally complete and condition-appropriate meals to designated groups of enrollees who would benefit from proper nutrition. Addressed food instability as a social determinant of health and helped enrollees manage their chronic condition to help minimize the chance of hospital readmissions.

ACDC PIP Measure Results

Table 3 displays ACDC's Comprehensive Diabetes Care PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 3. ACDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	83.58%	81.51%	No	Ø
HbA1c Poor Control (>9%) ***(lower rate is better)***	42.34%	44.77%	No	Ø
HbA1c Control (<8%)	50.18%	49.39%	No	Ø
Eye Exam (Retinal) Performed	57.30%	54.74%	No	Ø
Blood Pressure Control (<140/90 mm Hg)	54.20%	47.20%	No	Ø

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

CFDC Interventions

CFDC completed multiple targeted enrollee, provider, and MCP interventions. Key interventions include:

- **Case management and resource management.** Referred enrollees to the MCP's case management and resource management programs. Enrollees received full case management services including care coordination and education, and resources to improve self-management.
- **Home-based/telehealth visits.** Referred enrollees to home-based or telehealth programs. The home-based nurse practitioner program provided services such as HbA1c testing, specimen collection, and retinal exams to help close gaps in care for diabetes measures.
- **Healthy meal delivery service**. Provided nutritious meals to chronically ill enrollees with diabetes via home delivery.
- **Nutrition classes**. Provided nutrition classes designed by dietitians and culinary experts that aim to improve participant knowledge in food/nutrition/health; modify eating behaviors and cooking skills; and improve health-related metrics such as body mass index, HbA1c, blood pressure, and cholesterol levels.

- **Glucometer technology**. Provided enrollees, their providers, case managers, and pharmacists with remote access to enrollee blood glucose readings through the use of a prescribed meter and Bluetooth technology. This tracking allowed providers to review results and intervene when there was cause for concern.

CFDC PIP Measure Results

Table 4 displays CFDC's Comprehensive Diabetes Care PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 4. CFDC Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	79.38%	73.80%	No	Ø
HbA1c Poor Control (>9%) ***(lower rate is better)***	52.55%	53.01%	No	Ø
HbA1c Control (<8%)	40.15%	37.95%	No	Ø
Eye Exam (Retinal) Performed	35.58%	36.14%	Yes	No
Blood Pressure Control (<140/90 mm Hg)	27.55%	42.47%	Yes	Yes

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

HSCSN Interventions

HSCSN completed two interventions:

- **Care management.** Provided person-centered care planning linked to medical, behavioral, and social systems of support. Each enrollee has a care manager and individualized care plan, which considers personal values and the provider's medical treatment plan.
- **Care management staff development.** Care management staff received training on how to identify and assess barriers to diabetes management and select person-centered interventions likely to improve enrollee health outcomes. Care management staff also received training on provider and community-based diabetes self-management programs.

HSCSN PIP Measure Results

Table 5 displays HSCSN's Comprehensive Diabetes Care PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 5. HSCSN Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing	93.10%<	83.33%	No	Ø
HbA1c Poor Control (>9%) ***(lower rate is better)***	65.52%<	55.56%	Yes	No
HbA1c Control (<8%)	31.03%<	38.89%	Yes	No
Eye Exam (Retinal) Performed	62.07%<	50.00%	No	Ø
Blood Pressure Control (<140/90 mm Hg)	72.41%<	55.56%	No	Ø

~ Performance was likely influenced by the COVID-19 public health emergency.
<Denominator is less than 30. Caution is advised when interpreting results.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

MFC Interventions

MFC's PIP submission was a proposal and did not include interventions due to its October 1, 2020 start date.

MFC PIP Measure Results

MY 2021 will serve as MFC's baseline year and will be reported in the next annual report.

MCP Annual Rates for the Comprehensive Diabetes Care PIP Measures

Figures 1-5 display MCP annual performance rates for the Comprehensive Diabetes Care PIP measures for MYs 2017-2020. Figures also include MCP weighted averages.

Figure 1. HbA1c Testing

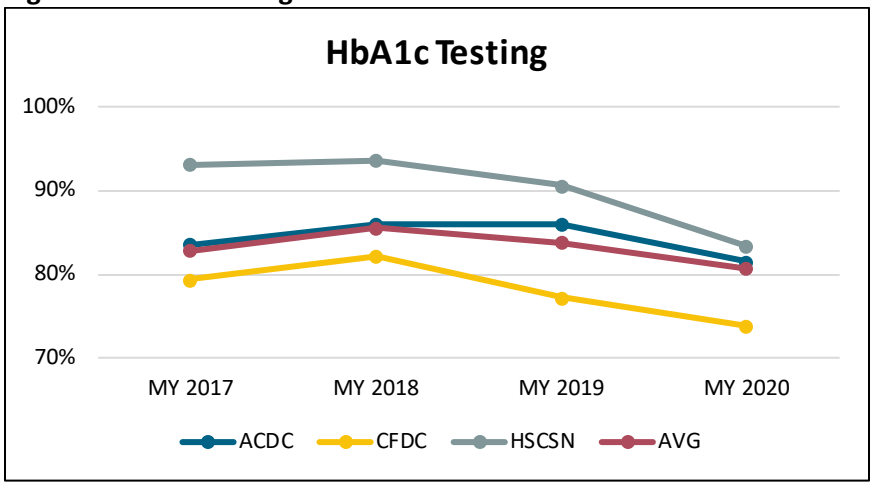


Figure 2. HbA1c Poor Control (>9%) (*Lower Rate is Better*)

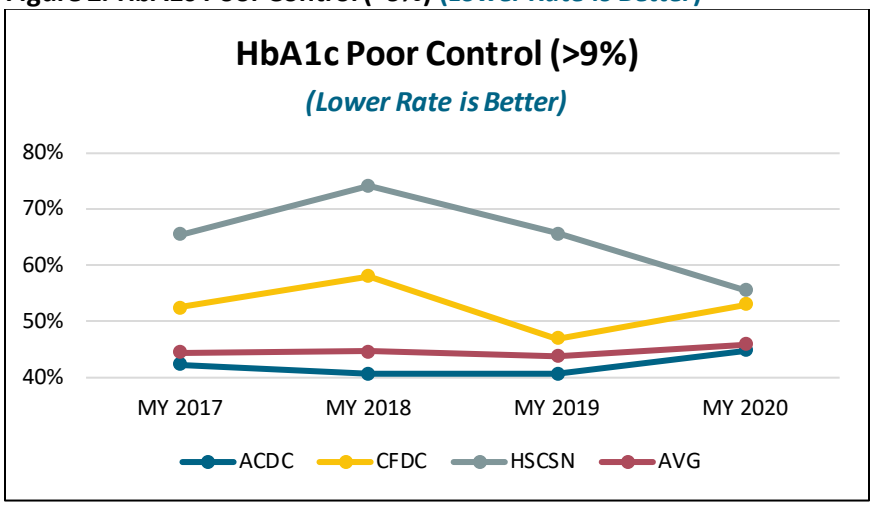


Figure 3. HbA1c Control (<8%)

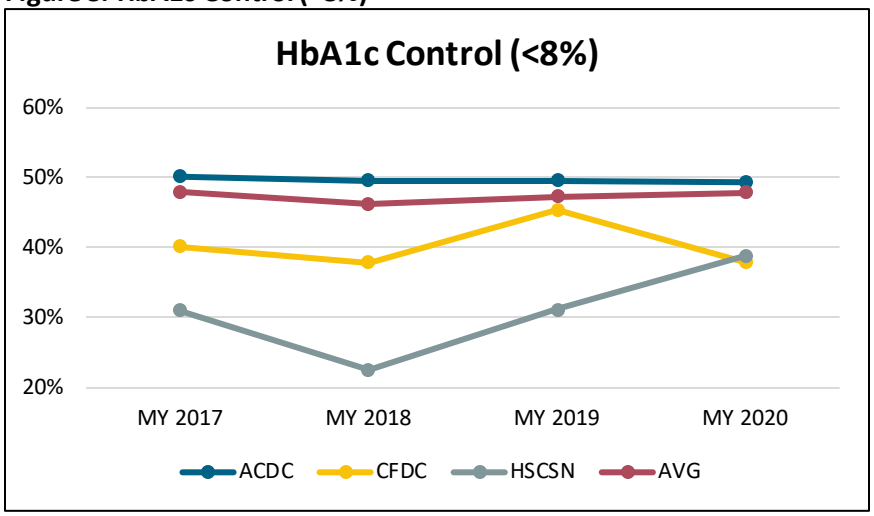


Figure 4. Eye Exam (Retinal) Performed

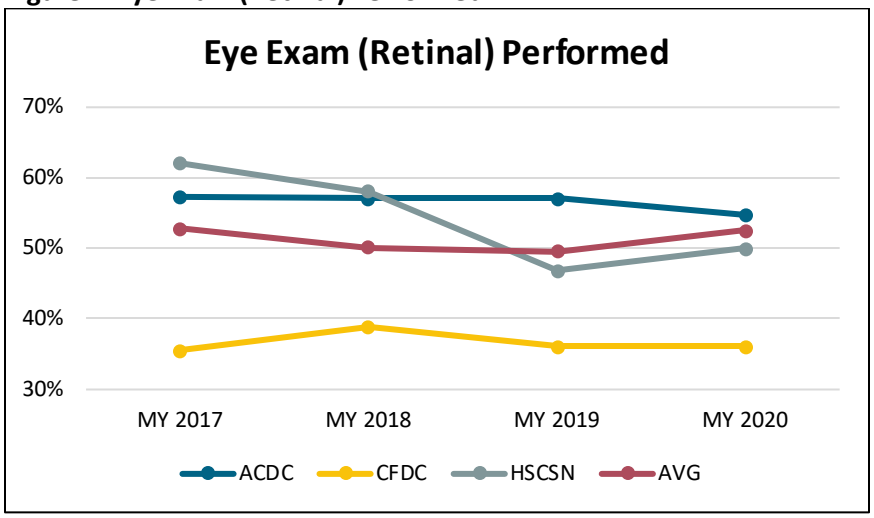
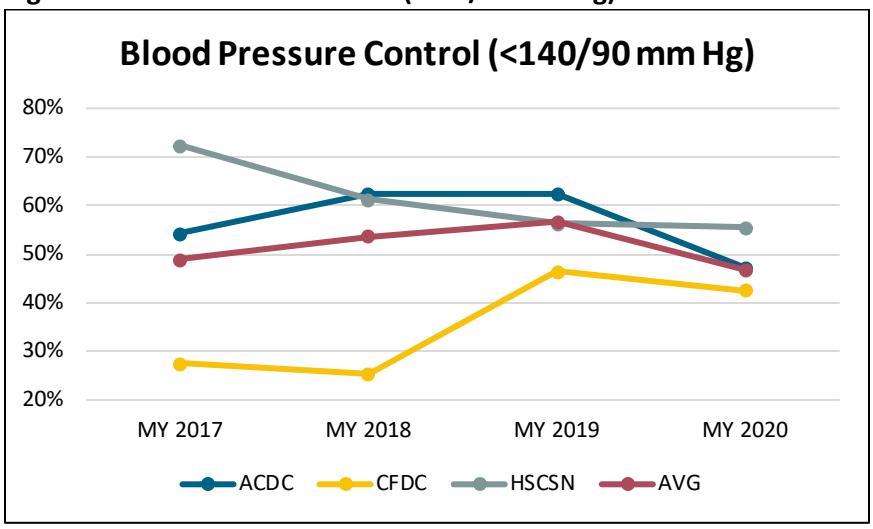


Figure 5. Blood Pressure Control (<140/90 mm Hg)



MCP PIP Validation Results

Table 6 includes MCP results for each PIP validation step for the Comprehensive Diabetes Care PIP.

Table 6. MCP PIP Validation Step Results - Comprehensive Diabetes Care PIP

2021 PIPs	ACDC	CFDC	HSCSN	MFC
Topic	Met	Met	Met	Partially Met
Aim Statement	Met	Partially Met	Met	Met
Population	Met	Met	Met	Met
Sampling Method	Met	NA	Met	NA
Variables and Performance Measures	Met	Partially Met	Met	Met
Data Collection Procedures	Met	Met	Met	Partially Met
Data Analysis and Interpretation of Results	Met	Met	Met	NA
Improvement Strategies	Met	Met	Partially Met	NA
Significant and Sustained Improvement	Partially Met	Met	Partially Met	NA

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

Table 7 includes 2021 overall validation scores for each MCP's Comprehensive Diabetes Care PIP. Performance ranges from 80% (MFC) to 96% (CFDC). MFC's PIP submission was a proposal and was scored only on applicable elements.

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

2021 (MY 2020)	ACDC	CFDC	HSCSN	MFC	MCP Average
Validation Score	82%	96%	85%	80%	86%
Confidence Level	**Moderate Confidence**	**High Confidence**	**Moderate Confidence**	**Moderate Confidence**	**Moderate Confidence**

Maternal Health PIP

ACDC Interventions

ACDC completed numerous targeted enrollee, provider, and MCP interventions. Key interventions include:

- **Interactive application.** Implemented an innovative, interactive app to assist expectant mothers throughout their pregnancy into the postpartum period.
- **In-home postpartum visit.** Discussed family planning options during an in-home postpartum visit.
- **Maternity management program.** Developed a Maternity Management Program, which included follow-up on enrollees who did not keep their medical appointments.
- **Scheduled appointments.** Assisted with scheduling postpartum appointments on the same day as the baby's one month well-child visit.
- **Provider incentive.** Offered an incentive to providers to send in the OB Authorization form within seven calendar days of the initial visit.

ACDC PIP Measure Results

Table 8 displays ACDC's Maternal Health PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 8. ACDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.67%	84.91%	Yes	No
Postpartum Care	79.08%	73.97%	No	Ø
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	10.26%	4.92%	No	Ø
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	48.08%	30.33%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	3.85%	3.28%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	25.64%	11.48%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	13.32%	13.16%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	41.29%	36.92%	No	Ø

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	3.59%	4.31%	Yes	No
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	14.66%	11.08%	No	Ø
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	27.56%	24.34%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception	5.13%	3.64%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception	27.74%	25.24%	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception	4.56%	3.70%	No	Ø

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

CFDC Interventions

CFDC completed multiple targeted enrollee, provider, and MCP interventions. A sample of interventions include:

- **Telehealth program.** Partnered with a community program that provided health-related services and information through telecommunication technologies. The program included home visits for enrollees with high-risk pregnancies.
- **OB case management.** Offered an OB Case Management Program at its Health and Wellness Outreach Center. The intervention transitioned to virtual case management in response to the pandemic.
- **Access to experts.** Partnered with a vendor that provided enrollees with on-demand access to an expert network of nurses, nutritionists, and lactation consultants.
- **Pregnancy support program.** Partnered with a national organization that provided prenatal care and education in a group setting. The support model engaged enrollees with their providers and provided an opportunity to share experiences with their peers.
- **Early pregnancy identification.** Partnered with a vendor that facilitated early identification of pregnancies and stratified pregnant women from high to low risk to ensure immediate outreach and intervention.

CFDC PIP Measure Results

Table 9 displays CFDC's Maternal Health PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 9. CFDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	65.81%	76.92%	Yes	Yes
Postpartum Care	69.49%	69.66%	Yes	No
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	20.00%	8.33%	No	Ø
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	46.67%	38.89%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	6.67%	0.00%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	23.33%	22.22%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	14.35%	14.12%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	34.72%	30.59%	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	1.39%	2.35%	Yes	No
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	7.87%	7.06%	No	Ø
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	23.42%	15.43%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception	5.62%	2.78%	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception	16.94%	14.44%	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception	1.93%	1.23%	No	Ø

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

HSCSN Interventions

HSCSN completed numerous targeted enrollee, provider, and MCP interventions. Some interventions include:

- **Care management.** Provided face-to-face meetings (including virtual) with a care manager.
- **Care plan modifications.** Modified general assessment and care plan tools to address factors such as family planning, overall women's health, and contraceptive methods.

- **Enrollee incentive.** Initiated enrollee incentives to encourage enrollee engagement. Enrollees were financially incentivized to complete virtual meetings with their care manager and to agree to a clinical goal.
- **Provider education.** Distributed information on HSCSN's OB Case Management Program components to its OB provider network.
- **Early identification of pregnancies.** Utilized lab and Chesapeake Regional Information System for Patients (CRISP) data for early identification of pregnancies.

HSCSN PIP Measure Results

Table 10 displays HSCSN's Maternal Health PIP measure results and level of improvement. The COVID-19 public health emergency presented barriers to care and likely influenced MY 2020 performance.

Table 10. HSCSN Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.86%	76.19%	Yes	No
Postpartum Care	60.34%	66.67%	Yes	No
Contraceptive Care Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	11.11%<	8.33%<	No	Ø
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	50.00%<	45.83%<	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	0%<	8.33%<	Yes	No
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	27.78%<	12.50%<	No	Ø
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	8.33%<	14.29%<	Yes	No
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	33.33%<	28.57%<	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	0%<	0%<	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	0%<	0%<	No	Ø
Contraceptive Care All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	27.96%	26.34%	No	Ø
Age 15-20 – Long-Acting Reversible Method of Contraception	3.76%	3.90%	Yes	No

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020~	Improvement	Statistically Significant Improvement
Age 21-44 – Most/Moderately Effective Method of Contraception	32.74%	20.23%	No	Ø
Age 21-44 – Long-Acting Reversible Method of Contraception	6.28%	3.50%	No	Ø

<Denominator is less than 30. Caution is advised when interpreting results.
~ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

MFC Interventions

MFC's PIP submission was a proposal and did not include interventions due to its October 1, 2020 start date.

MFC PIP Measure Results

MY 2021 will serve as MFC's baseline year and will be reported in the next annual report.

MCP Annual Rates for the Maternal Health PIP Measures

Figures 6-11 display MCP annual performance rates for the Maternal Health PIP measures for MYs 2019-2020. Figures also include MCP weighted averages.

Figure 6. Timeliness of Prenatal Care

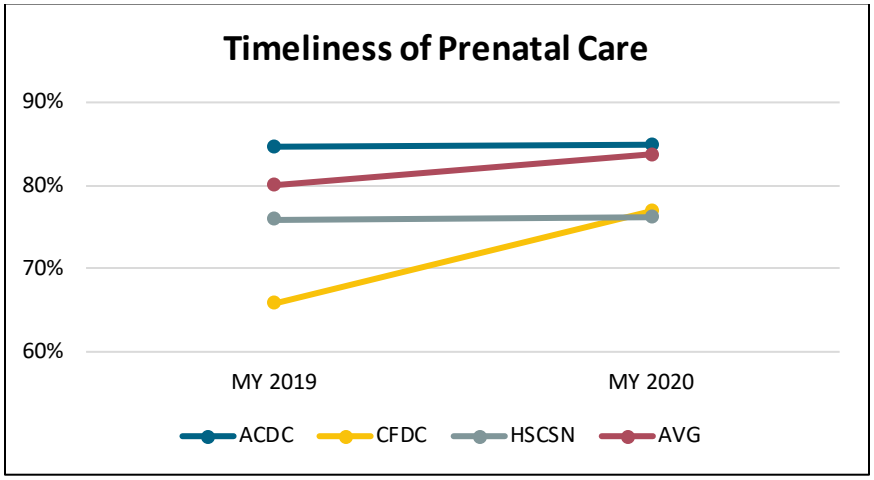


Figure 7. Timeliness of Postpartum Care

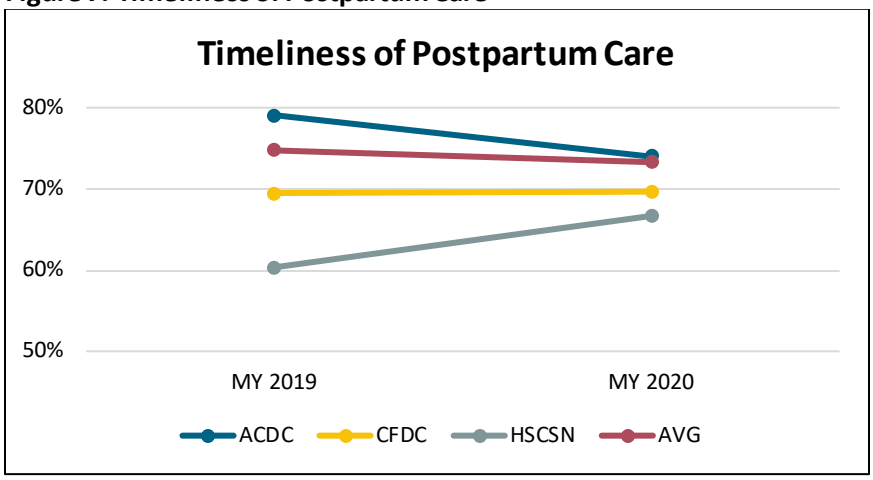


Figure 8. Contraceptive Care for Postpartum Women Ages 15-20

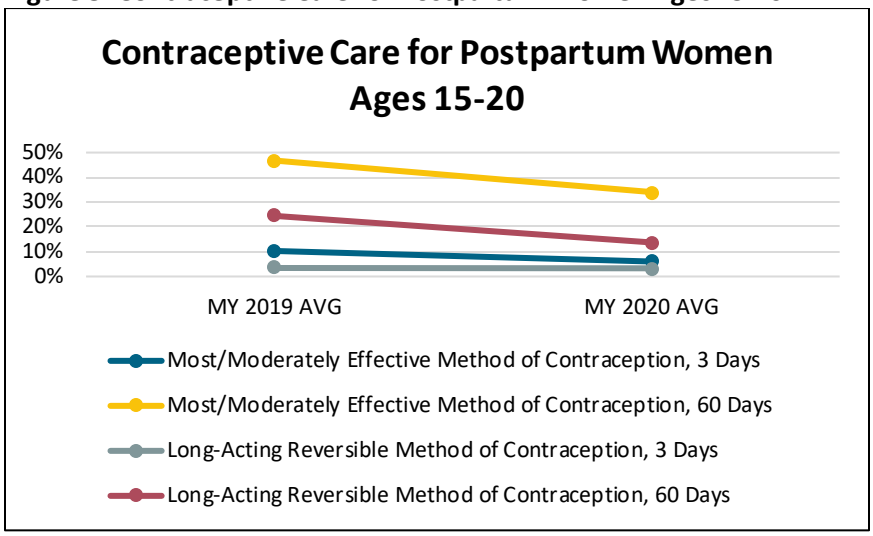


Figure 9. Contraceptive Care for Postpartum Women Ages 21-44

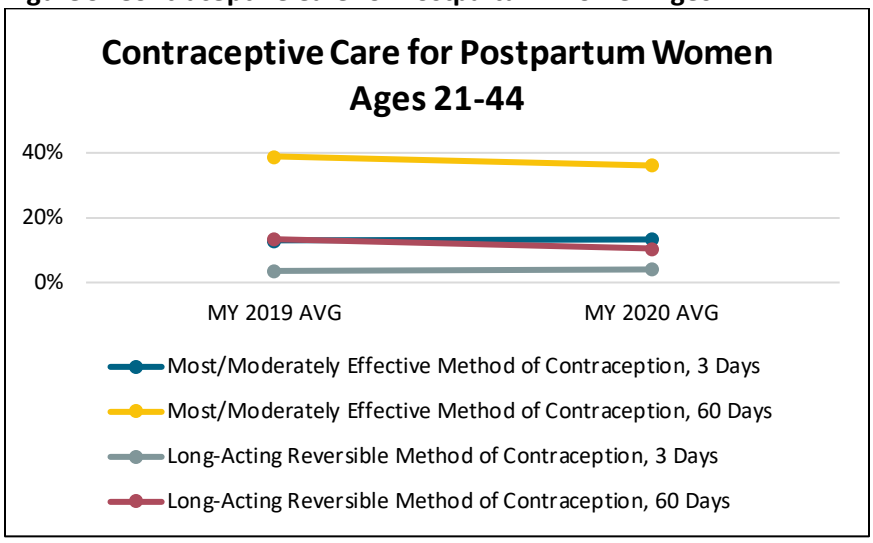


Figure 10. Contraceptive Care for All Women Ages 15-20

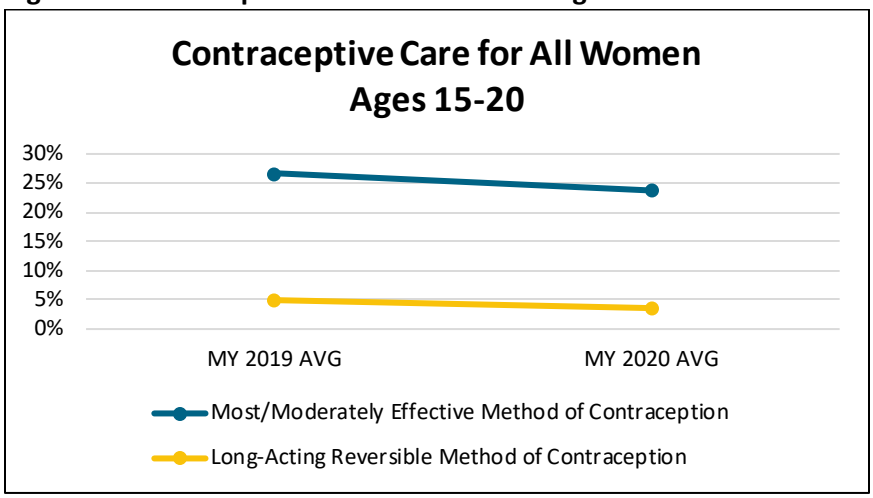
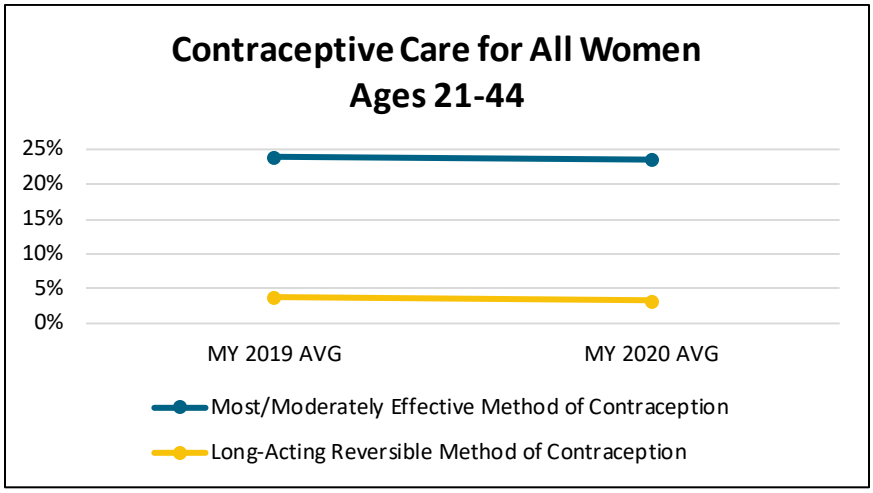


Figure 11. Contraceptive Care for All Women Ages 21-44



MCP PIP Validation Results

Table 11 includes MCP results for each PIP validation step for the Maternal Health PIP.

Table 11. MCP PIP Validation Step Results - Maternal Health PIP

2021 PIPs	ACDC	CFDC	HSCSN	MFC
Topic	Met	Met	Met	Partially Met
Aim Statement	Partially Met	Partially Met	Partially Met	Partially Met
Population	Met	Met	Met	Not Met
Sampling Method	Met	NA	Met	NA
Variables and Performance Measures	Met	Partially Met	Met	Partially Met
Data Collection Procedures	Met	Met	Met	Partially Met
Data Analysis and Interpretation of Results	Met	Met	Met	NA
Improvement Strategies	Met	Met	Met	NA
Significant and Sustained Improvement	Partially Met	Met	Partially Met	NA

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

Table 12 includes 2021 overall validation scores for each MCP's Maternal Health PIP. Performance ranges from 54% (MFC) to 96% (CFDC). MFC's PIP submission was a proposal and was scored only on applicable elements.

Table 12. MCP Validation Scores for the Maternal Health PIP

2021 (MY 2020)	ACDC	CFDC	HSCSN	MFC	MCP Average
Validation Score	94%	96%	94%	54%	85%
Confidence Level	**High Confidence**	**High Confidence**	**High Confidence**	**No Confidence**	**Moderate 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 29-32, later in the report.

Comprehensive Diabetes Care PIP

- ACDC, CFDC, and HSCSN reported their third remeasurement rates for the Comprehensive Diabetes Care measures. MFC submitted a proposal PIP.
- Performance was negatively impacted by the COVID-19 public health emergency.
- MCPs introduced telehealth and virtual services to engage enrollees in care.
- The MY 2020 MCP weighted averages were lower (or worse) than baseline performance for all measures.
- ACDC, HSCSN, and MFC received moderate confidence ratings for their Comprehensive Diabetes PIP. There was high confidence in CFDC's PIP.

Maternal Health PIP

- ACDC, CFDC, and HSCSN reported their first remeasurement rates for the Maternal Health measures. MFC submitted a proposal PIP.
- Performance was negatively impacted by the COVID-19 public health emergency.
- In general, interventions focused on the early identification of pregnant enrollees and attempts to engage them in appropriate prenatal and postpartum care. Regarding contraceptive care, MCPs focused on understanding the enrollee's individual desire for contraception and improving access, should the enrollee choose a method of contraception.
- The MCP weighted average increased for the Timeliness of Prenatal Care measure (80% to 84%), but declined for the Timeliness of Postpartum Care measure (75% to 73%).
- MCP weighted averages declined in all Contraceptive Care for Postpartum Women – Ages 15-20 measures.
- MCP weighted averages were mixed for the Contraceptive Care for Postpartum Women – Ages 21-44 measures.
- MCP weighted averages declined in all Contraceptive Care for All Women – Ages 15-20 and 21-44 measures.

Performance Measure Validation

Objective

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

Methodology

Qlarant validated District-selected PMs including MY 2020 PIP measures and fiscal year (FY) 2021 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) measures.[8]

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

- Information Systems Capabilities Assessment
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- EPSDT policies and training materials, as applicable

[8] District of Columbia FY 2021: October 1, 2020 through September 30, 2021.

- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies, and procedures)
- Demonstrations during the onsite visit
- Interviews with MCP staff
- Information submitted as part of the follow-up items requested after the onsite visit

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.[9]

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

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

Essential PMV activities included:

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

Qlarant conducted onsite PMV review activities in May 2021 for the PIP PMV and in October 2021 for EPSDT PMV. MCP onsite PMV review activities were conducted via virtual desk audit due to the COVID-19 public health emergency. After Qlarant approved final rates, Qlarant reported findings for the following audit elements including documentation (data integration and control and calculation process), 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 source codes.

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

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

[9] CMS EQRO Protocols

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 Measure Validation Results

All MCPs had appropriate systems in place to process accurate claims and encounters. Table 13 includes 2021 MCP PMV results based on the calculation of MY 2020 PIP measures. Compliance with each PMV element is reported by MCP and MCP average. The PIP PMV audit was not conducted for MFC due to its contract start date of October 1, 2020.

Table 13. PIP PMV Results

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

R – Reportable; measures were compliant with DHCF specifications.
¨ All MCPs received a "reportable" designation.
The PIP PMV audit was not conducted for MFC due to its contract start date of October 1, 2020.

Table 14 displays MCP MY 2020 PM rates and reports each PM's data collection methodology. MFC did not calculate and report rates due to its contract start date of October 1, 2020.

Table 14. PIP Performance Measure Results for MY 2020

Performance Measure	Data Collection Method+	ACDC	CFDC	HSCSN
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	Hybrid	47.20%	42.47%	55.56%
Eye Exam (Retinal) Performed	Hybrid	54.74%	36.14%	50.00%
HbA1c Control (<8%)	Hybrid	49.39%	37.95%	38.89%
HbA1c Poor Control (>9%) ***(lower rate is better)***	Hybrid	44.77%	53.01%	55.56%
Hemoglobin A1c (HbA1c) Testing	Hybrid	81.51%	73.80%	83.33%
Maternal Health				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	Hybrid	84.91%	76.92%	76.19%
Postpartum Care	Hybrid	73.97%	69.66%	66.67%
Contraceptive Care for Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	Administrative	4.92%	8.33%	8.33%<
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	Administrative	30.33%	38.89%	45.83%<
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	Administrative	3.28%	0.00%	8.33%<
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	Administrative	11.48%	22.22%	12.50%<
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	Administrative	13.16%	14.12%	14.29%<
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	Administrative	36.92%	30.59%	28.57%<
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	Administrative	4.31%	2.35%	0%<
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	Administrative	11.08%	7.06%	0%<
Contraceptive Care for All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	Administrative	24.34%	15.43%	26.34%
Age 15-20 – Long-Acting Reversible Method of Contraception	Administrative	3.64%	2.78%	3.90%
Age 21-44 – Most/Moderately Effective Method of Contraception	Administrative	25.24%	14.44%	20.23%
Age 21-44 – Long-Acting Reversible Method of Contraception	Administrative	3.70%	1.23%	3.50%

+ Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data.
< Denominator is less than 30. Caution is advised when interpreting results.

Table 15 details the MY 2020 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. PIP PM Aggregate Information and Weighted Averages Compared to Benchmarks for MY 2020

Performance Measure	Eligible Population	Numerator	MCP Average	Benchmark Comparison*
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	2,934	1,372	46.76%	♦
Eye Exam (Retinal) Performed	2,934	1,542	52.54%	♦♦
HbA1c Control (<8%)	2,934	1,406	47.94%	♦♦
HbA1c Poor Control (>9%) ***(lower rate is better)***	2,934	1,345	45.86%	♦
Hemoglobin A1c (HbA1c) Testing	2,934	2,366	80.64%	♦
Maternal Health				
Timeliness of Prenatal Care	1,973	1,653	83.76%	♦
Postpartum Care	1,973	1,446	73.29%	♦
Contraceptive Care for Postpartum Women				
Age 15-20 – Most/Moderately Effective Method of Contraception, 3 Days	182	11	6.04%	♦♦
Age 15-20 – Most/Moderately Effective Method of Contraception, 60 Days	182	62	34.07%	♦
Age 15-20 – Long-Acting Reversible Method of Contraception, 3 Days	182	6	3.30%	♦♦
Age 15-20 – Long-Acting Reversible Method of Contraception, 60 Days	182	25	13.74%	♦
Age 21-44 – Most/Moderately Effective Method of Contraception, 3 Days	1,438	191	13.28%	♦♦♦
Age 21-44 – Most/Moderately Effective Method of Contraception, 60 Days	1,438	519	36.09%	♦
Age 21-44 – Long-Acting Reversible Method of Contraception, 3 Days	1,438	58	4.03%	♦♦♦
Age 21-44 – Long-Acting Reversible Method of Contraception, 60 Days	1,438	151	10.50%	♦
Contraceptive Care for All Women				
Age 15-20 – Most/Moderately Effective Method of Contraception	3,429	814	23.74%	♦
Age 15-20 – Long-Acting Reversible Method of Contraception	3,429	123	3.59%	♦
Age 21-44 – Most/Moderately Effective Method of Contraception	11,006	2,590	23.53%	♦
Age 21-44 – Long-Acting Reversible Method of Contraception	11,006	367	3.33%	♦

* Comprehensive Diabetes Care and Timeliness of Prenatal Care and Postpartum Care benchmark sources: Quality Compass 2021 (MY 2020 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 2021 Child Core Set Chart Pack, November 2021 and Quality of Care for Adults in Medicaid: Findings from the 2021 Adult Core Set Chart, November 2021.

♦ The DC MCP Average is below the National Average.

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

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

EPSDT Performance Measures

Qlarant completed a comprehensive EPSDT PMV audit for the MCPs. All MCPs had appropriate systems in place to process accurate claims and encounters. Table 16 includes 2021 MCP PMV results based on the calculation of FY 2021 EPSDT measures. Compliance with each PMV element is reported by MCP.

Table 16. EPSDT PMV Results

Element	ACDC	CFDC	HSCSN	MFC	MCP Average
Data Integration and Control	100%	100%	100%	92%	98%
Data and Process Used to Produce Measures	100%	100%	100%	100%	100%
Denominator	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	88%	96%
Sampling	NA	NA	NA	NA	NA
Reporting	100%	100%	100%	100%	100%
Overall Rating	100%	100%	100%	95%	99%
Reporting Designation	R	R	R	R	R¨
Level of Confidence	**High Confidence** ❖	**High 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 2021 EPSDT measure results for each MCP.

Table 17. EPSDT Performance Measure Results

Performance Measure	ACDC	CFDC	HSCSN	MFC
Total Individuals Eligible for EPSDT for 90 Continuous Days	44,021	23,424	4,262	24,014
Average Period of Eligibility	0.91	0.91	0.95	0.91
Expected Number of Screenings	53,003	27,384	4,433	27,446
Total Screens Received	40,771	19,076	3,635	21,773
Screening Ratio	0.77	0.70	0.82	0.79
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	41,031	21,841	4,065	22,245
Total Eligibles Receiving at Least One Initial or Periodic Screen	27,044	14,253	2,781	13,484
Participation Ratio	0.66	0.65	0.68	0.61
Total Eligibles Referred for Corrective Treatment	12,669	5,975	2,622	2,739

Performance Measure	ACDC	CFDC	HSCSN	MFC
Total Eligibles Receiving Any Dental Service From a Dentist	23,650	11,326	2,483	10,441
Total Eligibles Receiving Preventive Dental Service From a Dentist	19,707	10,286	2,314	9,523
Total Eligibles Who Received Dental Treatment Services From a Dentist	9,192	3,962	908	3,944
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	2,291	1,380	204	0
Total Eligibles Receiving Diagnostic Dental Services	22,654	11,141	2,436	10,239
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	3,053	1,911	127	1726
Total Eligibles Receiving Any Preventative Dental or Oral Health Service	21,818	10,808	2,367	10,579
Total Number of Screening Blood Lead Tests	3,840	1,977	149	1,801

Table 18 displays key FY 2021 EPSDT measure results including screen, participation, and preventive dental service ratios. The table also reports the MCP weighted average for each key measure.

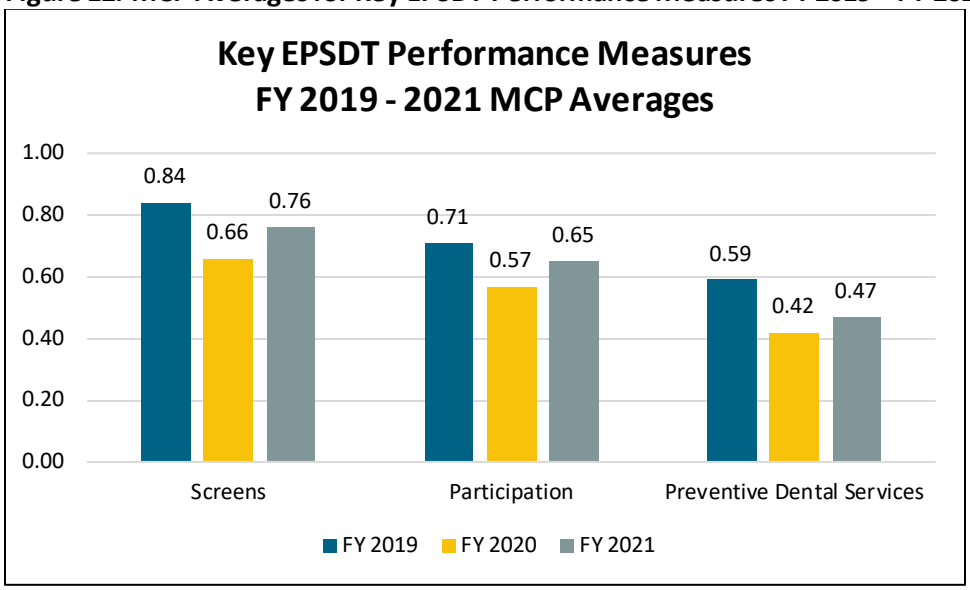
- **EPSDT Screening Ratio.** The calculation uses total screens received compared to the expected number of screens (for eligibles enrolled for 90 continuous days).
- **EPSDT Participation Ratio.** The calculation compares total eligibles who received at least one initial or periodic screen to total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

Table 18. FY 2021 Key EPSDT Performance Measure Results

Key EPSDT Performance Measures	ACDC	CFDC	HSCSN	MFC	MCP Average
EPSDT Screening Ratio	0.77	0.70	0.82	0.79	0.76
EPSDT Participation Ratio	0.66	0.65	0.68	0.61	0.65
EPSDT Preventive Dental Services Ratio	0.48	0.47	0.57	0.43	0.47

Figure 12 displays key EPSDT measure results over the last three years, FY 2019 - FY 2021.

Figure 12. MCP Averages for Key EPSDT Performance Measures FY 2019 - FY 2021



Conclusion

Aggregate summary conclusions for the PMV activities are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 29-32 within the MCP Quality, Access, Timeliness Assessment section.

PIP PMV

- All MCPs had information systems capable of capturing and processing data required for reporting.
- All audited MCPs received an overall rating of 100%. A PIP PMV audit was not conducted for MFC due to its start date of October 1, 2020.
- Stakeholders can have high confidence in the MCPs' PM calculations.
- The COVID-19 public health emergency created barriers to care and likely influenced performance.
- DHCF established a goal of meeting or exceeding the national average benchmarks for Comprehensive Diabetes Care and Timeliness of Prenatal and Postpartum Care measures. DHCF purposely did not establish goals for the Contraceptive Care measures. Providing access to contraceptive care, rather than influencing utilization, was central to the aim.
- Two Comprehensive Diabetes Care measures met or exceeded the DHCF goal, based on MCP weighted averages. These measures include Eye Exam (Retinal) Performed and HbA1c Control (<8%).
- Neither the Timeliness of Prenatal Care nor Postpartum Care PMs met the DHCF goal.

EPSDT PMV

- ACDC, CFDC, and HSCSN all received an overall rating of 100%. MFC received an overall rating of 95%.
- Stakeholders can have high confidence in the MCPs' PM calculations.

- Key MCP weighted average EPSDT measure results for FY 2021 improved compared to FY 2020 results, which were likely impacted by the COVID-19 public health emergency. The FY 2021 performance continues to lag behind the pre-pandemic performance of FY 2019.

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 2021 OSR. CFR standards (42 CFR §438) reviewed include:

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

Description of Data Obtained. MCPs provided documentation to support 2021 compliance with standards under review in August 2021. Supporting data was obtained during all three phases of review: pre-onsite visit, onsite visit, and post-onsite visit. Qlarant review activities occurred before, during, and after the virtual ("onsite") visit to the MCP in October 2021. Pre-onsite visit activities included evaluating policies, reports, meeting minutes, and other supporting documents submitted by the MCP. Onsite visit activities focused on MCP staff interviews, process demonstrations, and record reviews. Post-onsite visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

Technical Methods of Data Collection and Analysis. The 2021 OSR was conducted in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations.*[10] Qlarant conducted an interactive review with the MCP and reviewed and scored all applicable elements and components of each standard requiring evaluation. Qlarant uses the following scale when evaluating MCP compliance for each element and/or component:

- **Met.** Demonstrates full compliance. 1 point. Documentation and data sources provide evidence of compliance and MCP staff are able to describe processes consistent with documentation provided, if applicable.

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

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

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

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

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

DHCF initiated this process for the 2021 OSRs. To qualify for deeming, DHCF established the following criteria:

- The MCP must be NCQA accredited—Health Plan Accreditation.
- The MCP must demonstrate 100% compliance with the applicable federal regulation for the last two OSR cycles.
- The MCP must provide evidence of the most recent NCQA audit, which includes a 100% assessment in the applicable standards.

Using this information and the *NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards (Effective July 1, 2020 – June 30, 2021)*, Qlarant evaluated whether the MCP qualified for deeming of federal regulations.

Standards in which DHCF permitted deeming include:

- Subpart D: §438.206 - §438.242 MCO Standards
  - §438.206 Availability of Services

  - §438.207 Assurance of Adequate Capacity and Services
  - §438.208 Coordination and Continuity of Care
  - §438.214 Provider Selection
  - §438.224 Confidentiality
  - §438.230 Subcontractual Relationships and Delegation
  - §438.236 Practice Guidelines
- Subpart E: §438.330 Quality Assessment and Performance Improvement Program
- Subpart F: §438.402 - §438.424 Grievance and Appeal System
  - §438.416 Recordkeeping Requirements

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

ACDC and CFDC were the only MCPs that qualified for select deeming in the 2021 OSR. HSCSN and MFC did not have NCQA health plan accreditation status at the time the OSR was conducted.

Results

Table 19 displays 2021 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. 2021 MCP OSR Results

2021 OSR	ACDC	CFDC	HSCSN	MFC	MCP Average
§438.10 Information Requirements	100%	100%	100%	98%	99.58%
§438.56 Disenrollment Requirements and Limitations	100%	100%	100%	100%	100%
§438.100 - §438.114 Enrollee Rights and Protections	100%	100%	100%	100%	100%
§438.206 - §438.242 MCO Standards (See Table 20 for additional detail)	100%	100%	100%	98%	99.56%
§438.330 Quality Assessment and Performance Improvement Program	100%	100%	93%	100%	98.21%
§438.402 - §438.424 Grievance and Appeal System	98%	97%	93%	91%	94.77%
Overall Weighted Score	99%	99%	98%	96%	98.11%
Confidence Level	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖

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 2021 OSR revealed all MCPs must develop CAPs. Figure 13 illustrates MCP CAPs required by the standard. All MCPs are required to develop CAPs to address findings in the Grievance and Appeal Standard. HSCSN must additionally develop a CAP for the Quality Assessment and Performance Improvement Program Standard, while MFC must also develop CAPs for the Information Requirements and MCO Standards. In some instances, MCPs must start utilizing new templates developed and distributed by DHCF. Figure 9 does not reflect instances in which the MCPs' compliance were dependent on updated DHCF templates.

Figure 13. MCP OSR Elements/Components by Standard Requiring CAPs

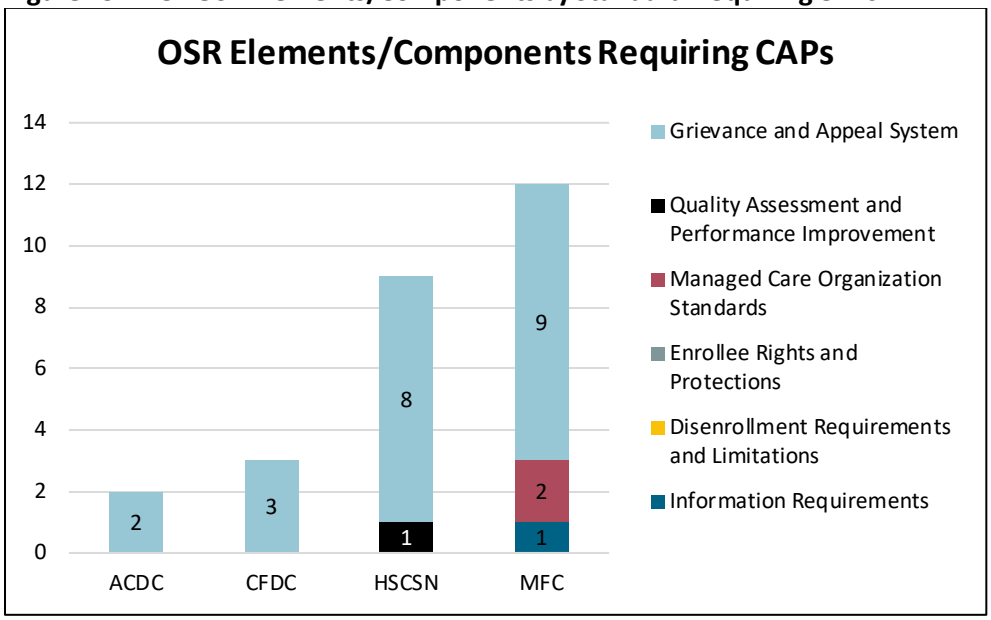


Table 20 details MCP results of the MCO Standards (§438.206 - §438.242) from the 2021 OSR. Performance, for each area of review, is reported as met, partially met, or not met.

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

Table 20. 2021 MCP OSR Results for MCO Standards - §438.206 - §438.242

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

MCO Standards	ACDC	CFDC	HSCSN	MFC
§438.230 Subcontractual Relationships and Delegation	Met	Met	Met	Partially Met
§438.236 Practice Guidelines	Met	Met	Met	Met
§438.242 Health Information Systems*	Met	Met	Met	Met

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

Table 21 details annual MCP results and MCP averages by standard from 2019 - 2021.

Table 21. 2019 - 2021 MCP OSR Results by Standard

OSR Standards	Year	ACDC	CFDC	HSCSN	MFC	MCP Average
Information Requirements	2019	98%	100%	98%	NA	98.33%
	2020	97%	100%	98%	89%	96.15%
	2021	100%	100%	100%	98%	99.58%
Disenrollment Requirements and Limitations	2019	NR	NR	NR	NR	NR
	2020	BS	BS	BS	BS	BS
	2021	100%	100%	100%	100%	100%
Enrollee Rights and Protections	2019	100%	100%	100%	NA	100%
	2020	94%	100%	89%	89%	93.06%
	2021	100%	100%	100%	100%	100%
MCO Standards	2019	99%	100%	99%	NA	99.34%
	2020	96%	100%	95%	96%	96.71%
	2021	100%	100%	100%	98%	99.56%
Quality Assessment and Performance Improvement Program	2019	100%	100%	93%	NA	96.43%
	2020	100%	100%	93%	100%	98.21%
	2021	100%	100%	93%	100%	98.21%
Grievance and Appeal System	2019	96%	82%	84%	NA	89.01%
	2020	98%	90%	88%	90%	91.59%
	2021	98%	97%	93%	91%	94.77%
Overall Weighted Score	2019	98%	94%	93%	NA	95.40%
	2020	97%	96%	93%	93%	94.67%
	2021	99%	99%	98%	96%	98.11%

NA - An OSR was not conducted for MFC in 2019.
NR - Not Reviewed: the Disenrollment Requirements and Limitations Standard was not reviewed until the baseline year (2020).
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 29-32 within the MCP Quality, Access, Timeliness Assessment section.

- The MCPs received overall weighted scores from 96% (MFC) to 99% (ACDC and CFDC) for the 2021 OSR. The MCP average was 98% (high confidence), which demonstrates improvement compared to the previous two OSRs.
- 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 demonstrated 100% compliance in Disenrollment Requirements and Limitations and Enrollee Rights and Protections standards.
- All MCPs were required to develop CAPs based on 2021 OSR results. The results of MCP 2020 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 available to enrollees during MY 2021. Activities conducted as part of the annual network adequacy evaluation include:

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

Description of Data Obtained. Qlarant obtained 2021 geographic access reports from the MCPs during the OSR. The reports conveyed MCP compliance with DHCF time and distance standards, as well as provider-to-enrollee ratios. Qlarant also obtained current provider directory information on the selected provider types, PCPs (adult and pediatric), and dental providers from the MCPs. Provider directory files included the following information: provider name, credentials, national provider identifier, provider type, specialty, practice name, address, and telephone number.

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

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

DHCF MCP Provider Network Standards

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

In 2019, telephone calls were conducted via secret shopper and traditional surveys. In 2020 and 2021, telephone surveys were conducted as traditional surveys only to reduce the burden on providers.[11] 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 2019 results compared to 2020 and 2021 results.

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 the provider in the online provider directory

[11] 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.

Results

Provider Network Standards

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

Provider-to-Enrollee Ratios. All MCPs have at least one PCP for every 500 enrollees. CFDC and HSCSN demonstrated compliance with having at least one dental provider for every 750 child and adolescent enrollees. ACDC fell short of meeting this requirement and MFC did not report this information.

Provider Appointment Access and Availability

Qlarant surveyed adult and pediatric PCPs and dental providers during 2021. Table 22 displays results of key provider access and availability measures for each MCP and the MCP weighted average.

Table 22. 2021 MCP Key Provider Access and Availability Measure Results

2021 Access and Availability	ACDC	CFDC	HSCSN	MFC	MCP AVG
Successful contact with provider	52%	49%	42%	55%	49%
Provider accepts the listed MCP	93%	91%	77%	94%	89%
Provider accepts new patients	94%	88%	94%	92%	92%

Three attempts were made to contact each provider. Unsuccessful contacts were most frequently due to a telephone hold time greater than five minutes.

Figures 14-15 illustrate MY 2021 adult and pediatric PCP compliance with routine and urgent appointment standards. Appointments were offered via in-person and telemedicine. For both adults and children, timely access was better achieved with routine care, compared to urgent care.

Figure 14. 2021 MCP Adult PCP Appointment Compliance

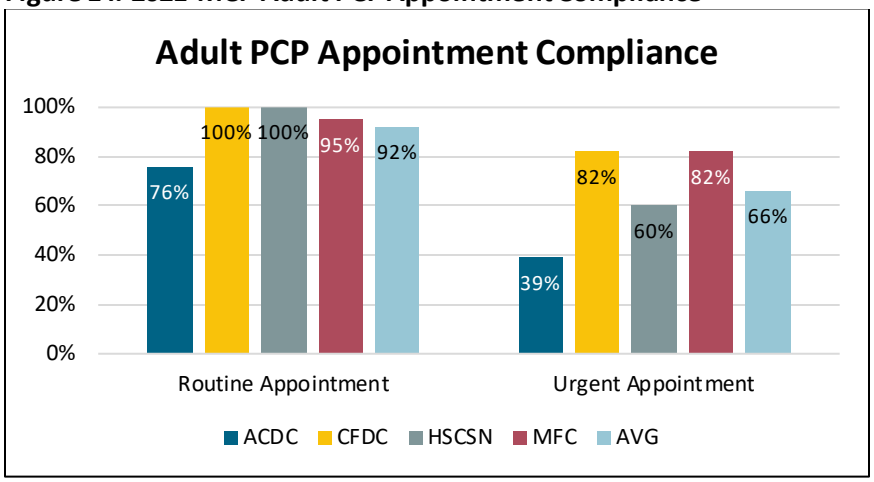
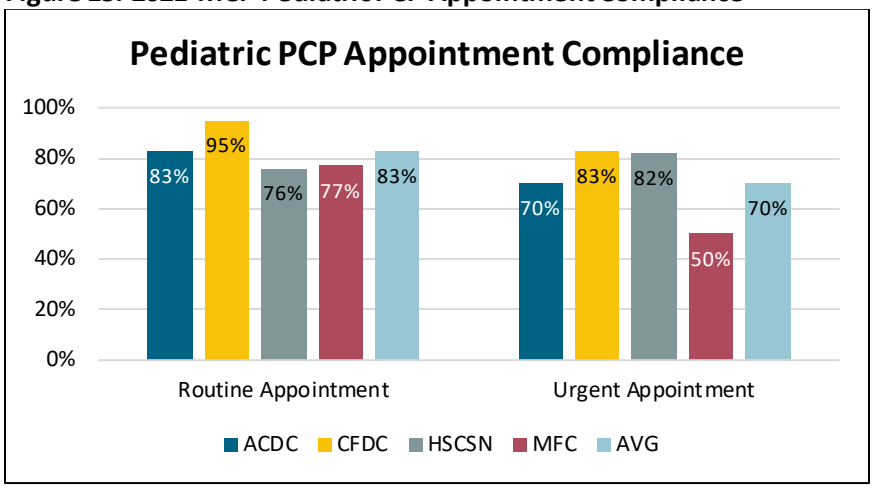


Figure 15. 2021 MCP Pediatric PCP Appointment Compliance



Figures 16-17 include MCP weighted averages trended from 2019 - 2021. Notably, urgent appointment timely compliance declined significantly for both adult and pediatric PCP. For adult PCPs, a 16 percentage point decline (from 82% in 2020 to 66% in 2021) was recognized. For pediatric PCPs, a 28 percentage point decline (from 98% in 2020 to 70% in 2021) occurred. When timely urgent appointments were not available, survey respondents indicated they would refer enrollees to an urgent care center or the emergency department.

Figure 16. 2019 - 2021 MCP Average Adult PCP Appointment Compliance

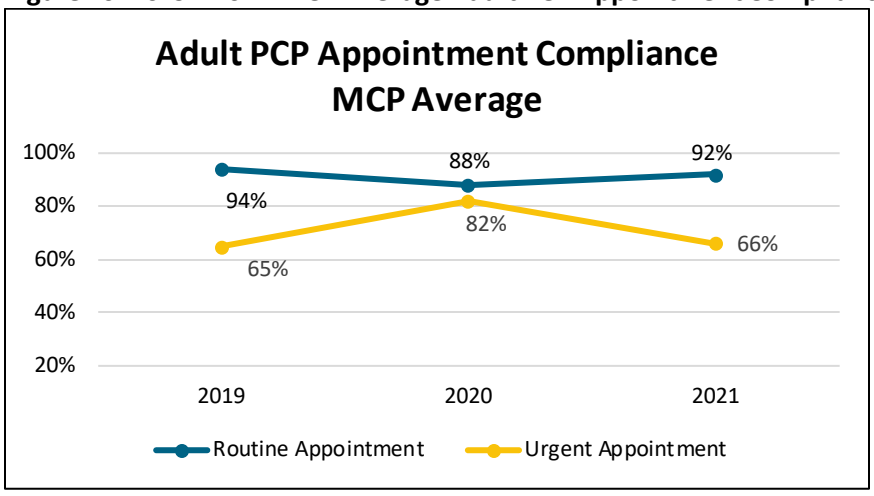


Figure 17. 2019 - 2021 MCP Average Pediatric PCP Appointment Compliance

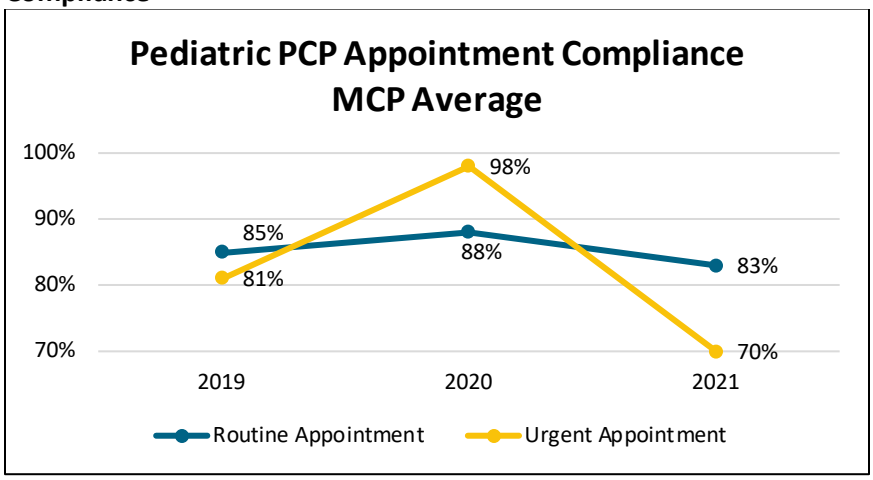


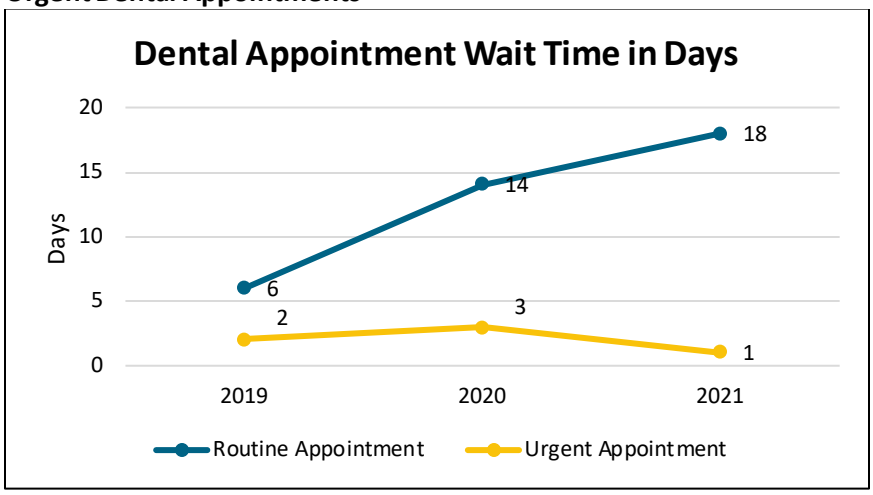
Table 23 details MCP dental provider survey results for routine and urgent appointment requests in 2021. DHCF does not have timeliness standards for dental providers.

Table 23. 2021 MCP Dental Appointment Wait Times for Routine and Urgent Care

2021 Dental Appointments	ACDC	CFDC	HSCSN	MFC	MCP AVG
Routine Care Appointment					
Wait Days Average	14	17	20	21	18
Wait Days Range	0 - 54	0 - 43	1 - 91	0 - 98	0 - 98
Urgent Care Appointment					
Wait Days Average	2	1	1	1	1
Wait Days Range	0 - 10	0 - 7	0 - 5	0 - 5	0 - 10

Figure 18 displays MCP average number of days to obtain routine and urgent dental appointments for 2019 - 2021. The average number of days to obtain a routine appointment has increased over the three-year period. This increase may be attributed to the COVID-19 public health emergency. Delaying care early in the pandemic may have subsequently influenced demand and wait time as enrollees feel more comfortable obtaining dental care with safety protocols in place.

Figure 18. 2019 - 2021 MCP Average Number of Days for Routine and Urgent Dental Appointments



Provider Directory Accuracy

Figure 19 provides 2021 MCP overall accuracy of provider directory validation results compared to the MCP average of 46%.

Figure 19. 2021 MCP Overall Accuracy of Provider Directory

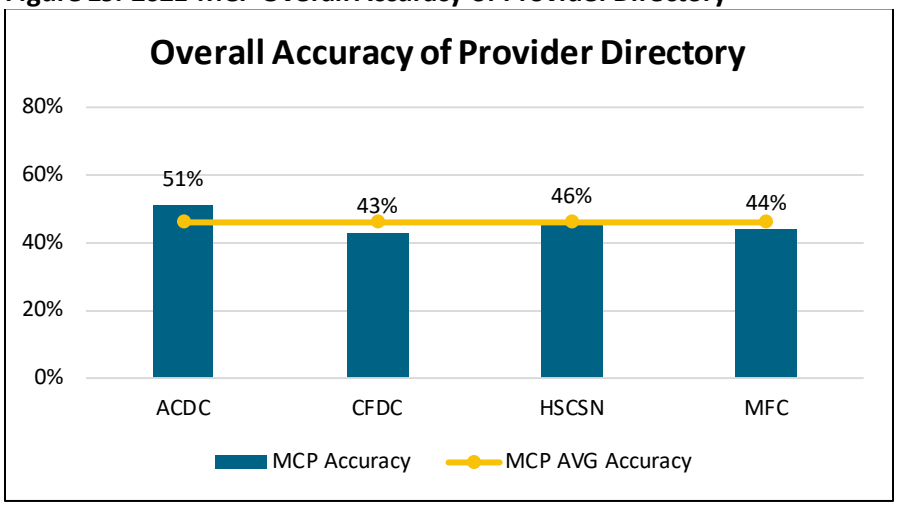
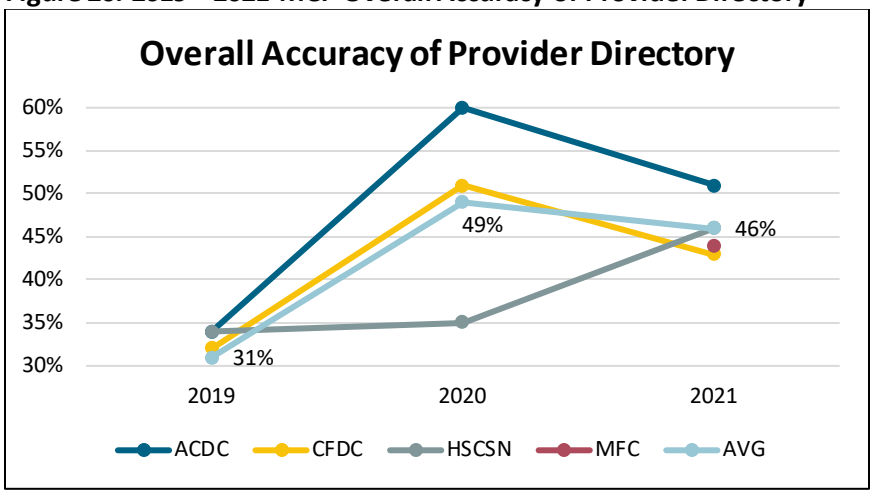


Figure 20 illustrates overall provider directory accuracy compared to MCP weighted averages trended from 2019 – 2021.

Figure 20. 2019 - 2021 MCP Overall Accuracy of Provider Directory



Data labels (31%, 49%, and 46%) refer to the MCP average.

Conclusion

Aggregate summary conclusions for the NAV activities are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 29-32 within the MCP Quality, Access, Timeliness Assessment section.

- MCPs have robust PCP networks and have access to at least 2 PCPs within 5 miles or 30 minutes of enrollees' residences.
- CFDC and HSCSN have at least one dental provider for every 750 child and adolescent enrollees. ACDC did not meet this standard and MFC did not report this statistic for assessment.
- MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 39% to 100% for 2021. MCP averages reveal the following timely access compliance ratings: 92% for adults accessing routine care, 66% for adults accessing urgent care, 83% for children accessing routine care, and 70% for children accessing urgent care.
- Adult and pediatric timely access to urgent appointments declined significantly from 2020 to 2021 (16 and 28 percentage points, respectively).
- The MCP average number of days to obtain a dental appointment for routine care increased annually since 2019; however, it has remained within a reasonable 18 day timeframe. The urgent appointment wait time decreased to an average of 1 day in 2021.
- Overall accuracy of MCP online provider directories ranged from 43% to 51% for 2021. The MCP average was 46%; this is a 3 percentage point decline from 2020.

Encounter Data Validation

Objective

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

study provide DHCF with a level of confidence in the completeness and accuracy of electronic encounter data submitted by the MCPs.

Methodology

Qlarant's 2021 EDV activities focused on an evaluation of provider office encounters occurring between July 1, 2019 and June 30, 2020.

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

- Electronic encounter data file received from DHCF for the period of review (July 1, 2019 - June 30, 2020)
- Information Systems Capabilities Assessment (ISCA) and HEDIS Roadmap documentation from the MCPs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.[12] To assess the completeness and accuracy of MCP encounter data, Qlarant completed the following activities:

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

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

The EDV study was conducted for the first time in 2021; therefore, no comparison results are available. Due to MFC's contract start date of October 1, 2020, the MCP was excluded from the study.

Results

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

Qlarant's medical record review evaluated the accuracy of diagnoses and procedure codes in the electronic encounter data. Table 24 displays MCP accuracy or "match rates." A match occurs when the

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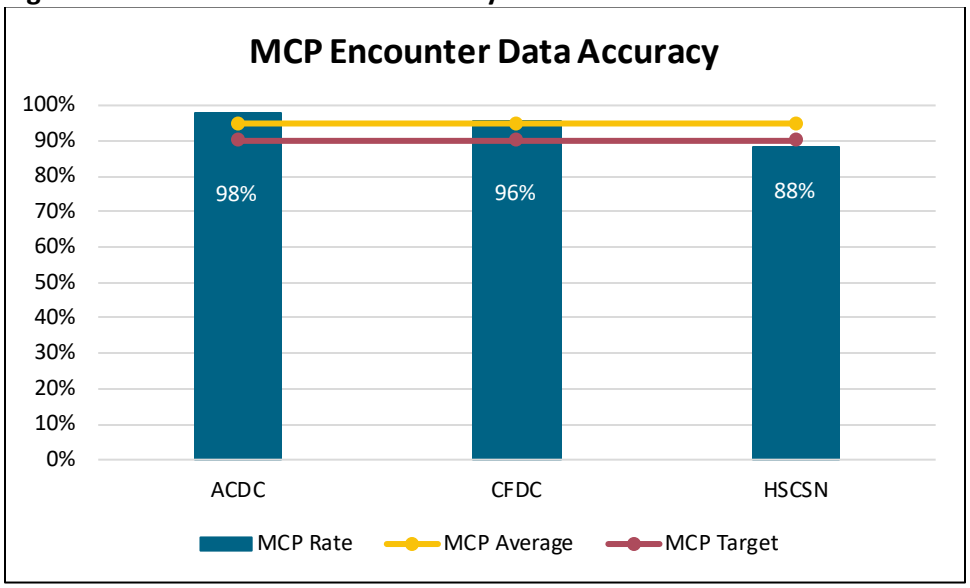
electronic diagnosis and procedure codes are supported by medical record documentation. The 2021 medical record reviews, evaluating encounters occurring between July 1, 2019 and June 30, 2020, confirmed, overall, high encounter data accuracy. The MCP weighted average was 95%, exceeding the DHCF established a target of 90%, for this first year of study. Individual MCP performance ranged from 88% (HSCSN) to 98% (ACDC).

Table 24. MCP Encounter Data Accuracy

2021 EDV	ACDC	CFDC	HSCSN	MCP AVG
Accuracy or Match Rate	98%	96%	88%	95%

Figure 21 illustrates MCP results compared to the MCP average and target.

Figure 21. MCP Encounter Data Accuracy Results



Tables 25 and 27 include analysis results at the diagnosis and procedure code levels, respectively. Tables 26 and 28 identify reasons for "no match."

MCP match rates for diagnosis codes ranged from 82% (HSCSN) to 98% (ACDC), with an average of 94%. The MCP average exceeds the 90% target established by DHCF.

Table 25. MCP Diagnosis Code Accuracy

Diagnosis Codes	ACDC	CFDC	HSCSN	MCP Average
Accuracy or Match Rate	98%	95%	82%	94%

Table 26 identifies reasons for "no match" diagnosis codes, all of which were due to insufficient documentation in the medical record to support the diagnosis code. No coding errors were identified during the review.

Table 26. Reasons for "No Match" in Diagnosis Codes

Diagnosis Codes	ACDC	CFDC	HSCSN	MCP Average
Percentage of "No Match" elements due to coding errors	0%	0%	0%	0%
Percentage of "No Match" elements due to lack of medical record documentation	100%	100%	100%	100%

Table 27 includes MCP procedure code accuracy. MCP match rates for procedure codes ranged from 93% (HSCSN) to 97% (ACDC), with an average of 96%. The MCP average match rate for procedure codes exceeds the 90% target established by DHCF.

Table 27. MCP Procedure Code Accuracy

Procedure Codes	ACDC	CFDC	HSCSN	MCP Average
Accuracy or Match Rate	97%	96%	93%	96%

Table 28 identifies reasons for "no match" procedure codes, most of which were due to insufficient documentation in the medical record to support the diagnosis code. Only ACDC experienced "no match" results due to a coding error. This occurred in 8% of "no match" instances (1 of 13).

Table 28. Reasons for "No Match" in Diagnosis Codes

Diagnosis Codes	ACDC	CFDC	HSCSN	MCP Average
Percentage of "No Match" elements due to coding errors	8%	0%	0%	2%
Percentage of "No Match" elements due to lack of medical record documentation	92%	100%	100%	98%

Conclusion

Aggregate summary conclusions for the EDV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 29-32 within the MCP Quality, Access, Timeliness Assessment section.

- An evaluation of each MCP's Information Systems Capabilities Assessment determined all MCPs had the capability to produce accurate and complete encounter data for the period under review.
- A medical record review determined an overall high level of encounter data accuracy. The MCP overall weighted average was 95%, which exceeded the DHCF established a target of 90% for the first annual EDV study. Only HSCSN did not meet the target and achieved an encounter data accuracy rate of 88%.

- An analysis at the diagnosis and procedure code level concluded an MCP average of 94% and 96%, respectively. HSCSN's diagnosis code accuracy was 82%, which did not meet the DHCF target by 8 percentage points.
- Almost all "no match" results were due to insufficient documentation in the medical record to support the claims. Only ACDC experienced an encounter in which the "no match" result was attributed to a coding error.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

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

Quality, Access, and Timeliness Definitions

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

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

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

Tables 29-32 highlight strengths and weaknesses for each MCP. Identified strengths and weaknesses correspond to the quality, access, and/or timeliness of services delivered to MCP enrollees. Only applicable domains for each strength or weakness are identified with a (★) or (●) indicating a positive or negative impact as described below. Not all domains were impacted by each strength or weakness. Where appropriate, weaknesses include recommendations.

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

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

- If the MCP demonstrated full compliance in the Quality Assessment and Performance Improvement Program Standard, performance would be identified with a ★ in the quality domain.

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

ACDC

Table 29. ACDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
●	●	●	**Weakness.** ACDC did not achieve improvement in any measures (the last remeasurement compared to baseline performance). MY 2020 performance was likely influenced by the COVID-19 public health emergency. **Recommendation.** Continue to adapt to COVID-19 public health emergency constraints and engage enrollees in care.
Maternal Health PIP			
★	★	★	**Strength.** ACDC received a score of 94% (high confidence). Overall, the MCP's PIP was methodologically sound.
●			**Weakness.** ACDC's aim statement did not clearly identify all populations relevant to the PIP. **Recommendation.** ACDC should amend its aim statement and clearly specify the population for the prenatal and postpartum care measures as women who had a delivery.
●			**Weakness.** ACDC did not achieve statistically significant improvement in any of the measures. **Recommendation.** While a formal recommendation is not being made related to the MCP not achieving statistically significant improvement during the first year of the COVID-19 public health emergency, ACDC should continue to develop and adjust strategies targeting barriers, particularly those related to the pandemic.
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			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollees' rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	**Strength.** ACDC received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** ACDC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** ACDC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** ACDC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** ACDC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** ACDC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** ACDC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** ACDC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** ACDC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** ACDC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★			**Strength.** ACDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	**Strength.** ACDC received a score of 98% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
	●		**Weakness.** ACDC's Handling of Enrollee Appeals and Access to the District Fair Hearing System Policy explains that an oral appeal filed by the enrollee should be followed up by a written, signed request, if possible. This is inconsistent with current regulatory requirements. **Recommendation.** ACDC should revise the policy to eliminate the requirement for enrollee written confirmation of an oral appeal.
	●		**Weakness.** ACDC's Provider Manual did not eliminate the requirement for enrollee signature of an oral appeal. **Recommendation.** ACDC should update its Provider Manual to eliminate the requirement for enrollee signature of an oral appeal.
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** ACDC provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	●		**Weakness.** ACDC did not meet the pediatric dental provider to enrollee ratio requirement. **Recommendation.** ACDC should evaluate the number of network dental providers serving child and adolescent enrollees and increase the number of participating dental providers to meet DHCF provider ratio requirements.
	●	●	**Weakness.** ACDC received a score of 76% and 39% for timely access to adult routine and urgent appointments, respectively. **Recommendation.** ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●	●	**Weakness.** ACDC received a score of 83% and 70% for timely access to pediatric routine and urgent appointments, respectively. **Recommendation.** ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** ACDC received a score of 51% for overall provider directory accuracy. **Recommendation.** ACDC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★			**Strength.** ACDC achieved an encounter data accuracy, or match rate, of 98%. Stakeholders can have confidence in the MCP's encounter/claims data.

CFDC

Table 30. CFDC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
★	★	★	**Strength.** CFDC received a score of 96% (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.
●			**Weakness.** CFDC's aim statement did not clearly identify all populations relevant to the PIP. **Recommendation.** CFDC should amend its aim statement and clearly specify the population includes enrollees 18 - 75 years of age with diabetes (type 1 and 2).
●			**Weakness.** CFDC identified variables related to its stratification strategy, which assigns a risk level for each enrollee, rather than identifying variables that support its aim statement/study question such as gender, age ranges, and receipt of a service. **Recommendation.** CFDC should identify objective, clearly defined, time-specific variables to answer the study question.
Maternal Health PIP			
★	★	★	**Strength.** CFDC received a score of 96% (high confidence). The MCP demonstrated statistically significant improvement in the Timeliness of Prenatal Care measure.
●			**Weakness.** CFDC's aim statement did not clearly identify all populations relevant to the PIP. **Recommendation.** CFDC should amend its aim statement and clearly specify the population as women who had a delivery for the prenatal and postpartum measures and women ages 15-44 years for the contraceptive care measures.
●			**Weakness.** CFDC identified variables related to its stratification strategy, which assigns a risk level for each enrollee, rather than identifying variables that support its aim statement/study question such as gender, age ranges, and receipt of a service. **Recommendation.** CFDC should identify objective, clearly defined, time-specific variables to answer the study question.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."

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% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollees' rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	**Strength.** CFDC received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** CFDC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** CFDC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** CFDC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** CFDC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** CFDC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** CFDC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** CFDC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★	★	★	**Strength.** CFDC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** CFDC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** CFDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	**Strength.** CFDC received a score of 97% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
●	●		**Weakness.** CFDC's Notice of Authorization Approval and Adverse Determination Decisions Policy does not explicitly state all content that is required for inclusion in an adverse determination letter. **Recommendation.** CFDC should revise its policy to specify all required adverse determination letter components including reasons for the adverse benefit determination and the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
	●		**Weakness.** CFDC's Enrollee Appeals Policy explains that an appeal filed orally by the enrollee should be followed up by a written, signed request, if possible. This is inconsistent with regulatory requirements that no longer require an oral appeal to be confirmed in writing. **Recommendation.** CFDC should revise the policy to eliminate the requirement for enrollee written confirmation of an oral appeal.
	●		**Weakness.** CFDC's Provider Manual did not eliminate the requirement for enrollee signature of an oral appeal. **Recommendation.** CFDC should update its Provider Manual to eliminate the requirement for enrollee signature of an oral appeal.
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** CFDC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	★	★	**Strength.** CFDC received a score of 100% and 95% for timely access to adult and pediatric routine appointments, respectively.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
	●	●	**Weakness.** CFDC received a score of 82% and 83% for timely access to adult and pediatric urgent appointments, respectively. **Recommendation.** CFDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** CFDC received a score of 43% for overall provider directory accuracy. **Recommendation.** CFDC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
★			**Strength.** CFDC achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the MCP's encounter/claims data.

HSCSN

Table 31. HSCSN Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
●			**Weakness.** HSCSN only documented two interventions for the 2020 measurement year. **Recommendation**. HSCSN should Implement (and document) additional interventions targeting enrollee, provider, and MCP barriers and consider strategies targeting the COVID-19 public health emergency.
●			**Weakness.** HSCSN did not sustain improvement or achieve statistically significant improvement in any of the measures. **Recommendation.** HSCSN should continue to develop and adjust strategies targeting barriers, particularly barriers related to the COVID-19 public health emergency.
Maternal Health PIP			
★	★	★	**Strength.** HSCSN received a score of 94% (high confidence) and improved performance in several measures.
●			**Weakness.** HSCSN incorrectly identified the study population for the prenatal and postpartum measures in its aim statement. **Recommendation.** HSCSN should clearly and correctly identify the study population, including postpartum women, in its aim statement.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
●			**Weakness.** HSCSN did not achieve statistically significant improvement in any of the measures. **Recommendation.** While a formal recommendation is not being made related to the MCP not achieving statistically significant improvement during the first year of the COVID-19 public health emergency, HSCSN should continue to develop and adjust strategies targeting barriers, particularly those related to the pandemic. HSCSN should also implement interventions early in the measurement year to achieve the greatest impact on PM results.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollees' rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	**Strength.** HSCSN received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** HSCSN provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** HSCSN provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Coordination and Continuity of Care requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** HSCSN provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** HSCSN provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** HSCSN provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** HSCSN provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** HSCSN provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
●			**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 on key indicator dashboard performance metrics.
Grievance and Appeal System			
●	●		**Weakness.** HSCSN's Notification of Adverse Benefit Determinations Policy incorrectly allows an enrollee and/or provider to request a District Fair Hearing without first exhausting HSCSN's appeal process. **Recommendation.** HSCSN should revise the policy to eliminate the enrollee's and/or provider's right to directly request a District Fair Hearing without first exhausting HSCSN's appeal process.
●		●	**Weakness.** HSCSN did not consistently acknowledge appeals in writing within two business days of receipt. **Recommendation.** HSCSN should demonstrate compliance with the two business day requirement for sending the enrollee a written acknowledgment of their request for appeal.
	●		**Weakness.** HSCSN's Appeal of Adverse Benefit Determinations Policy and Provider Manual requires the enrollee or designee to follow an oral appeal in writing. This is inconsistent with current regulatory requirements. **Recommendation.** HSCSN should revise the policy and Provider Manual to eliminate the enrollee's written confirmation of an oral appeal.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
●		●	**Weakness.** HSCSN did not consistently resolve grievances and provide notice within 90 days of receipt. **Recommendation**. HSCSN should demonstrate compliance with the 90-day resolution notice requirement for grievances.
●		●	**Weakness.** HSCSN did not consistently resolve and provide notice for expedited appeal requests within 72 hours of receipt. **Recommendation.** HSCSN should demonstrate compliance with the 72-hour resolution notice requirement for expedited appeal requests.
●		●	**Weakness.** HSCSN did not consistently make a reasonable effort to provide oral notice of resolution for an expedited appeal request. **Recommendation.** HSCSN should demonstrate compliance with the requirement to make a reasonable effort to provide oral notice of resolution for an expedited appeal request.
●	●		**Weakness.** HSCSN did not communicate the regulation change to eliminate the requirement of following an oral appeal by written confirmation to providers and delegates/subcontractors. **Recommendation.** HSCSN should demonstrate the MCP communicates changes in federal regulations or contractual requirements related to the grievance and appeal system to its providers and delegates/subcontractors.
●		●	**Weakness.** HSCSN did not demonstrate consistent compliance with its Appeal of Adverse Benefit Determinations Policy, which requires the Appeals and Grievances Committee to review requested appeals and ad hoc grievances, in which the enrollee/caregiver expressed dissatisfaction with the initial grievance resolution, on a monthly basis. **Recommendation.** HSCSN should demonstrate consistent compliance with its Appeal of Adverse Benefit Determinations Policy, which specifies the reporting structure and frequency of reporting appeal trends, opportunities for improvement, and action items/action plans.
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 100% compliance rating for timely access to adult routine appointments.
	●	●	**Weakness.** HSCSN received a score of 60% for timely access to adult urgent appointments. **Recommendation.** HSCSN should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
	●	●	**Weakness.** HSCSN received scores of 76% and 82% for timely access to pediatric routine and urgent appointments, respectively. **Recommendation.** HSCSN should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** HSCSN received a score of 46% for overall provider directory accuracy. **Recommendation.** HSCSN should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
●			**Weakness.** HSCSN achieved an encounter data accuracy, or match rate, of 88%. The DHCF established target was 90%. "No match" reasons were attributed to a lack of supporting documentation in the medical record. **Recommendation.** HSCSN should audit and educate providers on providing appropriate medical record documentation to support codes for billed claims.

MFC

Table 32. MFC Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Comprehensive Diabetes Care PIP			
●			**Weakness.** MFC did not describe how the PIP topic was relevant to its population using MCP-specific data. **Recommendation**. MFC should describe how the PIP topic is relevant to its population using MCP-specific data. Until baseline performance measure results are available and can be compared to benchmarks or goals, the MCP can demonstrate relevancy by reporting the percentage of its population that has diabetes and other contributing risk factors such as for overweight/obesity, physical inactivity, high blood pressure, etc. and health disparities based upon socio-economic factors.
●			**Weakness.** MFC did not describe how it plans to collect data for the PIP. **Recommendation**. MFC should answer all PIP questions as directed in the PIP instructions.
Maternal Health PIP			
●			**Weakness.** MFC received a score of 54% (low confidence) for its PIP submission. **Recommendation.** MFC should address all recommendations described below.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
●			**Weakness.** MFC did not describe how the PIP topic was relevant to its population using MCP-specific data. **Recommendation**. MFC should describe how the PIP topic is relevant to its population using MCP-specific data. Until baseline performance measure results are available and can be compared to benchmarks or goals, the MCP can demonstrate relevancy by reporting the percentage of its population that is of childbearing age, the number of deliveries, and health disparities based upon socio-economic factors.
●			**Weakness.** MFC's aim statement did not accurately and clearly identify all populations relevant to the PIP. **Recommendation.** MFC should amend its aim statement to reflect all populations and measures addressed by the PIP.
●			**Weakness.** MFC did not clearly define the contraceptive care population using descriptive characteristics consistent with the PIP study question. **Recommendation.** MFC should clearly define the characteristics of its study population for the contraceptive care performance measures based upon CMS specifications.
●			**Weakness.** MFC did not describe its data collection approach for the contraceptive care measures. **Recommendation.** MFC should describe how its data collection approach will capture all applicable enrollees for the contraceptive care measures.
●			**Weakness.** MFC did not identify any variables used to answer the PIP study question. **Recommendation.** MFC should identify variables that support the PIP study question and adequately contribute to measuring performance such as gender, age, and completed service.
●			**Weakness.** MFC inaccurately responded to a question about administrative data collection and ensuring data/encounters are complete. **Recommendation.** MFC should address compliance with administrative data submission requirements by all applicable providers.
PERFORMANCE MEASURE VALIDATION			
PIP Performance Measures			
This task was not completed for MFC due to its contract effective date of October 1, 2020. The PIP PMV focused on MY 2020 performance.			
EPSDT Performance Measures			
★	★	★	**Strength.** MFC received a score of 95% (high confidence).
●			**Weakness.** MFC did not collect tooth number data from its dental claims vendor and its source code did not specify tooth number. As a result, MFC had to report "0" for the Total Eligibles Receiving a Sealant on a Permanent Molar Tooth measure. **Recommendation:** MFC should collect tooth number data and update its program source code in order to report a rate for the next annual reporting cycle.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	**Strength.** MFC received a score of 98% (high confidence) in the Information Requirements Standard. Overall, the MCP communicates information on benefits and providers and how to access services.
●			**Weakness.** MFC's Enrollee Materials Policy does not specify there is no cost sharing imposed on the enrollee. **Recommendation:** MFC should update its policy to indicate there is no cost sharing imposed on enrollees.
Disenrollment Requirements and Limitations			
★	★	★	**Strength.** MFC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	**Strength.** MFC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollees' rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	**Strength.** MFC received a score of 98% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** MFC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** MFC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
●		●	**Weakness.** MFC did not provide evidence it is tracking compliance in completing Health Risk Assessments within 90 days of enrollment. **Recommendation:** MFC should develop a tracking system to assess compliance for completing Health Risk Assessments within 90 days of enrollment and meet its 80% performance threshold.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** MFC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** MFC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** MFC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
●	●		**Weakness.** MFC did not provide evidence of fully executed delegation agreements/amendments, which included language permitting DHCF, CMS, the HHS Inspector General, the Comptroller General, or their designees access to books, records, contracts, systems, etc. **Recommendation:** MFC should provide evidence of fully executed agreements/amendments including required language.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** MFC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** MFC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★			**Strength.** MFC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
●			**Weakness.** MFC did not provide evidence of a policy requiring the MCP to mail notice for denial of payment at the time of action. **Recommendation**. MFC should provide a policy that addresses sending the enrollee an adverse benefit determination for any claims denial (clean claims only) at the time of the denial.
●		●	**Weakness.** MFC did not consistently provide timely acknowledgment of grievances and appeals. **Recommendation.** MFC should demonstrate consistent compliance in sending enrollees a written acknowledgment, within two business days, of receipt of a grievance and receipt of an appeal.
●			**Weakness.** MFC's Enrollee Grievances, Complaints, and Inquiries Policy does not address the MCP requirement to ensure that individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. **Recommendation.** MFC should revise the policy to include the requirement to ensure that individuals who make decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
●			**Weakness.** The Enrollee Grievances, Complaints, and Inquiries Policy did not address the requirement to ensure that individuals who make decisions on grievances are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. **Recommendation.** MFC should revise the policy to address the requirement to ensure that individuals who make decisions on grievances are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
●		●	**Weakness.** MFC's Enrollee Appeals Policy requires that an appeal filed orally be followed by a written, signed request, unless the enrollee or authorized representative requests an expedited resolution. This is inconsistent with federal regulations that have eliminated the requirement for written confirmation of an oral appeal. **Recommendation.** MFC should revise the policy to eliminate the requirement for written confirmation of an oral appeal.
●		●	**Weakness.** A sample review of enrollee grievance records found MFC did not consistently demonstrate compliance with sending notice of grievance resolution to the enrollee within 90 calendar days of grievance receipt. **Recommendation.** MFC should demonstrate consistent compliance in sending enrollees written resolution of a grievance within 90 calendar days of grievance receipt.
●		●	**Weakness.** A sample review of appeals found MFC did not consistently provide timely notification of resolution for standard appeals. **Recommendation.** MFC should demonstrate consistent compliance with the 30-day enrollee notification of resolution for a standard appeal.
●		●	**Weakness.** A sample review of appeal files found MFC did not consistently make reasonable efforts to provide oral notice of an expedited resolution. **Recommendation.** MFC should demonstrate consistent compliance in making a reasonable attempt to provide oral notice to the enrollee of an expedited resolution.
●	●		**Weakness.** The Enrollee Grievances, Complaints, and Inquiries Policy does not address the requirement for MFC to maintain an accurate and accessible record of grievances for monitoring by the District and CMS. **Recommendation.** MFC should revise the policy to address the requirement for maintaining an accurate and accessible record of grievances for monitoring by the District and CMS.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
NETWORK ADEQUACY VALIDATION			
	★		**Strength.** MFC provided evidence of maintaining a provider network meeting DHCF geographic and provider-to-enrollee ratio requirements.
	★	★	**Strength.** MFC received a 95% compliance rating for timely access to adult routine appointments.
	●	●	**Weakness.** MFC received a score of 82% for timely access to adult urgent appointments. **Recommendation.** MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●	●	**Weakness.** MFC received scores of 77% and 50% for timely access to pediatric routine and urgent appointments, respectively. **Recommendation.** MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.
	●		**Weakness.** MFC received a score of 44% for overall provider directory accuracy. **Recommendation.** MFC should make provider directory accuracy a priority and update information routinely.
ENCOUNTER DATA VALIDATION			
This task was not completed for MFC due to its contract effective date of October 1, 2020. Encounters under review for the EDV activity occurred July 1, 2019 through June 30, 2020.			

Assessment of Previous Recommendations

During the course of conducting 2021 EQR activities, Qlarant evaluated MCP compliance in addressing previous annual recommendations.[13] MCPs were expected to remedy 2020 deficiencies and demonstrate full compliance. MCPs not addressing deficiencies are at risk of not being compliant with their contracts. Assessment outcomes, included in Tables 33-36, identify if the MCP adequately addressed 2020 recommendations. Color coded symbols specify results:

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

ACDC

ACDC adequately addressed 9 of 11 recommendations (that could be re-evaluated), demonstrating an 82% compliance rating. Figure 22 illustrates the compliance rating, which demonstrates the percentage of recommendations closed out during the review. Table 33 provides details of the 2021 assessment.

[13] 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 22. Assessment Outcome for ACDC 2020 Recommendations

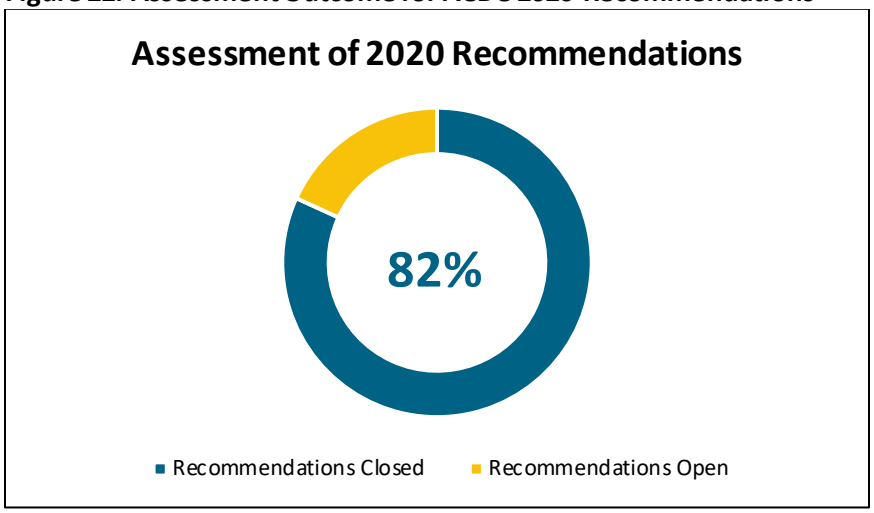


Table 33. Assessment of ACDC's Previous Annual Recommendations

2020 Recommendation	2021 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
There were no formal 2020 recommendations for ACDC.	
Maternal Health PIP	
There were no formal 2020 recommendations for ACDC.	
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
There were no formal 2020 recommendations for ACDC.	
EPSDT Performance Measures	
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. ACDC should enhance its enrollment data validation process to ensure accurate dates of birth are captured in its information system.	Not applicable. ACDC did not collect supplemental medical records for FY 2021 EPSDT reporting. Calculations were based on administrative data.
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
ACDC did not take action to address Provider Directory inaccuracies. The MCP 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.	▲ ACDC addressed Provider Directory recommendations and demonstrated compliance.
Disenrollment Requirements and Limitations	
ACDC did not fully communicate disenrollment information within the Enrollee Handbook. The MCP should revise the Enrollee Handbook to inform enrollees of disenrollment causes and the process to request disenrollment.	▲ ACDC updated its Enrollee Handbook. The MCP addressed recommendations and demonstrated compliance.
Enrollee Rights and Protections	

2020 Recommendation	2021 Assessment
ACDC's Enrollee Rights and Responsibilities Policy did not address all requirements. The MCP should revise the policy to assert the MCP 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, as well as other requirements specified in §438.102.	ACDC amended its Enrollee Rights and Responsibilities Policy and stated the MCP will not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, as well as other requirements identified in §438.102.
ACDC did not have a policy addressing emergency and post stabilization services. The MCP should develop a policy to address §438.114 requirements.	ACDC created an Emergency and Poststabilization Services Policy, which addresses all §438.114 requirements.
MCO Standards	
ACDC did not conduct a network provider survey during its 12-month contract period. The MCP should conduct an access to care survey at least once during the MCP contract year.	ACDC addressed the recommendation to conduct a network provider survey.
ACDC did not provide evidence of follow-up with providers who failed to meet network adequacy standards. The MCP should complete corrective actions with providers failing to meet network adequacy standards consistent with its policy.	ACDC addressed the recommendation to complete corrective actions with providers failing to meet network adequacy standards.
ACDC failed to consistently demonstrate providing notice to providers for covered outpatient drug authorization decisions within 24 hours. The MCP should consistently comply with the requirement of completing provider notification of outpatient drug preauthorization request decisions, by telephone or other telecommunication devices, within 24 hours of receipt of the request.	ACDC provided evidence of compliance through policy revisions and quarterly monitoring and reporting.
Quality Assessment and Performance Improvement Program	
There were no formal 2020 recommendations for ACDC.	
Grievance and Appeal System	
ACDC's Provider Manual and Enrollee Handbook did not reflect the correct timeframe for enrollee grievance resolution. ACDC should amend the documents to specify a 90-day grievance resolution notification timeframe.	ACDC updated its Provider Manual and Enrollee Handbook and specified a 90-day grievance resolution notification timeframe.
ACDC issued an appeal resolution letter, which included an error and resulted in communicating inaccurate information to the enrollee. The MCP should ensure results of the appeal documented in the letter are consistent with results documented in the enrollee record.	A random sample record review of appeal resolution letters demonstrated full compliance.
NETWORK ADEQUACY VALIDATION	
ACDC should educate and work with its pediatric PCPs to improve compliance in obtaining timely routine appointments (89% compliance in 2020).	Compliance in obtaining timely routine appointments with pediatric PCPs declined (83% in 2021). This opportunity for improvement remains in place and the recommendation continues.

2020 Recommendation	2021 Assessment
ACDC should improve the overall accuracy of its provider directory (60% in 2020). Provider information should be updated on a regular basis.	ACDC's overall accuracy of its provider directory declined (51% in 2021). This opportunity for improvement remains in place and the recommendation continues.

CFDC

CFDC adequately addressed 8 of 10 recommendations, demonstrating an 80% compliance rating. Figure 23 illustrates the compliance rating, which demonstrates the percentage of recommendations closed out during the review. Table 34 provides details of the 2021 assessment.

Figure 23. Assessment Outcome for CFDC 2020 Recommendations

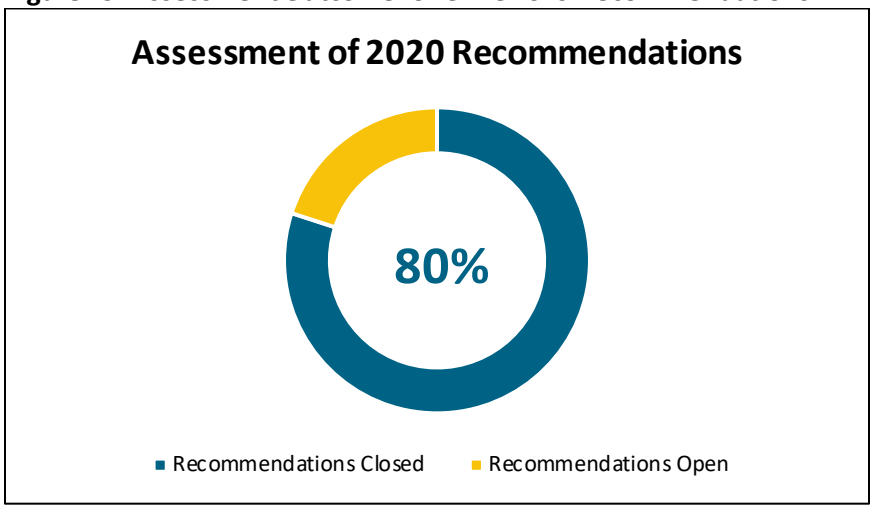


Table 34. Assessment of CFDC's Previous Annual Recommendations

2020 Recommendation	2021 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
There were no formal 2020 recommendations for CFDC.	
Maternal Health PIP	
There were no formal 2020 recommendations for CFDC.	
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
CFDC had data entry errors in its final rate worksheet and had to resubmit rates. The MCP 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.	CFDC's 2021 PMV final rate worksheet was accurate.
EPSDT Performance Measures	
There were no formal 2020 recommendations for CFDC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2020 recommendations for CFDC.	

2020 Recommendation	2021 Assessment
Disenrollment Requirements and Limitations	
CFDC did not fully communicate disenrollment information within the Enrollee Handbook. The MCP should revise the Enrollee Handbook to inform the enrollee of the disenrollment process, including contact information and a telephone number.	CFDC updated its Enrollee Handbook. The MCP addressed recommendations and demonstrated compliance.
CFDC did not outline the availability of the grievance process in its Disenrollment Causes and Processes Policy. The MCP should revise its policy and include grievance procedures as they relate to enrollee disenrollment.	CFDC updated its Disenrollment Causes and Processes Policy. The MCP addressed recommendations and demonstrated compliance.
Enrollee Rights and Protections	
CFDC's Emergency Department and Post-Stabilization Care Policy omitted reference to DHCF (part of new requirement). The MCP should amend its policy and state CFDC will not deny emergency services based on emergency room provider failure to notify DHCF.	CFDC amended its Emergency Department and Post-Stabilization Care Policy and addressed the recommendation.
MCO Standards	
There were no formal 2020 recommendations for CFDC.	
Quality Assessment and Performance Improvement Program	
There were no formal 2020 recommendations for CFDC.	
Grievance and Appeal System	
A record review demonstrated CFDC did not consistently follow policy in acknowledging appeals, providing timely grievance and appeal resolution notice, making a 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. The MCP 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.	A record review demonstrated CFDC complied with recommendations.
CFDC did not specify the parties to an appeal in its Enrollee Appeals Policy (even though revisions were approved during the 2019 CAP process). The MCO should revise its Enrollee Appeals Policy to identify parties of an appeal as specified in §438.406 (b)(6)(i)(ii).	CFDC amended its Enrollee Appeals Policy to address the recommendation.
CFDC's Provider Manual incorrectly asserted enrollees have the right to request a fair hearing from DHCF at any point during the appeal process. The MCP should correct its Provider Manual and state enrollees must exhaust CFDC's one-level appeal process before requesting a District fair hearing.	CFDC amended its Provider Manual to address the recommendation.

2020 Recommendation	2021 Assessment
CFDC's Provider Manual identified an incorrect timeframe to authorize or provide services previously denied and subsequently approved. The MCP 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).	CFDC amended its Provider Manual to address the recommendation.
NETWORK ADEQUACY VALIDATION	
CFDC received a score of 81% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary.	Compliance in obtaining timely urgent appointments with adult PCPs marginally increased in 2021 (82%). This opportunity for improvement remains and the recommendation continues.
CFDC received a score of 51% for overall provider directory accuracy. CFDC should make provider directory accuracy a priority and update information routinely.	CFDC's overall accuracy of its provider directory declined (43% in 2021). This opportunity for improvement remains in place and the recommendation continues.

HSCSN

HSCSN adequately addressed 16 of 21 recommendations, demonstrating a 76% compliance rating. Figure 24 illustrates the compliance rating, which demonstrates the percentage of recommendations closed out during the review. Table 35 provides details of the 2021 assessment.

Figure 24. Assessment Outcome for HSCSN 2020 Recommendations

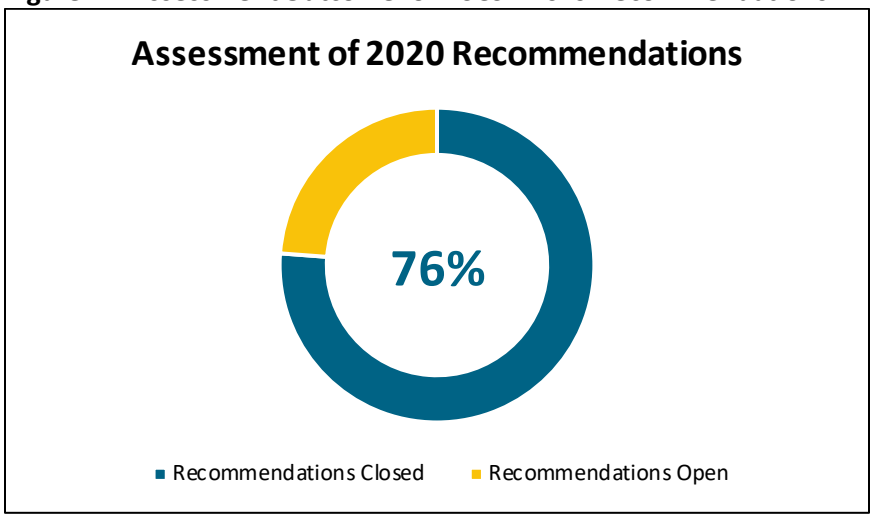


Table 35. Assessment of HSCSN's Previous Annual Recommendations

2020 Recommendation	2021 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
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. 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.	HSCSN demonstrated some improvement. The MCP's PIP validation score was 85% (moderate confidence). HSCSN demonstrated improvement in documenting adequate data analysis; however, the MCP continues to have an opportunity for improvement in documenting interventions completed for the measurement year. HSCSN did not achieve sustained or statistically significant improvement in any of the measures. This opportunity for improvement remains in place and the recommendation continues.
Maternal Health PIP	
HSCSN reported an error in one of the PM rates. The MCP should add a validation step to its reporting process to ensure accurate rate submissions.	HSCSN's 2021 PIP submission reported accurate PM rates.
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
HSCSN had data entry errors/discrepancies in reporting final PIP measure and PIP PMV measure rates and had to resubmit rates. The MCP 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.	HSCSN's 2021 PIP PM reporting was accurate.
EPSDT Performance Measures	
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. The MCP should review and update source code annually and include quality checks to ensure accurate numerator events.	HSCSN's 2021 EPSDT PM reporting was accurate.
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
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. The MCP should ensure its downloadable PDF provider directory is updated no later than 30 calendar days after receiving updated information.	HSCSN addressed the recommendation and updates its PDF provider directory no later than 30 calendar days after receiving updated information.
Disenrollment Requirements and Limitations	

2020 Recommendation	2021 Assessment
HSCSN included an incorrect CFR reference in its Change in Enrollee Status/Disenrollment Policy. The MCP should amend the policy and correctly reference §438.702(a)(4), rather than to §438.702(a)(3).	▲ HSCSN updated its Change in Enrollee Status/Disenrollment Policy. The MCP corrected the error in the CFR reference and demonstrated compliance.
HSCSN's Change in Enrollee Status/Disenrollment Policy did not consider a disenrollment approved, should HSCSN or DHCF fail to make a timely determination. The MCP should revise the policy to address the requirement: If HSCSN or DHCF fails to make a disenrollment determination within the time limit, the disenrollment is considered approved.	▲ HSCSN revised its Change in Enrollee Status/Disenrollment Policy. The MCP addressed the disenrollment approval requirement and demonstrated compliance.
HSCSN's Enrollee Status/Disenrollment Policy included an incorrect time period related to re-enrollment. The MCP should amend its Enrollee Status/Disenrollment Policy to reflect the requirement that it will automatically re-enroll a beneficiary who lost eligibility for a period of two months or less (not three months or less as specified in the policy).	▲ HSCSN updated its Change in Enrollee Status/Disenrollment Policy. The MCP addressed the re-enrollment requirement and demonstrated compliance.
Enrollee Rights and Protections	
HSCSN's Enrollee Rights and Responsibilities Policy did not reference compliance with Federal and State laws as specified in §438.100(d). The MCP should revise its Enrollee Rights and Responsibilities Policy and confirm compliance with Federal and State laws as required in §438.100(d).	▲ HSCSN amended its Enrollee Rights and Responsibilities Policy and referenced compliance with Federal and State laws as specified in §438.100(d).
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. The MCP should revise the 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).	▲ HSCSN revised its Enrollee Rights and Responsibilities Policy. The MCP addressed the requirement to prohibit or restrict a provider, as specified in the regulation, to advise or advocate on behalf of the enrollee/patient requirement and demonstrated compliance.
MCO Standards	
HSCSN's access and availability-related policies and Provider Manual did not reflect accurate and/or complete access requirements. The MCP 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).	▲ HSCSN amended its access and availability-related policies and Provider Manual to reflect accurate and/or complete access requirements.

2020 Recommendation	2021 Assessment
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. The MCP 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 accessibility standards. HSCSN should develop a process for monthly monitoring of corrective action plans and resurveying providers to ensure compliance with HSCSN-established requirements.	▲ HSCSN addressed the provider survey and monitoring recommendations.
HSCSN did not provide evidence of an annual review for its utilization management review criteria. The MCP should ensure its utilization management review criteria is reviewed and approved by its Quality Council (or other relevant medical oversight body) at least annually.	▲ HSCSN addressed the recommendation and provided evidence of an annual review of its utilization management review criteria.
HSCSN did not follow its Vendor Oversight Policy by conducting annual audits of each delegate, nor did it ensure quarterly performance reporting to its Vendor Oversight Committee. The MCP should conduct annual vendor audits and complete quarterly performance reporting as required by its Vendor Oversight Policy.	▲ HSCSN adequately addressed the recommendation by conducting an annual audit of each delegate reporting findings to the Vendor Oversight Committee.
Quality Assessment and Performance Improvement Program	
HSCSN did not provide evidence of consistent subcommittee quarterly reporting to the Quality Management Oversight Committee (QMOC). The MCP should ensure consistent, quarterly subcommittee reporting to the QMOC. This also includes reporting of under and overutilization of services.	● HSCSN demonstrated some improvement. HSCSN reporting demonstrates monitoring of utilization trends. The MCP's QMOC met twice in 2021; however, quarterly reporting on the status of subcommittees' key indicator dashboard performance is not consistently occurring. This opportunity for improvement remains in place and the recommendation continues.
Grievance and Appeal System	

2020 Recommendation	2021 Assessment
A record review demonstrated HSCSN did not consistently follow policy providing timely notice of adverse determinations and timely acknowledgment or resolution of appeals. The review 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 denial to provide expedited appeal resolution. The MCP should ensure compliance in providing timely notice of adverse determinations, acknowledgment 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.	A record review demonstrated HSCSN provided timely notice of adverse determinations but did not consistently demonstrate compliance with providing timely written acknowledgment of an appeal or oral and written resolution notice for expedited appeal requests.
HSCSN's Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy did not specify the MCP informs the enrollee of the limited time available to present evidence and testimony and make legal and factual arguments prior to standard or extended appeal resolution. The MCP should amend its policy to state the MCP informs the enrollee of the limited time available to present evidence and testimony and make legal and factual arguments prior to standard or extended appeal resolution.	HSCSN amended its Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy to reflect that it informs the enrollee of the limited time available to present evidence and testimony and make legal and factual arguments prior to standard or extended appeal resolution.
HSCSN's Provider Manual did not include a grievance resolution timeframe. The MCP should update its Provider Manual and specify a 90-day grievance resolution notification timeframe.	HSCSN updated its Provider Manual to correctly define the grievance resolution timeframe of 90 days.
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. The MCP should amend its 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.	HSCSN amended its Appeal of Adverse Benefit Determinations (Non-Certification Decisions) Policy and requires the MCP to authorize or provide disputed services no later than 72 hours from the date it receives notice reversing the determination.
NETWORK ADEQUACY VALIDATION	
HSCSN received compliance ratings ranging from 71%-83% for timely access to adult routine and urgent appointments and pediatric routine appointments. The MCP should follow up with noncompliant providers and provide education and require corrective actions, as necessary.	Compliance in obtaining timely routine appointments with adult PCPs increased to 100%. The opportunity for improvement remains and the recommendation continues for urgent appointments with adult PCPs (60%) and routine appointments with pediatric PCPs (76%).

2020 Recommendation	2021 Assessment
HSCSN received a score of 35% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	HSCSN's overall accuracy of its provider directory increased (46% in 2021); however, there is additional opportunity for improvement. The recommendation continues.

MFC

MFC adequately addressed 21 of 23 recommendations, demonstrating a 91% compliance rating. Figure 25 illustrates the compliance rating, which demonstrates the percentage of recommendations closed out during the review. Table 36 provides details of the 2021 assessment.

Figure 25. Assessment Outcome for MFC 2020 Recommendations

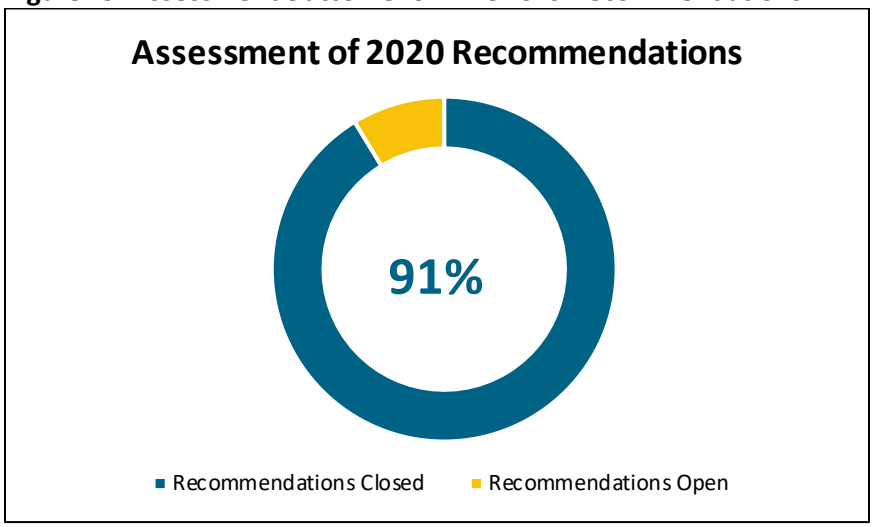


Table 36. Assessment of MFC's Previous Annual Recommendations

2020 Recommendation	2021 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Comprehensive Diabetes Care PIP	
Due to MFC's contract start date of October 1, 2020, the MCP did not submit a PIP report in 2020.	
Maternal Health PIP	
Due to MFC's contract start date of October 1, 2020, the MCP did not submit a PIP report in 2020.	
PERFORMANCE MEASURE VALIDATION	
PIP Performance Measures	
Due to MFC's contract start date of October 1, 2020, a PMV audit of PIP PMs was not conducted.	
EPSDT Performance Measures	
There were no formal 2020 recommendations for MFC's information system readiness review.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
MFC's Enrollee Materials Policy stated the Enrollee Handbook will include cost sharing, if any. DHCF prohibits cost sharing. The MCP should revise its Enrollee Materials Policy and state it does not impose cost sharing.	MFC did not update its Enrollee Materials Policy to state it does not impose cost sharing. This opportunity for improvement remains in place and the recommendation continues.

2020 Recommendation	2021 Assessment
MFC's Enrollee Handbook specified incorrect requirements for timely filing of a grievance, appeal, and fair hearing. The MC should correct its Enrollee Handbook and state grievances may be filed at any time (not within 90 days of the 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).	MFC updated its Enrollee Handbook to reflect correct timely filing deadlines for a grievance, appeal, and fair hearing.
MFC's Enrollee Materials Policy did not specify the Provider Directory is available in paper form, upon request. The MCP should revise its Enrollee Materials Policy and state the Provider Directory is available in paper form, upon request.	MFC amended its Enrollee Materials Policy regarding Provider Directory availability in paper form.
MFC's Provider Directory did not include behavioral health providers. The MCP should update its web-based and paper copy provider directories and include behavioral health providers.	MFC addressed recommendations for inclusion of behavioral health providers.
MFC did not have a machine-readable provider directory or formulary drug list available on its website. The MCP should post a machine-readable provider directory and formulary drug list on its website.	MFC posted a machine-readable provider directory and formulary drug list on its website.
Disenrollment Requirements and Limitations	
MFC did not communicate the disenrollment process, for cause and without cause, within the Enrollee Handbook. The MCP should revise the Enrollee Handbook to inform the enrollee of the disenrollment process and include contact information and a telephone number.	MFC updated its Enrollee Handbook to inform the enrollee of the disenrollment process and included contact information.
MFC's Disenrollment of Enrollees Policy did not include the enrollee moving out of the MCP's service area as a cause for disenrollment. The MCP should amend its Disenrollment of Enrollees Policy and include the disenrollment for cause reason of moving out of the MCP's service area.	MFC amended its Disenrollment of Enrollees Policy to specify moving out of the MCP's service area as a cause for disenrollment.
Enrollee Rights and Protections	
MFC 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. The MCP 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.	MFC updated its Enrollee Rights and Responsibilities Policy and explains MFC enrollees have the right to exercise their rights, and that exercising those rights, does not adversely affect the way MFC, MFC providers, or DHCF treats enrollees.
MCO Standards	

2020 Recommendation	2021 Assessment
MFC's Geographical Access and Adequacy of Provider Network Policy did not include requirements to submit documentation to the State. The MCP 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.	MFC addressed the recommendation and amended its Geographical Access and Adequacy of Provider Network Policy to specify documentation submission requirements.
MFC did not identify a timeframe for conducting health risk assessments within its Health Risk Assessment for New Enrollees Policy. The MCP should specify the MCP will conduct health risk assessments within 90 days of enrollment within its Health Risk Assessment for New Enrollees Policy.	MFC revised its Health Risk Assessment for New Enrollees Policy and specified the MCP will conduct health risk assessments within 90 days of enrollment.
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. The MCP 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.	MFC amended its Utilization Management Criteria Policy and stated 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.
MFC's delegation agreements did not include all required components. The MCP should update its delegation agreements and specify inspection and audit parameters including requirements of §438.230(c)(3)(i)(ii)(iii)(iv).	MFC did not provide evidence of fully executed agreements/amendments for all delegated agencies with the revised language. This opportunity for improvement remains in place and the recommendation continues.
Quality Assessment and Performance Improvement Program	
There were no formal 2020 recommendations for MFC.	
Grievance and Appeal System	
MFC did not address the deemed exhaustion of the appeal process in its Enrollee Appeals Policy. The MCP should revise its policy and assert if MFC 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.	MFC amended its Enrollee Appeals Policy and stated if MFC 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.
MFC's Enrollee Grievances, Complaints, and Inquiries Policy included multiple grievance categories and procedures for each, including exceptions for sending written acknowledgments. The MCP should revise its policy to eliminate exceptions for sending written acknowledgments. There are no separate categories of grievances per the MCP contract.	MFC revised its Enrollee Grievances, Complaints, and Inquiries Policy to eliminate exceptions for sending written acknowledgments.

2020 Recommendation	2021 Assessment
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. MFC should amend its policy to inform enrollees of their limited time to present evidence and testimony and make legal and factual arguments for standard and extended appeals.	MFC amended its Enrollee Appeals Policy to 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.
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. 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.	MFC updated documents to reflect the 90-day grievance resolution timeframe.
MFC's Provider Manual communicated incorrect appeal resolution notice timeframes. The MCP 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).	MFC amended its Provider Manual and communicated the correct appeal resolution notice timeframes.
MFC's Enrollee Handbook and Provider Manual did not accurately reflect the expedited resolution of appeals timelines. The MCP should update documents to include expedited resolution notice within 72 hours (not 3 calendar days).	MFC amended its Enrollee Handbook and Provider Manual to accurately reflect resolution timeframes for expedited resolution.
MFC's Enrollee Grievances, Complaints, and Inquiries Policy did not address grievance resolution consistent with §438.10. The MCP should revise its policy and require the MCP to comply with grievance resolution consistent with §438.10 and specify the requirements.	MFC revised its Enrollee Grievances, Complaints, and Inquiries Policy to address grievance resolution consistent with §438.10.
MFC's Enrollee Appeals Policy specified its appeal resolution notice is compliant with §438.10 but does not explain the requirements. The MCP should amend its Enrollee Appeals Policy and explain §438.10 requirements.	MFC updated its Appeals Policy to explain §438.10 requirements.
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. 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.	MFC amended its Provider Manual to explain the MCP will not take any punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal.

2020 Recommendation	2021 Assessment
MFC did not specify in its Enrollee Appeals Policy, the enrollee requirement to timely file an appeal when continuing benefits during the appeal process. The MCP should update its policy to include the requirement, for the continuation of benefits, the enrollee must timely file an appeal.	MFC amended its Enrollee Appeals Policy to specify the requirement, for the continuation of benefits, the enrollee must timely file an appeal.
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. The MCP 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.	MFC revised its Enrollee Appeal and Fair Hearing Process policies to state the enrollee withdrawing the request for a fair hearing as a reason for discontinuing benefits.
NETWORK ADEQUACY VALIDATION	
Due to MFC's contract start date of October 1, 2020, the NAV activity was not conducted.	

State Recommendations

Quality Strategy Goals

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 drafted its *Medicaid Managed Care Quality Strategy*.[14] Table 37 identifies quality strategy goals, using the Institute for Healthcare Improvement Triple Aim framework.

Table 37. 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

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

Evaluating and Holding MCPs Accountable for Quality Performance

DHCF evaluates MCP progress in meeting quality strategy goals through:

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

DHCF also holds MCPs accountable through procedures outlined in its *Managed Care Program Quality Management Manual*. The manual describes MCP performance expectations and required follow-up corrective actions. Based on performance, and whether the occurrence is first time or repeated, DHCF may issue a non-compliance warning letter, require a CAP or enhanced monitoring, and/or sanction the noncompliant MCP. As demonstrated in Tables 33-36, which evaluated compliance with previous annual recommendations, this strategy has largely proven its effectiveness.

DHCF has also implemented a Managed Care Program Accountability Set, which uses select industry-standard quality performance measures to hold MCPs accountable for their performance and to drive quality improvement. This newly established program (October 1, 2021) uses a minimum performance level (MPL) and high performance level (HPL) benchmarks to evaluate MCP performance. MCPs must meet the MPL for measures established by DHCF. MCPs failing to meet the MPLs for select measures may have to submit an improvement plan; receive a warning letter, which may require a CAP; or accept and comply with other corrective actions, such as quarterly reporting using a rapid-cycle quality improvement process, enhanced monitoring, and/or additional technical assistance sessions. MCPs meeting or exceeding HPL benchmarks will receive public recognition.[15]

Recommendations on How DHCF Can Target Quality Strategy Goals and Objectives

The intent of the Medicaid Managed Care Quality Strategy is to provide an overarching framework for DHCF to drive quality and performance improvement among its contracted MCPs, with the ultimate goal of improving health outcomes for its enrollees. While MCPs are committed to quality and have developed strategies to demonstrate improvement, they are all in a position in which there is an opportunity to close gaps in care and quality. An analysis of HEDIS and CAHPS survey measures included in Appendix A1 and A2, respectively, demonstrate MCP averages fall short of meeting national average benchmarks in many measures relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care. Figures 26 and 27 illustrate the MCP averages performed better than national average benchmarks in 35% of select HEDIS measures and 35% of CAHPS survey measures. This demonstrates the MCP averages fell short of the national average benchmarks in most measures and signifies an opportunity for improvement.

[15] Due to the COVID-19 public health emergency and its impact on utilization, and subsequent Managed Care Program Accountability Set performance measures, DHCF has delayed the collection of baseline performance and establishment of benchmarks. DHCF continues to monitor the public health emergency and will resume the program under reasonable conditions.

Figure 26. MY 2020 HEDIS MCP Average Performance Compared to National Average Benchmarks

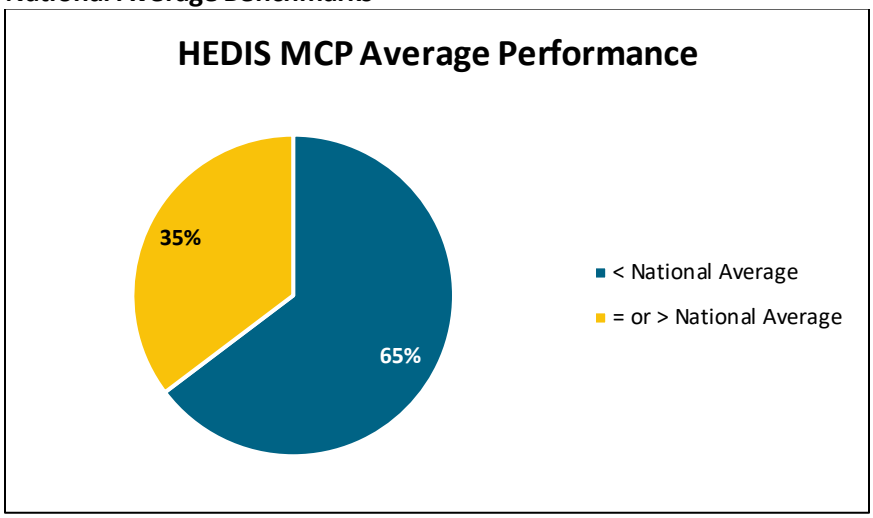
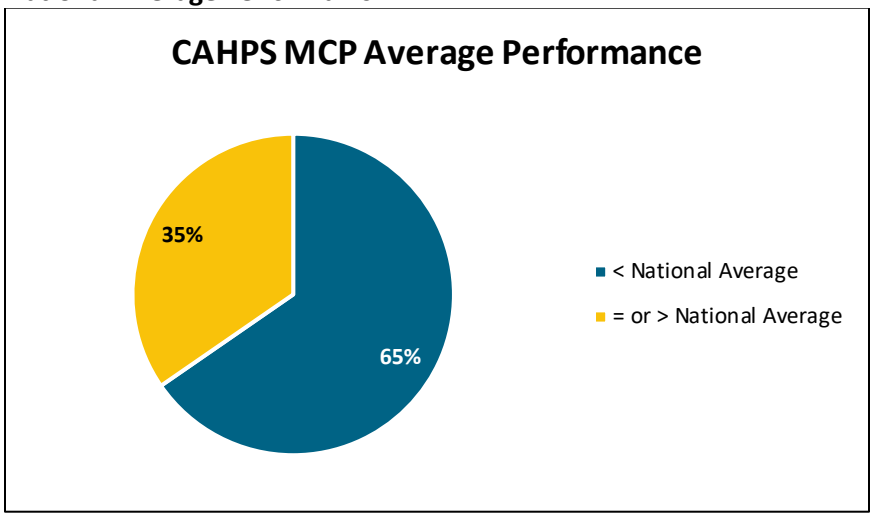


Figure 27. MY 2020 CAHPS MCP Average Performance Compared to National Average Benchmarks



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

After the MCPs report MY 2021 performance in 2022 for the Comprehensive Diabetes Care PIP, they will have reported four years of remeasurement results. ***Qlarant recommends*** DHCF close out the Comprehensive Diabetes Care PIP and implement a replacement PIP targeting Goal 2, which includes improving comprehensive behavioral health services. An example of a PIP targeting this goal and objective includes Improving Mental Health by targeting Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up After Hospitalization for Mental Illness measures.

The MCPs are required to conduct an initial screening of each enrollee's physical, behavioral, and social needs upon enrollment. Barriers exist to obtaining this critical information from enrollees, which can

negatively impact care coordination and management. ***Qlarant recommends*** DHCF establish targets for the MCPs to complete initial screenings within 30, 60, and 90 days. MCPs should make multiple attempts to obtain and complete these screenings, which provide valuable information including identification of risk factors such as social determinants of health (SDoH), chronic conditions, substance use, mental health disorders, and other health and safety issues. If MCPs improve compliance in completing these screenings, they can potentially achieve improvements related to Goals 1-3 by ensuring access to quality, whole-person care; improving the management of chronic conditions; and improving population health.

As previously stated, Qlarant reports on key measures from the CAHPS experience of care survey in Appendix A2. The MCPs met or exceeded the national average benchmarks in only 35% of the reported measures. ***Qlarant recommends*** DHCF review CAHPS survey performance and identify one or more measures for the MCPs to target and direct strategies to improve performance. For example, Qlarant recommends MCPs aim to improve performance in the Coordination of Care measure. Improved care coordination can target Goal 1 through multiple objectives including promoting effective communication between patients and their care providers and supporting appropriate case management and care coordination.

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

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

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

DHCF aims to move more fee-for-service (FFS) Medicaid beneficiaries into the Medicaid managed care program. The *District of Columbia Medicaid Managed Care Quality Strategy* reports FFS coverage costs up to five times more compared to beneficiaries enrolled in managed care. This additional expenditure is due to substantially higher rates of emergency department utilization, hospital admissions, and inpatient stays. ***Qlarant recommends*** DHCF continue to move FFS Medicaid beneficiaries into the District's managed care program, where enrollee care is managed through coordinated efforts and enrollee education is provided to improve self-management and enhance the utilization of their primary care provider or medical home. This strategy also targets all four Quality Strategy goals; provides a more organized, accountable, and person-centered environment; and aims to improve health outcomes.

DHCF is expanding behavioral health services in its Medicaid managed care program. ***Qlarant recommends*** DHCF identify specific behavioral health performance measures, monitor baseline performance, and set targets that drive performance improvement. Consider incorporating such measures into the Managed Care Program Accountability Set. This recommendation supports Goals 1 and 2 and their respective objectives of addressing behavioral health comorbidities and improving comprehensive behavioral health services.

DHCF is holding MCPs accountable as previously described by way of procedures outlined in its *Managed Care Program Quality Management Manual*. This strategy appears to make an impact. The 2021 EQR activities found MCPs fully addressed the majority of recommendations made in 2020—ACDC: 82%, CFDC: 80%, HSCSN: 76%, and MFC: 91%. This represents an improvement compared to the previous annual assessment. ***Qlarant recommends*** DHCF continue to hold MCPs responsible for performance and require corrective actions. These improvements influence performance and advancements in meeting Goals 1-3.

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

Conclusion

As DC's contracted EQRO, Qlarant evaluated DHCF's managed care programs, DCHFP and CASSIP, to assess compliance with federal and DC-specific requirements. Review and validation activities occurred over the course of 2021 and assessed MY 2020 and MY 2021 performance, as applicable. Qlarant evaluated each participating MCP and found:

- For the Comprehensive Diabetes Care PIP, MCPs reported their third remeasurement results. Overall, there is a moderate level of confidence in MCP PIP reported activities and findings. An analysis of the MCP weighted averages concluded performance was lower (or worse) than baseline performance for all diabetes-related measures. Worse performance appears to be the result of COVID-19 public health emergency barriers to care. MCPs should continue to develop strategies to engage enrollees in care during the pandemic.
- For the Maternal Health PIP, MCPs reported their first remeasurement results. Overall, there is a moderate level of confidence in MCP PIP reported activities and findings. Most interventions focused on the early identification of pregnant enrollees and attempts to engage them in appropriate prenatal and postpartum care. These efforts contributed to success in achieving improvement in the Timeliness of Prenatal Care measure (80% to 84%).
- 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 2021 weighted OSR score was 98%, which demonstrates improvement compared to the previous two OSRs. All MCPs were required to complete CAPs, most of which related to the Grievance and Appeal System Standard.

- MCPs have robust PCP networks demonstrating at least 99% compliance with geographic and provider-to-enrollee requirements. MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 39% to 100% for 2021. Adult and pediatric timely access to urgent appointments declined significantly from 2020 to 2021 (16 and 28 percentage points, respectively), providing an opportunity to improve access to timely appointments. MCPs should also improve the accuracy of their provider directories.
- A medical record review, for the EDV activity, determined an overall high level of encounter data accuracy. The MCP overall weighted average was 95%, which exceeded the DHCF established target of 90% for the first annual EDV study.
- All MCPs demonstrated strengths and weaknesses in the areas of quality, access, and timeliness. MCPs should address specific recommendations made to improve performance in these areas.
- All four MCPs addressed most of their previous annual recommendations, which improved compliance.
- DHCF continues to strive to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services through its managed care programs. DHCF's *Medicaid Managed Care Quality Strategy* provides a framework to achieve improvements and ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care. DHCF is holding MCPs accountable with its quality improvement approach defined in its *Managed Care Program Quality Management Manual*.
- DHCF should consider implementing Qlarant's recommendations, which if acted upon, may improve processes and close gaps in care and quality. Recommendations describe how DHCF can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to DC managed care enrollees.

Appendix A1 - HEDIS® Measures Collected and Reported to NCQA

The HEDIS performance measure tables include select 2021 (MY 2020) results for each managed care plan (MCP). The tables also display MCP weighted averages 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 MCP Weighted Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The MCP Weighted Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦ ♦
The MCP Weighted Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦ ♦ ♦

Effectiveness of Care Domain

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	46.51%	22.73%	54.55%	44.51%	♦
Antidepressant Medication Management - Effective Acute Phase Treatment	48.79%	38.02%	35.48%	46.98%	♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	31.30%	24.33%	22.58%	30.12%	♦
Appropriate Testing for Children with Pharyngitis - 3-17 Yrs	89.34%	45.23%	90.14%	83.18%	♦ ♦
Appropriate Testing for Children with Pharyngitis - 18-64 Yrs	67.53%	50.00%	45.16%	64.76%	♦ ♦
Appropriate Testing for Children with Pharyngitis - 65+ Yrs	NA	NA	NA	NA	NC
Appropriate Testing for Children with Pharyngitis - Total	77.53%	47.69%	76.47%	73.42%	♦
Appropriate Treatment for Upper Respiratory Infection (3 months-17 Yrs)	97.57%	97.88%	96.86%	97.59%	♦ ♦ ♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Appropriate Treatment for Upper Respiratory Infection (18-64 Yrs)	85.82%	88.74%	90.67%	86.36%	♦ ♦ ♦
Appropriate Treatment for Upper Respiratory Infection (65+ Yrs)	NA	NA	NA	NA	NC
Appropriate Treatment for Upper Respiratory Infection (Total)	93.62%	95.16%	95.91%	93.97%	♦ ♦ ♦
Asthma Medication Ratio (5-11 Yrs)	67.46%	61.76%	81.43%	70.92%	♦
Asthma Medication Ratio (12-18 Yrs)	54.15%	57.14%	81.08%	62.17%	♦
Asthma Medication Ratio (19-50 Yrs)	49.51%	52.17%	77.08%	51.91%	♦
Asthma Medication Ratio (51-64 Yrs)	51.22%	37.50%	0.00%	50.23%	♦
Asthma Medication Ratio (Total)	55.31%	53.64%	80.60%	59.63%	♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 months-17 Yrs)	92.84%	94.17%	93.94%	93.07%	♦ ♦ ♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64 Yrs)	53.83%	52.63%	100.00%	53.95%	♦ ♦ ♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+ Yrs)	NA	NA	NA	NA	NC
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	76.19%	75.93%	94.59%	76.63%	♦ ♦ ♦
Breast Cancer Screening	60.79%	38.31%	NA	58.23%	♦ ♦
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	NC
Cervical Cancer Screening	62.53%	44.04%	56.80%	59.94%	♦ ♦
Childhood Immunization Status - Combination 2	70.32%	60.83%	75.29%	68.90%	♦
Childhood Immunization Status - Combination 3	66.42%	58.88%	74.12%	65.41%	♦
Childhood Immunization Status - Combination 4	65.45%	58.15%	74.12%	64.51%	♦
Childhood Immunization Status - Combination 5	55.23%	51.09%	51.76%	54.44%	♦
Childhood Immunization Status - Combination 6	43.07%	38.20%	48.24%	42.42%	♦
Childhood Immunization Status - Combination 7	54.26%	50.36%	51.76%	53.54%	♦
Childhood Immunization Status - Combination 8	42.82%	37.96%	48.24%	42.18%	♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Childhood Immunization Status - Combination 9	37.71%	33.58%	29.41%	36.77%	♦
Childhood Immunization Status - Combination 10	37.47%	33.33%	29.41%	36.54%	♦
Childhood Immunization Status - DTaP	73.24%	63.02%	80.00%	71.76%	♦
Childhood Immunization Status - Hepatitis A	82.48%	78.59%	89.41%	82.05%	♦
Childhood Immunization Status - Hepatitis B	85.64%	81.27%	84.71%	84.89%	♦
Childhood Immunization Status - HiB	83.70%	75.91%	87.06%	82.52%	♦
Childhood Immunization Status - Influenza	46.72%	46.47%	57.65%	47.01%	♦
Childhood Immunization Status - IPV	85.64%	81.02%	90.59%	85.03%	♦
Childhood Immunization Status - MMR	83.21%	79.81%	88.24%	82.80%	♦
Childhood Immunization Status - Pneumococcal Conjugate	73.97%	65.94%	78.82%	72.79%	♦
Childhood Immunization Status - Rotavirus	63.26%	60.58%	58.82%	62.68%	♦
Childhood Immunization Status - VZV	82.24%	79.32%	89.41%	81.98%	♦
Chlamydia Screening in Women (16-20 Yrs)	72.96%	59.26%	76.02%	72.40%	♦ ♦ ♦
Chlamydia Screening in Women (21-24 Yrs)	77.89%	74.29%	78.47%	77.67%	♦ ♦ ♦
Chlamydia Screening in Women (Total)	75.26%	66.67%	77.06%	74.85%	♦ ♦ ♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	47.20%	42.47%	55.56%	46.76%	♦
Comprehensive Diabetes Care - Eye Exams	54.74%	36.14%	50.00%	52.54%	♦ ♦
Comprehensive Diabetes Care - HbA1c Testing	81.51%	73.80%	83.33%	80.64%	♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	49.39%	37.95%	38.89%	47.94%	♦ ♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) *(Lower is Better)*	44.77%	53.01%	55.56%	45.86%	♦ ♦ ♦
Controlling High Blood Pressure	45.26%	45.26%	66.67%	45.37%	♦
Diabetes Monitoring for People with Diabetes and Schizophrenia	53.85%	12.50%	100.00%	47.22%	♦
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	68.56%	37.10%	72.55%	65.50%	♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (13-17 Yrs)	NB	NA	NA	NA	NC

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (18+ Yrs)	NB	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (Total)	NB	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (13-17 Yrs)	NB	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (18+ Yrs)	NB	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (Total)	NB	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (6-17 Yrs)	40.24%	30.00%	50.00%	41.55%	♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (18-64 Yrs)	28.07%	19.39%	7.69%	24.11%	♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (Total)	32.02%	21.19%	39.62%	29.95%	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (6-17 Yrs)	58.54%	50.00%	60.00%	57.75%	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (18-64 Yrs)	38.60%	29.59%	15.38%	34.40%	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (Total)	45.06%	33.05%	49.06%	42.22%	♦
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (13-17 Yrs)	NA	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (18-64 Yrs)	NB	NA	NA	NA	NC

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (65+ Yrs)	NB	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (Total)	NB	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (13-17 Yrs)	NB	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (18-64 Yrs)	NB	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (65+ Yrs)	NB	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (Total)	NB	NA	NA	NA	NC
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (6-17 Yrs)	39.66%	40.91%	27.50%	37.08%	♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (18-64 Yrs)	46.02%	15.35%	15.15%	35.36%	♦ ♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (Total)	44.85%	17.42%	21.92%	35.64%	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (6-17 Yrs)	59.48%	72.73%	42.50%	57.30%	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (18-64 Yrs)	60.58%	26.14%	36.36%	49.05%	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (65+ Yrs)	0.00%	0.00%	0.00%	NA	NC
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (Total)	60.38%	29.92%	39.73%	50.52%	♦
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	42.82%	34.55%	45.28%	42.46%	♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	56.67%	28.57%	53.85%	52.00%	♦
Immunizations for Adolescents - Combination 1	79.81%	76.16%	89.24%	80.01%	♦ ♦
Immunizations for Adolescents - Combination 2	48.18%	44.04%	62.33%	48.70%	♦ ♦ ♦
Immunizations for Adolescents - HPV	49.64%	47.45%	63.68%	50.49%	♦ ♦ ♦
Immunizations for Adolescents - Meningococcal	81.51%	79.32%	91.03%	81.97%	♦ ♦
Immunizations for Adolescents - Tdap/Td	83.21%	78.83%	90.58%	83.10%	♦
Kidney Health Evaluation for Patients With Diabetes (18-64 Yrs)*	39.65%	38.41%	39.47%	39.50%	♦ ♦ ♦
Kidney Health Evaluation for Patients With Diabetes (65-74 Yrs)*	53.85%	NA	NA	50.00%	♦ ♦ ♦
Kidney Health Evaluation for Patients With Diabetes (75-85 Yrs)*	0.00%	0.00%	0.00%	0.00%	♦ ♦ ♦
Kidney Health Evaluation for Patients With Diabetes (Total)*	39.72%	38.30%	39.47%	39.55%	♦ ♦ ♦
Lead Screening in Children	82.48%	73.97%	87.06%	81.21%	♦ ♦ ♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11 Yrs)	34.48%	0.00%	35.90%	34.29%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17 Yrs)	43.90%	0.00%	46.94%	45.07%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	40.00%	0.00%	43.80%	41.51%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11 Yrs)	34.48%	0.00%	33.33%	32.86%	♦ ♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17 Yrs)	34.15%	0.00%	32.65%	32.39%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	34.29%	0.00%	32.85%	32.55%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11 Yrs)	27.59%	0.00%	20.51%	22.86%	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17 Yrs)	29.27%	0.00%	30.61%	29.58%	♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	28.57%	0.00%	27.74%	27.36%	♦
Non-Recommended Cervical Cancer Screening in Adolescent Females *(Lower is Better)*	0.26%	0.00%	0.00%	0.21%	♦
Persistence of Beta-Blocker Treatment after a Heart Attack	75.76%	75.00%	NA	75.61%	♦
Pharmacotherapy for Opioid Use Disorder (16-64 Yrs)	23.56%	26.09%	50.00%	24.49%	♦
Pharmacotherapy for Opioid Use Disorder (65+ Yrs)	NA	NA	NA	NA	NC
Pharmacotherapy for Opioid Use Disorder (Total)	23.56%	25.71%	50.00%	24.39%	♦
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	92.97%	68.42%	NR	88.79%	♦ ♦ ♦
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	72.43%	60.53%	NR	70.40%	♦ ♦
Risk of Continued Opioid Use ≥ 15 Days (18 -64 Yrs) *(Lower is Better)*	3.85%	1.62%	1.09%	3.45%	♦
Risk of Continued Opioid Use ≥ 15 Days (65 Yrs) *(Lower is Better)*	0.00%	0.00%	0.00%	NA	NC
Risk of Continued Opioid Use ≥ 15 Days (Total) *(Lower is Better)*	3.85%	1.62%	1.09%	3.45%	♦
Risk of Continued Opioid Use ≥ 31 Days (18 -64 Yrs) *(Lower is Better)*	1.87%	0.43%	1.09%	1.63%	♦
Risk of Continued Opioid Use ≥ 31 Days (65 Yrs) *(Lower is Better)*	0.00%	0.00%	0.00%	NA	NC
Risk of Continued Opioid Use ≥ 31 Days (Total) *(Lower is Better)*	1.87%	0.43%	1.09%	1.63%	♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	75.38%	100.00%	NA	78.67%	♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	84.51%	0.00%	NA	83.33%	♦ ♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	80.15%	90.91%	NA	80.95%	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	71.43%	60.00%	NA	69.49%	♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	55.00%	0.00%	NA	55.00%	♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	62.39%	60.00%	NA	62.18%	♦
Statin Therapy for Patients With Diabetes - Received Statin Therapy	66.56%	67.01%	NA	66.61%	♦ ♦
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	65.65%	51.52%	NA	64.06%	♦
Use of Imaging Studies for Low Back Pain	87.38%	90.34%	82.61%	87.77%	♦ ♦ ♦
Use of Opioids at High Dosage *(Lower is Better)*	1.29%	0.00%	0.00%	1.21%	♦
Use of Opioids From Multiple Providers - Multiple Pharmacies *(Lower is Better)*	5.79%	0.00%	11.11%	5.61%	♦ ♦ ♦
Use of Opioids From Multiple Providers - Multiple Prescribers *(Lower is Better)*	24.57%	27.59%	55.56%	25.11%	♦ ♦ ♦
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies *(Lower is Better)*	2.82%	0.00%	0.00%	2.66%	♦ ♦ ♦
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	21.95%	20.00%	NA	21.74%	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (3-11 Yrs)	68.15%	73.97%	69.67%	69.11%	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (12-17 Yrs)	70.21%	78.90%	77.84%	72.16%	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	68.86%	75.31%	72.99%	70.18%	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Yrs)	73.33%	74.32%	77.46%	74.00%	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Yrs)	74.47%	85.32%	75.45%	75.57%	♦ ♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	73.72%	77.31%	76.64%	74.54%	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Yrs)	71.85%	73.29%	71.72%	72.02%	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Yrs)	74.47%	86.24%	71.26%	74.99%	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	72.75%	76.81%	71.53%	73.04%	♦ ♦ ♦

* New Measure introduced in MY 2020
NA - Small Denominator; the organization followed specifications, but the denominator was too small (e.g., <30) to report a valid rate
NB - No Benefit
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NR - Not Reported

Access and Availability Domain

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Adults' Access to Preventive/Ambulatory Health Services (20-44 Yrs)	72.64%	47.24%	79.42%	68.39%	♦
Adults' Access to Preventive/Ambulatory Health Services (45-64 Yrs)	82.32%	57.01%	NA	78.05%	♦
Adults' Access to Preventive/Ambulatory Health Services (65+ Yrs)	88.89%	60.00%	NA	86.00%	♦ ♦
Adults' Access to Preventive/Ambulatory Health Services (Total)	75.90%	50.25%	79.42%	71.50%	♦
Annual Dental Visit (2-3 Yrs)	42.30%	39.04%	36.67%	41.40%	♦ ♦ ♦
Annual Dental Visit (4-6 Yrs)	53.64%	44.30%	47.86%	51.50%	♦ ♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Annual Dental Visit (7-10 Yrs)	55.79%	49.21%	47.19%	53.73%	♦ ♦
Annual Dental Visit (11-14 Yrs)	58.85%	46.34%	52.01%	56.34%	♦ ♦
Annual Dental Visit (15-18 Yrs)	56.40%	37.56%	47.96%	53.35%	♦ ♦ ♦
Annual Dental Visit (19-20 Yrs)	41.46%	32.88%	43.65%	40.97%	♦ ♦ ♦
Annual Dental Visit (Total)	53.57%	43.82%	47.64%	51.52%	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NB	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+ Yrs)	NB	41.36%	NA	41.10%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	NB	41.36%	NA	40.73%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NB	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+ Yrs)	NB	52.56%	33.33%	51.85%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	NB	52.56%	33.33%	51.85%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	NB	33.33%	22.22%	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+ Yrs)	NB	32.81%	33.33%	32.84%	♦

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	NB	32.82%	29.63%	32.61%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17 Yrs)	NB	33.33%	18.18%	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+ Yrs)	NB	36.01%	31.82%	35.89%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	NB	35.99%	27.27%	35.61%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NB	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+ Yrs)	NB	4.63%	NA	4.60%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	NB	4.63%	NA	4.56%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NB	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18 + Yrs)	NB	15.38%	33.33%	16.05%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	NB	15.38%	33.33%	16.05%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	NB	NA	NA	NA	NC

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+ Yrs)	NB	3.13%	5.56%	3.23%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	NB	3.08%	3.70%	3.12%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17 Yrs)	NB	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+ Yrs)	NB	4.99%	9.09%	5.11%	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	NB	4.95%	6.06%	4.99%	♦
Prenatal and Postpartum Care - Timeliness of Prenatal Care	84.91%	76.92%	76.19%	83.76%	♦
Prenatal and Postpartum Care - Postpartum Care	73.97%	69.66%	66.67%	73.29%	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11 Yrs)	34.78%	50.00%	33.33%	37.14%	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Yrs)	37.84%	28.57%	48.48%	41.56%	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	36.67%	38.46%	46.15%	40.18%	♦

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Utilization Domain

HEDIS Performance Measures	ACDC	CFDC	HSCSN	MCP Weighted Average	Comparison to Benchmarks
Child and Adolescent Well-Care Visits (3-11 Yrs)*	59.04%	46.65%	64.36%	57.70%	♦ ♦
Child and Adolescent Well-Care Visits (12-17 Yrs)*	58.88%	45.51%	59.60%	57.56%	♦ ♦ ♦
Child and Adolescent Well-Care Visits (18-21 Yrs)*	36.56%	26.76%	46.11%	37.21%	♦ ♦ ♦
Child and Adolescent Well-Care Visits (Total)*	55.47%	44.01%	59.02%	54.44%	♦ ♦ ♦
Well-Child Visits in the First 30 Months of Life (0-15 Months)*	44.52%	38.38%	37.78%	43.38%	♦
Well-Child Visits in the First 30 Months of Life (15-30 Months)*	70.39%	58.23%	73.26%	68.06%	♦

* New Measure introduced in MY 2020

NA - Small Denominator; the organization followed specifications, but the denominator was too small (e.g., <30) to report a valid rate

NB - No Benefit

NC - No Comparison (no benchmark available)

NR - Not Reported

Appendix A2 - CAHPS®

The CAHPS® survey measure tables include 2021 (MY 2020) 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 %	CFDC %	HSCSN %	MCP Average %	Comparison to Benchmarks
Getting Care Quickly Composite (Always+Usually)	76.84	NA	NA	76.84	♦
Getting Needed Care Composite (Always+Usually)	81.75	NA	78.39	80.07	♦
How Well Doctors Communicate Composite (Always+Usually)	92.67	92.08	91.40	92.05	♦ ♦ ♦
Customer Service Composite (Always+Usually)	91.29	85.60	91.51	89.47	♦
Coordination of Care Composite (Always+Usually)	82.80	NA	NA	82.80	♦
Rating of All Health Care (8+9+10)	77.21	76.23	77.24	76.89	♦
Rating of Personal Doctor (8+9+10)	86.79	82.43	83.07	84.10	♦ ♦
Rating of Specialist Seen Most often (8+9+10)	85.64	NA	NA	85.64	♦ ♦
Rating of Health Plan (8+9+10)	82.60	72.89	76.51	77.33	♦
Flu measure - Had flu shot or spray in the nose since July 1, 2020	39.90	39.04	31.76	36.90	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	78.18	75.80	NA	76.99	♦ ♦

Adult CAHPS Survey Measures	ACDC %	CFDC %	HSCSN %	MCP Average %	Comparison to Benchmarks
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	54.88	50.64	NA	52.76	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	46.99	49.68	NA	48.34	♦ ♦

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 %	CFDC %	HSCSN %	MCP Average %	Comparison to Benchmarks
Child Survey - General Population: Getting Care Quickly Composite (Always+Usually)	NA	NA	88.17	88.17	♦ ♦
Child Survey - General Population: Getting Needed Care Composite (Always+Usually)	NA	NA	85.35	85.35	♦
Child Survey - General Population: How Well Doctors Communicate Composite (Always+Usually)	89.04	NA	92.50	90.77	♦
Child Survey - General Population: Customer Service Composite (Always+Usually)	NA	NA	90.83	90.83	♦ ♦ ♦
Child Survey - General Population: Coordination of Care Composite (Always+Usually)	NA	NA	91.35	91.35	♦ ♦ ♦
Child Survey - General Population: Rating of All Health Care (8+9+10)	87.70	NA	87.55	87.63	♦
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	92.35	NA	91.32	91.84	♦ ♦
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	NA	NA	85.95	85.95	♦

Child CAHPS Survey Measures	ACDC %	CFDC %	HSCSN %	MCP Average %	Comparison to Benchmarks
Child Survey - General Population: Rating of Health Plan (8+9+10)	87.44	82.69	83.58	84.57	♦

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 %	CFDC %	HSCSN %	MCP Average %	Comparison to Benchmarks
Child Survey - CCC Population: Family Centered Care: Getting Needed Information Child Survey (Always+Usually)	NA	NA	89.90	89.90	♦
Child Survey - CCC Population: Access to Prescription Medicines	NA	NA	88.21	88.21	♦
Child Survey - CCC Population: Coordination of Care for Children With Chronic Conditions	NA	NA	66.03	66.03	♦
Child Survey - CCC Population: Access to Specialized Services (Always+Usually)	NA	NA	90.51	90.51	♦
Child Survey - CCC Population: Family Centered Care - Personal Doctor Who Knows Child	NA	NA	NA	NA	NC

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