GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

MEDICAID MANAGED CARE

QUALITY STRATEGY

2024–2027 Quality Strategy

Glossary of Acronyms

Acronym	Definition	Acronym	Definition
ADA	Americans with Disabilities Act	ED	Emergency Department
Alliance	DC Healthcare Alliance	EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
APM	Alternative Payment Methodology	EQR	External Quality Review
BH	Behavioral Health	EQRO	External Quality Review Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems®	FFS	Fee-For-Service
CASSIP	Child and Adolescent Supplemental Security Income Program	FQHC	Federally Qualified Health Center
CHIP	Children's Health Insurance Program	FY	Fiscal Year
CMS	Centers for Medicare & Medicaid Services	HCBS	Home- and Community-Based Services
CY	Calendar Year	HCDMA	Health Care Delivery Management Administration
DBH	Department of Behavioral Health	HCPRA	Health Care Policy and Research Administration
DC/District	District of Columbia	HCRIA	Health Care Reform and Innovation Administration
DCAS	DC Access System	HEDIS	Healthcare Effectiveness Data and Information Set
DCHFP	District of Columbia Healthy Families Program	HIE	Health Information Exchange
DDCP	District Dual Choice Program	HIT	Health Information Technology
DHCF	Department of Health Care Finance	HPL	High Performance Level
DQHO	Division of Quality and Health Outcomes	HRSN	Health-Related Social Needs
D-SNP	Dual-Eligible Special Needs Plan	HSCSN	Health Services for Children with Special Needs

Acronym	Definition	Acronym	Definition
eCQM	Electronic Clinical Quality Measures	OSR	Operational Systems Review
ICP	Immigrant Children's Program	P4P	Pay-For-Performance
IDD	Intellectual and Developmental Disability	PCP	Primary Care Provider
IDEA	Individuals with Disabilities Education Act	PCR	Plan All-Cause Readmissions
IHI	Institute for Healthcare Improvement	PDSA	Plan-Do-Study-Act
LANE	Low Acuity Non-Emergent	PHE	Public Health Emergency
LARC	Long-Acting Reversible Contraception	PIP	Performance Improvement Project
LTCA	Long-Term Care Administration	PMPM	Per Member Per Month
LTSS	Long-Term Services and Supports	PPA	Potentially Preventable Admission
MADS	Medical Alert Devices and Services	PRTF	Psychiatric Residential Treatment Facility
MCAC	Medical Care Advisory Committee	QAPI	Quality Assessment and Performance Improvement
MCP	Managed Care Plan	SED	Serious Emotional Disturbance
MDW	Medicaid Data Warehouse	SMI	Serious Mental Illness
MMIS	Medicaid Management Information System	SSI	Supplemental Security Income
MPL	Minimum Performance Level	SUD	Substance Use Disorder
MY	Measurement Year	TBD	To Be Determined
NCQA	National Committee for Quality Assurance	TOC	Transition Of Care
NF	Nursing Facility	UM	Utilization Management
NQF	National Quality Forum	VBP	Value-Based Purchasing

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Section 1

Purpose and Scope

Purpose

The Managed Care Quality Strategy is the framework used by the District of Columbia (DC or District) Department of Health Care Finance (DHCF) for guiding the agency's mission to provide comprehensive, cost-effective, and quality healthcare services to District residents with the goal of improving health outcomes. The purpose of the Managed Care Quality Strategy is to:

- Establish a quality improvement program that is aligned with the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy and the Institute for Healthcare Improvement's (IHI) "triple aim" of improving the patient experience of care, improving the health of District residents, and reducing the costs of healthcare.
- Improve Medicaid beneficiary satisfaction with care and services.
- Identify opportunities for improvement in health outcomes of the Medicaid beneficiaries through preventive care services, chronic disease and special needs management, long-term care support, and health promotion.
- Identify opportunities to improve the quality of care and quality of services by implementing interventions aimed at ensuring access to high quality and culturally appropriate care.
- Identify and implement innovative best-practices of care delivery.

Scope

The following are included in the scope of the Quality Strategy:

- All Medicaid and Children's Health Insurance Program (CHIP) managed care beneficiaries in all demographic groups.
- All aspects of care, including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by the District of Columbia Medicaid Managed Care Program.
- All aspects of the Managed Care Plan (MCP) performance related to access to care, quality of care, and quality of service, including provider network adequacy, provider contracting, and credentialing.
- All covered services, including preventive care, primary care, specialty care, ancillary care, emergency services, chronic disease, special needs care, dental services, behavioral health (BH) services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, prescription drugs, and long-term services and supports (LTSS).

- All aspects of the MCPs' internal administrative processes related to service and quality of care, including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management and care coordination services, utilization review activities, preventive health services, health education, information services, and quality improvement.

Section 2

Background and Introduction

The DHCF provides healthcare services to low-income children, adults, elderly persons, and persons with disabilities. Over 300,000 District residents (more than 40 percent of all residents) received healthcare services administered by DHCF at some point in 2023.

Vision, Mission, and Values

The mission of the DHCF is to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia.

In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children, CHIP, and Medical Charities (a locally-funded program).

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

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

Values:

- Accountability
- Compassion
- Empathy
- Professionalism
- Teamwork

Strategic Priorities:

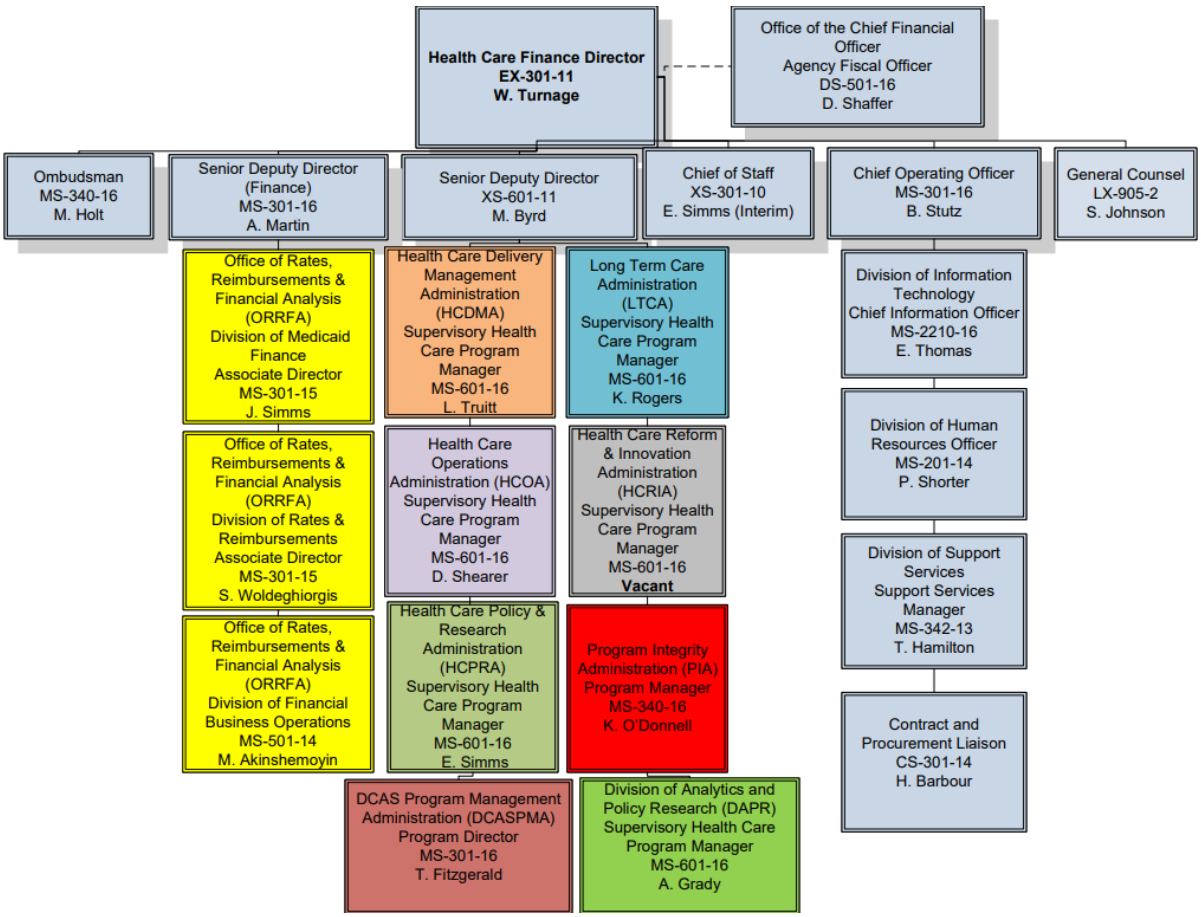
- Building a health system that provides whole-person care
- Ensuring value and accountability
- Strengthening internal operational infrastructure

Agency Organization

The agency operates under the direction of the Office of the Director, which is responsible for executive management, policy direction, strategic and financial planning, public relations, and resource management. The Office of the Director controls and coordinates agency operations to ensure the attainment of the agency's goals and objectives.

To carry out the responsibilities of the Department, DHCF is organized into eight major areas of administration that are designed to carry out the mission of DHCF. Each administration and office have management oversight of its functional areas.

Figure 1. DHCF Organizational Chart[1]



DC Access System Project Management Administration

The DC Access System (DCAS) Project Management Administration has responsibility to design, develop, implement, and manage the DCAS, which is an integrated eligibility system for all health and human services for the District. In addition, this administration is responsible for supporting the functionality and funding for all components of DCAS and their

[1] https://dhcf.dc.gov/publication/department-health-care-finance-organizational-chart

seamless interface with the Health Benefits Exchange and Department of Human Services program components.

Health Care Delivery Management Administration

The Health Care Delivery Management Administration (HCDMA) ensures quality services and practices pervade all activities that affect the delivery of healthcare to beneficiaries served by the District's Medicaid, CHIP, and DC Healthcare Alliance (Alliance) programs. HCDMA accomplishes this through informed benefit design; use of prospective, concurrent, and retrospective utilization management (UM); ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service (FFS) providers. Lastly, HCDMA is responsible for oversight of the MCP contracts.

Health Care Operations Administration

The Health Care Operations Administration ensures the division of programs that pertain to the payment of claims and manages the fiscal agent contract, the administrative contracts, systems, and provider enrollment and requirements. The office provides contract management of the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the Medicaid Management Information System (MMIS) Fiscal Intermediary contract, as well as additional administrative contracts.

Health Care Policy and Research Administration

The Health Care Policy and Research Administration (HCPRA) maintains the Medicaid and CHIP state plans that govern eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; develops policy for the Alliance program and other publicly funded healthcare programs administered or monitored by DHCF based on sound analysis of local and national healthcare and reimbursement policies and strategies; and ensures coordination and consistency among healthcare and reimbursement policies developed by the various divisions within DHCF.

Health Care Reform and Innovation Administration

The Health Care Reform and Innovation Administration (HCRIA) identifies, validates, and disseminates information about new healthcare models and payment approaches serving Medicaid beneficiaries, with the goal of enhancing healthcare quality, improving care and outcomes, promoting health equity, and enhancing the value and efficiency of DHCF programs. The division creates and tests new delivery system and payment models among providers in the District and builds collaborative learning networks to facilitate innovation, implement effective practices, and facilitate technology improvements to support delivery system re-design and improvement.

Long-Term Care Administration

The Long-Term Care Administration (LTCA) provides oversight and monitoring of programs targeted to elderly persons, persons with physical disabilities, and persons with intellectual and developmental disabilities (IDDs). Through program development and day-to-day operations, the LTCA also ensures access to needed cost-effective, high-quality extended

and long-term care services for Medicaid beneficiaries residing in home- and community-based or institutional settings. The office also provides contract management for the Dual-Eligible Special Needs Plan (D-SNP) contract.

Program Integrity Administration

As part of the oversight of the managed care contracts, DHCF has engaged with the MCPs to identify non-allowable costs, including those for overpayment or other instances of fraud, waste, or abuse. DHCF collects data quarterly from MCPs, which includes information related to claims identified as overpayments and the amounts recovered.

Division of Analytics and Policy Research

The Division of Analytics and Policy Research (DAPR) transforms data into meaningful information to support decision-making, effectiveness, and transparency in the District's Medicaid and locally funded health coverage programs. Its functions include: analytics and reporting to meet DHCF policy, operational, and other needs; fulfillment of data requests from sister agencies, researchers, and other external stakeholders; research to inform current program issues and future innovations; and collaboration within and outside of DHCF on data use and interpretation.

Managed Care Programs

Since 1994, the District has enrolled children and families, pregnant women, and children and adults with special needs into managed care, which covers acute, primary, specialty, and certain BH services. The table below highlights the Managed Care Programs available in the District, including the populations served and authority.

Table 1. Summary of DC Managed Care Programs[2]

Program Name	Populations Served	Plan Name	MCP Type	Managed Care Authority
District of Columbia Healthy Families Program (DCHFP)	Medicaid children without disabilities, parents, expansion adults ages 20 years–65 years, Supplemental Security Income (SSI)-eligible adults, and CHIP.	AmeriHealth Caritas District of Columbia	MCP	1932(a)
		Amerigroup DC		
		MedStar Family Choice DC		
Child and Adolescent Supplemental Security Income Program (CASSIP)	Medicaid children and adults with disabilities under the age of 26 years.	Health Services for Children with Special Needs (HSCSN)	MCP — Special Needs Plan	1915 (a)

[2] There are no officially recognized tribes residing in the District. Enrollment in the Medicaid Managed Care Program is voluntary for tribal members.

Program Name	Populations Served	Plan Name	MCP Type	Managed Care Authority
District Dual Choice Program (DDCP)	Beneficiaries dually eligible for Medicaid and Medicare.	UnitedHealthcare	D-SNP	1915(a) 1915(c) 1915 (i)
Alliance	Individuals over the age of 20 years who are not eligible for Medicaid.	AmeriHealth Caritas District of Columbia Amerigroup DC MedStar Family Choice DC	MCP	N/A; 100% Locally-Funded Program
Immigrant Children's Program (ICP)	Children under the age of 21 years who are not eligible for Medicaid due to citizenship or immigration status.	AmeriHealth Caritas District of Columbia Amerigroup DC MedStar Family Choice DC	MCP	N/A; 100% Locally-Funded Program

In 2019, DHCF announced a five-year Medicaid reform effort to transform the Managed Care Program into a more organized, accountable, and person-centered system for District residents. Since then, DHCF achieved its initial goals to increase expectations for value-based purchasing (VBP), increase access to care, and increase care coordination. Investments in health information exchange (HIE), practice transformation, and provider technical assistance to support reform are ongoing. In 2024, DHCF and the Department of Behavioral Health (DBH) will begin the transformation of the BH system by carving BH services into the Medicaid Managed Care Program.

DCHFP

DCHFP provides free health insurance to DC residents who meet certain income and US citizenship or eligible immigration status to qualify for DC Medicaid, including CHIP. DCHFP covers doctor visits, vision and dental care, prescription drugs, hospital stays, and transportation for appointments. DCHFP also offers special programs for newborn infants, children with disabilities or special healthcare needs, and people with HIV and AIDS.

CASSIP

CASSIP is a program that provides services to children and young people (ages 0 up to 21 years) who have special healthcare needs and receive SSI benefits or are SSI-eligible. The District contracts with an MCP to provide Medicaid healthcare benefits and additional services to eligible enrollees. Enrollees will have access to preventive healthcare and specialty care to help with chronic conditions such as asthma, diabetes, and BH needs. In addition, enrollees have access to emergency care, non-emergency transportation, pharmacy, durable medical equipment, dental care, vision and hearing care, mental health

and substance use disorder (SUD) services, rehabilitation services, maternal health, and LTSS.

DDCP

DDCP is exclusively for dually-eligible beneficiaries and aims to better coordinate their Medicare and Medicaid benefits. In 2022, the District expanded into a more comprehensive program that integrates Medicare and Medicaid benefits into a single program, enabling one set of comprehensive benefits and one accountable entity to coordinate the delivery of services to help coordinate the unique needs of individuals. Dual-eligible individuals who are 21 years of age or older and receive both Medicare (Parts A, B, and D) and Medicaid coverage are eligible to enroll in a D-SNP.

Alliance

Alliance is a health coverage program offered to individuals and families not eligible for Medicaid. Alliance is a locally-funded program that includes a range of healthcare services, including primary care services, doctor visits, prescription drugs, dental services, and wellness programs. To be eligible for Alliance, an individual must be a resident of the District, have no other health insurance (including Medicaid and Medicare), and meet a certain income threshold. Alliance-eligible individuals enroll with one of the MCPs participating in the DCHFP.

ICP

The ICP is a health coverage program offered to children under the age of 21 years who are not eligible for Medicaid due to citizenship or immigration status. The ICP includes a range of healthcare services, such as primary care services, doctor visits, prescription drugs, dental services, and wellness programs. To be eligible for the ICP, one must be a resident of the District, have no other health insurance (including Medicaid and Medicare), and meet a certain income threshold. Services covered under the ICP are similar to the services covered under Medicaid for children under age 21 years. ICP-eligible children enroll with one of the MCPs participating in the DCHFP.

FFS

Although the vast majority of DC Medicaid beneficiaries are enrolled in managed care, approximately 16% were enrolled in FFS in FY 2022. DHCF is responsible for the clinical, administrative, and claims functions of the FFS population. FFS beneficiaries include Medicaid-covered groups not in managed care, as well as members who are awaiting managed care assignment and are temporarily placed in FFS until they are assigned to a Managed Care Program and participating MCP.

Populations Not Included in Managed Care

Individuals are excluded from Managed Care[3] if they are:

[3] Individuals who are eligible for the Elderly and Persons with Physical Disabilities (EPD) Waiver Program may enroll in DDCP for integrated Medicare and Medicaid benefits. Individuals who are eligible for the IDD and Individual and Family Support Waiver Programs may enroll in DDCP for Medicare benefits and coordination of Medicaid benefits.

- Enrolled in Program of All-Inclusive Care for the Elderly
- Eligible for the IDD Waiver Program
- Eligible for the Individual and Family Support Waiver Program
- Eligible for the Elderly and Persons with Physical Disabilities Waiver Program
- Placed on a spend-down
- Incarcerated
- Admitted to a psychiatric residential treatment facility (PRTF) for more than 30 days and the MCP requests that the beneficiary be disenrolled from their plan (MCPs are responsible for individuals approved for PRTF up until 30 days)
- Under the age of 21 years and placed in the foster care system

Section 3

Development and Review of Quality Strategy

With input provided by the MCPs, the EQRO, and the Medical Care Advisory Committee (MCAC), DHCF identified goals and objectives for the Medicaid MCPs across all populations and programs. These goals are supported by performance measures used by the District to track and monitor progress in meeting the overarching quality strategy goals and objectives. Many of the District-identified MCP performance measures are from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and/or are part of the CMS Adult and Child Core Set Performance Measures (see Table 2).

DHCF published its initial Managed Care Quality Strategy in January 2020.[4] This document is the second edition of the District's Managed Care Quality Strategy. While building upon the first edition, this document incorporates edits made to reflect changes in the District's Managed Care Program, addresses CMS feedback received in Spring 2021, and incorporates recommendations from the CMS Quality Strategy Toolkit released in Fall 2021.

Updates and Revisions

DHCF updates the Quality Strategy based on MCP performance, stakeholder feedback, achievement of goals, changes in DHCF priorities, and any significant change to the Medicaid program. Significant changes include the following:

- Changes to the delivery system model.
- Addition of new populations or services into managed care.

[4] 2019–2023 DC Medicaid Managed Care Quality Strategy

- Significant changes to District or federal regulations governing quality.
- Quality deficiencies identified through analysis of MCP performance measures that result in a change to the goals or objectives of the Quality Strategy.

DHCF submits updates and revisions of the Managed Care Quality Strategy to CMS for review no less than every three years unless there is a significant change to the Medicaid Program. The effectiveness of the quality strategy is assessed annually through the recommendations provided by the External Quality Review Organization (EQRO), and findings are highlighted in the annual External Quality Review (EQR) Technical Report[5].

Obtaining Public Comment

DHCF has several mechanisms for obtaining and considering public comments on the Quality Strategy. The DC MCAC is a forum for key participants and stakeholders in the Medicaid program, including consumers, advocates, providers, and DC officials, to review the program's operations and offer advice for improvements directly to the DHCF. DHCF solicited MCAC comments on the updated Quality Strategy during a meeting held on 12/20/2023.

DHCF posted the draft Quality Strategy for public comment on the District Register from 12/08/2023–01/07/2024. After reviewing the public comments received, DHCF finalized the Quality Strategy document and submitted it to CMS on 01/31/2024. The final Quality Strategy is posted and available to the public on the DHCF website.

Section 4
Goals and Objectives

Goals and Objectives

The Managed Care Quality Strategy is the framework used by the DHCF for guiding the agency's mission to provide comprehensive, cost-effective, and quality healthcare services to District residents with the goal of improving health outcomes. The 2022 EQRO found that MCPs are committed to quality, have developed strategies to demonstrate improvement, and are all in a position to close gaps in care and quality, specifically relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care. In partnership with the MCPs and other stakeholders, the District aims to achieve the goals and objectives of the Quality Strategy highlighted in the table below. A new managed care contract began April 1, 2023, following procurement. To align performance of the MCPs with this contract, the District will use this first year to establish baseline metrics for the program. Baseline data will not be available until after 2024, at which time, it will be reviewed to set targets for future measure years.

[5] MCO External Quality Review Annual Technical Reports | dhcf (dc.gov)

Table 2. Quality Strategy Goals and Objectives

Better Care				
Goal 1: Ensure Access to quality, whole-person care				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
DCHFP, CASSIP, DDCP, DC Healthcare Alliance, ICP	1.1. The MCP average for CAHPS® measure "Rating of Health Plan" will increase by 3% until achieving the established target. This measure will be reported separate for Child CAHPS® and for Adult CAHPS®.	**Measurement Year (MY) 2024 Baseline:** To be determined (TBD)	MY 2025:	Agency for Healthcare Research and Quality (AHRQ), CAHPS
	1.2. The MCP average for CAHPS measure "Rating of Personal Doctor" will increase by 3% until achieving the established target. This measure will be reported separate for Child CAHPS® and for Adult CAHPS®.	**MY 2024 Baseline:** TBD	MY 2025:	AHRQ, CAHPS
	1.3. The MCP average rate for the percentage of enrollees contacted by their health plan within 48 hours after an emergency department (ED) visit will increase by 3%.	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF
	1.4 All four MCPs achieve NCQA Case Management Accreditation status of a three-year designation by 2025.	**MY 2024 Baseline:** four eligible DC MCPs	MY 2025: four of four MCPs	DHCF
	1.5 Improve percentage of specialty visits' notes shared with the Primary Care Provider (PCP) within 60 days of the visit.	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF
	1.6 The Hospital Emergency Department Utilization Report captures the percentage of MCP follow-up after ED and inpatient admit within 48 hours.	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF
DCHFP, CASSIP, DDCP, Alliance, ICP	1.7 Improve percentage of BH provider referrals from PCPs for enrollees with an initial BH diagnosis.	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF
	1.8 Percentage of enrollees with a BH visit within 30 days following diagnosis of a BH condition by PCP	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF

Better Care				
Goal 1: Ensure Access to quality, whole-person care				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
	1.9 Percentage of enrollees turning 21 years old within the MY had a visit with an adult PCP.	**MY 2024 Baseline:** TBD	MY 2025: TBD	DHCF
	1.10 The MCP average HEDIS rate for controlling high blood pressure will increase by 3%.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	1.11 The MCP average HEDIS rate for diabetes screening for enrollees with schizophrenia or bipolar disorder who are using antipsychotic medication will increase by 3%.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA

Healthy People, Healthy Community				
Goal 2: Improve Management of Chronic Conditions				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
DCHFP, CASSIP, DDCP, Alliance, ICP	2.1. The MCP average HEDIS rate for HbA1c Control will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	2.2. The MCP average HEDIS rate for adherence to antipsychotic medications for individuals with schizophrenia will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	2.3. The MCP average HEDIS rate for follow-up after an ED visit for alcohol and other drug dependence within 30 days will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	2.4. The MCP average HEDIS rate for follow-up after an ED visit for alcohol and other drug dependence within seven days will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	2.5. The MCP average HEDIS rate for follow-up after an ED visit for Mental Illness within seven days will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA

Healthy People, Healthy Community				
Goal 2: Improve Management of Chronic Conditions				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
	2.6. The MCP average HEDIS rate for follow-up after an ED visit for Mental Illness within 30 days will increase by 3 percentage points.	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	2.7. The MCP average HEDIS rates for the following diabetes care measures will improve by 3%:			NCQA
	1. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	2. Eye Exam (retinal) for Patients with Diabetes	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	3. Statin Therapy for Patients with Diabetes (2 rates below) A. Received statin therapy B. Statin therapy adherence 80%	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	4. Kidney Health Evaluation for Patients with Diabetes	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	5. Blood Pressure Control for Patients with Diabetes	**MY 2024 Baseline:** TBD	MY 2025: TBD	

Healthy People, Healthy Community				
Goal 3: Improve Population Health				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
DCHFP, CASSIP, Alliance, ICP	3.1. The MCP average HEDIS rates for the following maternal health measures will improve by 3%:			NCQA, Office of Population Affairs
	1. Timeliness of Prenatal Care	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	2. Postpartum Care	**MY 2024 Baseline:** TBD	MY 2025: TBD	

Healthy People, Healthy Community				
Goal 3: Improve Population Health				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
	3. Contraceptive Care for All Women			
	A. Most to Moderate (Ages 15 years–20 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	B. Most to Moderate (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	C. Long-Acting Reversible Contraception (LARC) (Ages 15 years–20 years)	**MY 2024 Baseline**: TBD	MY 2025: TBD	
	D. LARC (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	4. Contraceptive Care for Postpartum Women			
	A. Most to Moderate, 3 days (Ages 15 years–20 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	B. Most to Moderate, 3 days (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	C. Most to Moderate, 60 days (Ages 15 years–20 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	D. Most to Moderate, 60 days (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	E. LARC, 3 days (Ages 15 years–20 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	F. LARC, 3 days (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	G. LARC, 60 days (Ages 15 years–20 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	H. LARC, 60 days (Ages 21 years–44 years)	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	3.2. The MCP Average HEDIS rates for the number of children and adolescents who received a well-child visit will improve by 3 percentage points across all age categories:			NCQA

Healthy People, Healthy Community				
Goal 3: Improve Population Health				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
	1. Ages 3 years–11 years	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	2. Ages 12 years–17 years	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	3. Ages 18 years–21 years	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	4. Total	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	3.3 The MCP Average HEDIS rates for the number of children who received a well-child visit in the first 30 months of life will improve by 3%:			NCQA
	1. First 15 months of life	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	2. 15 months–30 months	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	3.4 The MCP Average HEDIS rates for the number of children who received Lead Screening will improve by 3%:	**MY 2024 Baseline:** TBD	MY 2025: TBD	NCQA
	3.5. Reduce health disparities by closing the performance gaps of four HEDIS measures in at least one of the following demographic factors: age, race/ethnicity, primary language, gender, or disability status.			NCQA
	• Child and Adolescent Well-Care Visits	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	• Asthma Medication Ratio	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	• Prenatal and Postpartum Care	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	• Follow-Up After Hospitalization for Mental Illness	**MY 2024 Baseline:** TBD	MY 2025: TBD	
DDCP	3.6 Increase the percentage of LTSS members with an LTSS	**MY 2024 Baseline:** TBD	MY 2025: TBD	CMS

Healthy People, Healthy Community				
Goal 3: Improve Population Health				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
	Comprehensive Assessment and Update (MLTSS-1)			
	3.7 Increase the percentage of LTSS members with an LTSS Comprehensive Care Plan and Update (MLTSS-2)	**MY 2024 Baseline:** TBD	MY 2025: TBD	CMS
	3.8 Increase the percentage of LTSS members with an LTSS Reassessment/Care Plan Update after Discharge (MLTSS-4)	**MY 2024 Baseline:** TBD	MY 2025: TBD	CMS
	3.9. The MCP average HEDIS rates for the following Social Need Screening and Intervention measures will improve by 3% (**Test Measure**):			NCQA
	A. Food Screening B. Food Intervention	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	C. Housing Screening D. Housing Intervention	**MY 2024 Baseline:** TBD	MY 2025: TBD	
	E. Transportation Screening F. Transportation Intervention	**MY 2024 Baseline:** TBD	MY 2025: TBD	

Pay for Value				
Goal 4: Ensure high-value, appropriate care				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
DCHFP, Alliance, ICP	4.1. Through VBP arrangements and the District's pay-for-performance (P4P) program, the MCP (DCHFP) will have:			AHRQ, DHCF, NCQA
	1. Percentage of total medical expenditures included in a VBP program administrated by the MCP increase year over year	**Calendar Year (CY) 2024 Baseline:** 30% (as this is a new measure)	CY 2025: 40% CY 2026: 50%	

Pay for Value				
Goal 4: Ensure high-value, appropriate care				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
			CY 2027: 60%	
	2. Demonstrated any improvement in the following P4P quality measures:[6]			
	A. Potentially Preventable Admissions (PPAs)	**CY 2024 Baseline:** TBD	CY 2025: TBD	
	B. Low Acuity Non-Emergent (LANE)	**CY 2024 Baseline:** TBD	CY 2025: TBD	
	C. Plan All-Cause Readmissions (PCRs)	**CY 2024 Baseline:** TBD	CY 2025: TBD	
	4.2 By CY 2025, all providers participating in a VBP or P4P program with the MCPs will work with the District's Designated HIE Entity to be credentialed to use the PopHealth Analytics tool in the DC HIE.			DHCF

Provider Satisfaction				
Proposed Goal 5: Improve Clinician Experience				
Program	**Objectives**	**Baseline**	**Target**	**Measure Steward**
DCHFP, CASSIP, DDCP, Alliance, ICP	5.1 Improve the MCP average rating percentage for the following three areas of focus: • Satisfaction with Health Plan • Satisfaction with UM • Satisfaction with Claims	**CY 2024 Baseline:** TBD	CY 2025: TBD	DHCF
	5.2 Maintain or exceed compliance of clean claims processing within 90 days.	**CY 2024 Baseline:** TBD	CY 2025: 99% of clean claims processing	DHCF

The performance measures highlighted in the table above are used by DHCF to monitor and track progress towards meeting the Quality Strategy Goals and Objectives. In addition, they

[6] In addition to the P4P program, these measures are also being monitored to evaluate hospital direct payments.

serve as public accountability for the MCPs and the District as a whole. Should the MCPs fall short of meeting established targets, DHCF has outlined the procedures MCPs must follow to address noncompliance with regulatory requirements in the "DHCF Managed Care Program Quality Management Manual." This monitoring and tracking process includes annual EQRO report findings, corrective action plans, compliance monitoring, and enhanced monitoring for MCPs who have findings.

Section 5

Quality Assessment and Performance Improvement

DHCF requires that MCPs establish and implement a comprehensive Quality Assessment and Performance Improvement (QAPI) Program that is reviewed annually and approved by DHCF. Each MCP is required to have processes in place to evaluate the impact and effectiveness of its QAPI Program. Each MCP QAPI Program includes the following:

- Description of Quality Management Committee and oversight structure
- Integration of quality assurance with other management functions
- Standards for service accessibility
- Process for reviewing and adopting Clinical Practice Guidelines
- Mechanisms for assessing and addressing health disparities
- Mechanisms for detecting under- and over-utilization of services
- Completion of DHCF-required Performance Improvement Projects (PIPs)
- Collection and submission of all designated quality performance measure data

The MCPs are required to submit an annual evaluation report highlighting QAPI program successes and lessons learned.[7]

The DHCF Quality Improvement Program utilizes the IHI's Model for Improvement framework for designing, implementing, and evaluating quality improvement initiatives. This process involves setting aims, establishing measures, selecting changes, and testing changes using the Plan-Do-Study-Act (PDSA) cycle, an adoption by DHCF of the W. Edwards Deming cycle of performance improvement. The PDSA cycle includes a series of steps for gaining knowledge about how to improve a process or outcome[8]:

- **Plan** — State the objective of the test/observation; make predictions about what will happen and why. Develop a plan to test the change by answering the questions, "Who? What? When? Where?" Determine what data needs to be collected.

[7] For more information on MCO QAPI requirements, please refer to Appendix A, "Requirements for the QAPI Program."
[8] IHI. Model for Improvement: Plan-Do-Study-Act Cycles. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx.

- **Do** — Implement the test on a small scale, document problems and unexpected observations, and begin to analyze the data.
- **Study** — Complete the data analysis and compare data to the predictions made in the planning phase, summarize, and reflect on what was learned.
- **Act** — Determine what modifications should be made and prepare a plan for the next test.

DHCF conducts the following activities to drive Quality Improvement in the Medicaid Program:

- Using HEDIS, the CMS Core Measure Sets, and other performance measures to continually assess each MCP's achievement of the DHCF goals.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring CAHPS survey results and enrollee grievances to determine how satisfied Medicaid enrollees are with the care and services they receive.
- Monitoring the MCP Quality Improvement activities and compliance with federal and District contractual requirements.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve service delivery and to leverage resources to achieve common goals.
- Trending performance measure results to ensure the MCP's performance is improving over time.
- Studying healthcare disparities by race, ethnicity, gender, age, language spoken, and disability status to implement target interventions to ensure all enrollees have access to high quality care.

To assess performance of the District's Managed Care Programs and to ensure MCPs utilize evidenced-based practices and run effective programs, the MCPs:

- Submit all NCQA Health Plan HEDIS measures, nearly all of the CMS Child, Adult, and Behavioral Health Core Set measures, and CAHPS survey results annually.
- Maintain NCQA Health Plan and Case Management Accreditation.[9]
- Submit all requested information to the EQRO for the purposes of conducting EQR activities, as defined in 42 CFR §438, on behalf of DHCF.

Interventions

DHCF has developed a series of interventions aligned with the Quality Strategy objectives and designed to provide comprehensive, cost-effective, and quality healthcare services to District residents with the goal of improving health outcomes.

[9] DDCP requires D-SNP to obtain and maintain NCQA Medicaid Health Plan Accreditation only, as NCQA Medicare and Medicaid Health Plan Accreditations include care management standards.

Behavioral Health Transformation Demonstration

On November 6, 2019, CMS approved the District's Behavioral Health Transformation demonstration with an effective date of January 1, 2020. Most new services authorized under the waiver were phased in beginning on the effective date. The demonstration allows the District's Medicaid program to pay for services provided to adults ages 21 years–64 years with serious mental illness (SMI)/serious emotional disturbance (SED) or SUD residing in an institution for mental diseases. Additionally, the demonstration adds new community-based services designed to improve BH treatment capacity and strengthen transitions from emergency, inpatient, and residential treatment.

The demonstration furthers the District's goals of 1) ensuring Medicaid provides a broader continuum of BH services and supports for individuals with SMI/SED, SUD, or other BH needs; 2) advancing the District's goals in the Opioid Strategic Plan, LIVE.LONG.DC., to improve outcomes for individuals with opioid use disorder and other SUDs; and 3) supporting movement towards a more person-centered system of physical and behavioral healthcare for Medicaid beneficiaries that facilitates coordinated treatment.

As a result of the Section 1115 Behavioral Health Transformation Demonstration, in 2022, the District transitioned most new or updated services and new provider types to permanent Medicaid State Plan Authority.

The District's multi-phase BH Redesign efforts continue now that most aspects of the 1115 Demonstration have been made permanent. The next phase includes integration of BH services into the Managed Care Program.

My DC Health Home

Launched in January 2016, the My DC Health Home program offers care coordination services to Medicaid beneficiaries with mental healthcare needs — including primary and hospital health services, mental healthcare, substance abuse care, and LTSS. My DC Health Homes are community-based mental health providers, also known as Core Services Agencies, which have hired nurses, primary care doctors, and others with social- and health-related backgrounds, to create Care Teams. Each person who decides to receive services through the My DC Health Home benefit will be linked with a Care Team that will work with the person's doctors, family, and anyone else the person selects to:

- Pay special attention to their healthcare needs.
- Ensure needed medical services are received.
- Help get needed social services, such as housing and food.

DHCF reports the Health Home Core Set of performance measures for My DC Health Home to CMS on an annual basis. The most recent My DC Health Home Program (also known as the Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions Program) performance data can be found by viewing the Performance on the Health Home Core Set Measures data on the Medicaid.gov website.

My Health GPS

Launched in July 2017, My Health GPS Program is for approved PCPs who deliver comprehensive care management services to the District's Medicaid beneficiaries with three

or more qualifying chronic conditions. This program provides three different per member per month (PMPM) rates. The members are stratified by an assigned Group One (lower) or Group Two (higher) acuity level. These two acuity levels have specific PMPM rates associated. The third PMPM rate is based on the completion of an initial or annual assessment and care plan service. The providers deliver care management services using an interdisciplinary team embedded in the primary care setting and aim to improve the integration of medical health, BH, community supports, and social services.

The My Health GPS Program is designed to produce the following outcomes for eligible beneficiaries:

- Lower rates of avoidable ED use
- Reductions in preventable hospital admissions and re-admissions
- Reductions in healthcare costs
- Improvements in the experience of care, quality of life, and beneficiary satisfaction
- Improved health outcomes

DHCF reports the Health Home Core Set of performance measures for My Health GPS to CMS on an annual basis. The most recent My Health GPS Program (also known as the Chronic Conditions Program) performance data can be found by viewing the Performance on the Health Home Core Set Measures data on the Medicaid.gov website.

P4P Program

DHCF is relaunching an MCP P4P program in CY 2024, for the DCHFP and CASSIP programs which may include capitation payment withhold tied to MCP performance on select quality improvement performance measures. DHCF has currently selected three outcomes-based measures that aim to reduce the following: 1) Plan All-Cause Readmissions (PCRs), 2) Potentially Preventable Admissions (PPA), and 3) Low Acuity Non-Emergent (LANE) ED visits, with the intent to potentially include additional measures. DHCF chose three performance measures to incentivize the risk-based MCPs to maximize provision of case management and primary and preventive care in the least acute setting. The Division of Quality and Health Outcomes (DQHO) works closely with the MCPs to address barriers and implement effective interventions to improve P4P measures. The results of the MCP P4P program are published biannually in the Managed Care Performance Reports section on DHCF's website.[10]

PIPs

Each MCP is required to annually conduct PIPs designed to achieve, through ongoing measurements and interventions, significant improvement in clinical or non-clinical care areas expected to have a favorable effect on health outcomes. The MCPs' PIPs must include measurements of performance using objective quality indicators, implementation, and reporting of interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. PIPs topics and supporting measures align with goals and objective

[10] https://dhcf.dc.gov/page/dhcf-policies-and-publications

accordingly. Furthermore, an individual's participation in one intervention does not exclude their participation in the other intervention.

As of October 2021, the MCPs participating in DCHFP are conducting a Maternal Health PIP and a Comprehensive Diabetes Care PIP. CASSIP is conducting a Maternal Health PIP and a Childhood Obesity Management and Prevention PIP. The D-SNP Health Plan is conducting a Fall Risk PIP.

- **BH:** This PIP targets adults and children (ages six years and older) with a diagnosis of mental illness or intentional self-harm. The aim is to improve follow-up visits for mental illness within 7 days and 30 days post-hospital discharge or ED visit. All participating MCPs (DCHFP, CASSIP, and DDCP) are expected to participate in this PIP. MY 2024 will serve as baseline and interventions are not required until MY 2025.
- **Maternal Health:** This PIP targets women and aims to encourage timely prenatal and postpartum care to achieve improvements to both maternal health and birth outcomes. MY 2019 serves as the baseline period. MCPs in DCHFP and CASSIP are participating in the Maternal Health PIP.
- **Childhood Obesity Management and Prevention:** This CASSIP-only PIP targets children and adolescents ages 3 years–21 years and aims to improve compliance with weight assessment and counseling for nutrition and physical activities, as well as well-care visits. MY 2021 serves as the baseline period.
- **Fall Risk Management:** This DDCP-only PIP targets adults with problems falling, walking, or balancing, and aims at assessing and addressing fall risk in the D-SNP population and for enrollees in LTSS and Home- and Community-Based Services (HCBS) programs. MY 2022 served as the baseline period.

Table 3 highlights a summary of the PIP topics, Aim Statements, and examples of MCP Interventions.

Table 3. Summary of PIP Topics, Aim Statements, and Interventions[11]

PIP Topic	PIP Aim Statement	MCP PIP Intervention Highlights
Comprehensive Diabetes Care[12]	Will implementation of targeted educational and outreach interventions improve performance in process and outcome measures for enrollees with diabetes during the measurement year?	**Prepared meal delivery program:** Provided nutritionally complete and diabetes-appropriate meals to enrollees who would benefit from proper nutrition. Addressed food instability as a social determinant of health and helped enrollees manage their chronic condition to reduce the chance of hospital admissions. **Non-emergent medical transportation**: Provided enrollees with convenient, immediate transportation for their non-emergent medical needs through the Lyft service.

[11] More detailed information on MCP PIP interventions aimed at improving access, quality, or timeliness of care can be found in the District's EQRO Annual Technical Review Report. To read the District of Columbia Annual Technical Reports, please visit https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.
[12] The Comprehensive Diabetes Care PIP will be closed out after five (5) years of remeasurement and after the MCPs report MY 2022 performance in 2023.

PIP Topic	PIP Aim Statement	MCP PIP Intervention Highlights
		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.
BH	Will implementation of enrollee, provider, and MCP interventions increase the rates of timely follow-up after ED visits and hospital stays for mental illness?	Examples of PIP intervention will be provided once baseline is established (MY 2024).
Maternal Health	Will implementation of enrollee, provider, and MCP interventions increase the rate of timely prenatal and postpartum visits and/or the utilization rates of most or moderately effective contraception for women 15 years – 44 years of age over the MY?	**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. **Obstetric case management:** Offered an Obstetric Case Management Program at its Health and Wellness Outreach Center. The intervention transitioned to virtual case management in response to the public health emergency (PHE). **Screening software (Aunt Bertha):** Used the Aunt Bertha platform to screen for Health-Related Social Needs (HRSNs) and make referrals to community-based resources to support a healthy pregnancy. **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.
Childhood Obesity Management and Prevention	Will implementation of enrollee, provider, and MCP interventions increase the rate of weight assessment and counseling for nutrition and physical activities, and well-care visits for children and adolescents 3 years–21 years of age?	**Transportation Education**: Provided enrollees a step-by-step education workflow for scheduling transportation through its vendor. Implemented in October 2022. **Enrollee Wellness Incentive Program:** Educational material developed in the form of text and website language introduced newly approved monetary increases. This was not implemented until December 2022.

PIP Topic	PIP Aim Statement	MCP PIP Intervention Highlights
		Provider training: Held virtual training on utilization of Z-codes. Training was not initiated until the end of December 2022. **Unable to reach enrollees:** Implemented a workflow process initiated by the Care Support Specialist when enrollees are hard to reach. Implemented in January 2022. **Mitigation plan for Care Management staff retention:** Initiated work with recruiting agencies for temporary to permanent staff, annual review of salaries, retention, and sign-on bonuses. Ongoing since 2021.
Fall Risk Management	• Will member education on fall prevention decrease the number of falls in enrollees 65 years of age and older during the MY? • Will implementation of a comprehensive assessment and fall risk management plan decrease the number of falls for enrollees 18 years of age and older with a history of falls during the MY?	**Provider training:** Initiated provider education on how to prevent falls or treat problems with balance or walking. **Assessment and care planning:** Implemented fall risk assessments and care planning to prevent or decrease the number of falls.

To further drive improvement on the MCP PIPs, DHCF and the MCPs participate in Quarterly Quality Collaborative Meetings. During Fiscal Year (FY) 2024, the MCPs (DCHFP and CASSIP) are implementing rapid-cycle PDSA quality improvement projects aimed at improving timeliness of prenatal and postpartum services. During the Quality Collaborative Meetings, the MCPs share their baseline metrics, updates on project process measures, project deliverables, and outcome measures. The MCPs are required to report progress on their projects to DHCF on a quarterly basis.

Health Disparities

Efforts and Initiatives to Reduce Disparities in Healthcare

Health Disparities Plan

DHCF is committed to addressing health equity in its Managed Care Program. In an effort to identify health disparities, MCPs are required to report the following HEDIS measures by race, ethnicity, age, gender, language spoken, or disability status:

- Child and Adolescent Well-Care Visits
- Asthma Medication Ratio
- Prenatal and Postpartum Care: Prenatal Visits
- Prenatal and Postpartum Care: Timeliness of Prenatal Care
- Follow-Up After Hospitalization for Mental Illness
- LTSS Minimizing Facility Length of Stay (D-SNP-only)
- Poor Diabetes Control (D-SNP-only)
- Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (D-SNP only)

These eight quality measures were selected through a collaborative process with the MCPs. Once the demographically-stratified MCP quality measures are collected, DHCF will aggregate and analyze the data to identify any potential healthcare disparities. MY 2024 serves as the baseline year, and the information will be used to help inform the development of a Health Equity Plan.

In collaboration with the MCPs and the EQRO, DHCF will set realistic and reasonable performance benchmarks based on the MCP-reported quality performance measures.[13] DQHO will identify a select number of performance measures in an Accountability Set that will be held to a minimum performance level (MPL) benchmark and a high-performance level (HPL) benchmark. MCPs must meet or exceed the MPL for most measures, except for those noted by DHCF for reporting purposes only. DHCF establishes an HPL for each required performance measure and publicly acknowledges that the MCPs met or exceeded the HPLs. The MPL and HPL benchmarks for each required performance measure will be based on the percentiles of the national Medicaid results as reported in NCQA's Quality Compass, if applicable. In the event that a non-HEDIS measure is included in the Accountability Set, then DHCF, the EQRO, and/or DHCF's contracted actuaries will determine an appropriate benchmark for that performance measure.

DHCF is working with a number of agencies to improve the health of District residents, including Medicaid beneficiaries. These coordination of activity efforts also seek to address disparities.

- **DC Health:** In partnership with the DC Healthy Housing Collaborative — a multi-sector coalition seeking to address substandard housing conditions that contribute to significant health issues affecting District residents — DC Health and DHCF focus on the home assessment and remediation project to support families with children with asthma to have asthma triggers in their home remediated.
- **DBH:** The two agencies are working to integrate the continuum of BH services into the DHCF Managed Care Program, effective April 1, 2024. Integrating services into the MCPs allows the plans to see the complete picture of the beneficiary/consumer needs

[13] To access Managed Care performance and EQR reports, please visit the following webpages: https://dhcf.dc.gov/publication/district-columbia%E2%80%99s-medicaid-managed-care-performance-report-january-december-2019 and https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports

and better coordinate benefits. Part of this effort is sharing data to monitor the quality of BH services offered in the District.

- **Department of Energy and Environment:** The agencies work together to promote the importance of lead screenings and to report lead-poisoned children to the Department of Energy and Environment's Childhood Lead Poisoning Prevention Program, which provided family lead education and referrals for social and environmental services when a child has an elevated blood lead level.
- **Maternal Health Advisory Group:** DHCF convenes an advisory entity seeking to improve maternal health:
  - The Maternal Health Advisory Group is an 18-member group composed of stakeholders with experience in maternal health, including from DC Health, to inform the expansion of coverage and maternal health services. The Advisory Group advises on training, public outreach, program support, and other items related to implementation of new maternal health coverage and benefits. Although the Advisory Group does not issue formal recommendations, it provides valuable feedback to the agency. Furthermore, the Perinatal Mental Health Task Force which was a 21-member governmental and non-governmental sector task force that included DC Health, DBH, and members from DC Council, with the aim to provide recommendations to improve perinatal mental health in the District and with a focus on reducing disparities will be incorporated into the Maternal Health Advisory Group.

HRSNs

MCPs are required to assess enrollees to identify social factors impacting their health and overall wellbeing. In FY 2023, the MCPs are required to incorporate and use a DHCF-approved, minimum set of HRSN screening questions within their existing HRSN questionnaires. These efforts are intended to uniformly identify Medicaid beneficiaries' social needs and ensure common community-wide understanding of HRSN needs. DHCF is planning to incorporate the use of the Social Need Screening and Intervention HEDIS measure. This measure includes six indicators (one each for screening and intervention across three social needs: Food, Housing, and Transportation) and uses four methods to report: Administrative, Hybrid, Survey, and Electronic Clinical Data Systems.[14] DHCF will determine how to best track and report HRSN data once standardized data collection across all MCPs has been implemented.

QAPI Program

Each MCP is required to develop a QAPI Program, which describes the MCP's systematic approach for assessing and improving the quality of care utilizing the continuous quality improvement framework. The QAPI program must include a mechanism for reducing racial, socioeconomic, and ethnic disparities in healthcare utilization and in health outcomes. Analysis of interventions must compare healthcare utilization data for enrollees by subgroups, such as race/ethnicity, language, and DC ward; prior year performance; and,

[14] https://www.ncqa.org/blog/social-need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/

where possible, against regional and national benchmarks. Annually, the MCPs are required to submit an evaluation report highlighting QAPI program successes and lessons learned.[15]

Section 6
Quality Strategy and Managed Care Program Oversight

Managed Care Quality Strategy

The DQHO is the lead office within the Department of Health Care Finance responsible for updating and implementing the District's Managed Care Quality Strategy. DQHO relies on several partners for successful oversight:

- **EQRO:** As required by federal regulations, DHCF contracts with an independent EQRO to conduct annual reviews of the quality, accessibility, and timeliness of services provided to beneficiaries enrolled in an MCP through DCHFP, CASSIP, and DDCP.
- **MCPs:** DHCF also relies on information from the MCP performance metric reporting, including grievances and appeals and QAPI reports. In addition, the MCPs support the management structure through PIPs, quality improvement collaboratives, health and wellness programs, and care coordination activities.
- **Other Partners:** DHCF partners with other District agencies (e.g., DC Health, DBH), providers and provider organizations (e.g., DC Primary Care Association), and national organizations (e.g., NCQA).

MCP Quality Collaborative

In partnership with the MCPs, DHCF hosts Quarterly MCP Quality Collaborative meetings that encourage active participation and engagement by:

- Offering opportunities for each MCP to showcase their efforts towards meeting the District's Quality Strategy Goals;
- Gathering and soliciting MCP feedback on various quality improvement initiatives; and
- Developing and implementing a strategic rapid-cycle process improvement projects.

During FY 2023, the DCHFP and CASSIP MCPs implemented a rapid-cycle process improvement project aimed at improving health outcomes for pregnant enrollees. In alignment with the District's BH integration plans, the Quality Collaborative intends to focus its next rapid-cycle process improvement project within the BH domain.

Reviewing and Evaluating Quality Strategy Effectiveness

Data collection and analysis and other activities are used in the evaluation of the effectiveness of the interventions described in the Quality Strategy. Included within the

[15] For more information on MCO QAPI requirements, please refer to Appendix A, "Requirements for the QAPI Program."

analysis are trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data by MCPs. DHCF has developed various MCP Performance Measure Dashboards utilizing Data Visualization software, which the Agency intends to publish on the DHCF website in 2024.

The Annual EQR Annual Technical Report also features the EQRO's assessment of the effectiveness of the Managed Care Quality Strategy. MCP-specific findings on the quality, access, and timeliness of the District's Managed Care Program are featured in the EQR Annual Technical Reports, which are submitted to CMS annually, and are available to the public on the DHCF website.[16]

Managed Care Program Oversight

Contract Compliance

DHCF has detailed procedures for the regular oversight, monitoring, and evaluation of its MCPs. DHCF provides each MCP with the Managed Care Quality Program Manual as reference to the Compliance Actions. DHCF monitors all aspects of the Managed Care Program, including the performance of each MCP in at least the following areas:

- Administration and management
- Availability and accessibility of services, including network adequacy
- Case management and care coordination
- BH management
- Claim management
- Enrollee-facing materials
- Finance
- Grievances and appeals systems
- Marketing
- QAPI Program [see Appendix A]
- Quality Program Manual
- Other Contract Provisions as needed

DHCF reviews all deliverables submitted by the MCPs and, as applicable, requires revisions. DHCF conducts ongoing compliance reviews and data analyses to monitor MCP compliance with District and federal requirements. Findings from the activities above are discussed on an ongoing basis and with the MCPs at the bi-monthly operational meetings.

[16] MCO External Quality Review Annual Technical Reports | dhcf (dc.gov)

Compliance (Operational Systems) Review

42 CFR §438.350 requires states contracting with MCPs to conduct annual, independent reviews of the Medicaid Managed Care Program. To meet these requirements, DHCF contracts with an independent EQRO. The EQRO evaluates quality, accessibility, and timeliness of healthcare services furnished by the MCPs through a variety of mandatory and optional activities following the CMS-developed EQRO Protocols.

One EQRO activity involves conducting a compliance review, also known as the Operational Systems Review (OSR). OSRs are designed to assess MCP compliance with structural and operational standards, which may influence the quality, accessibility, and timeliness of healthcare services provided to Medicaid beneficiaries. The audit determines MCP compliance with Medicaid managed care regulations found in the CFR and DHCF-specific contractual requirements. The standards include applicable elements of:

- Subpart A: §438.10 — Information Requirements
- Subpart B: §438.56 — Disenrollment Requirements
- Subpart C: §438.100 — Enrollee Rights and Protections
- Subpart D: §438.206–§438.242 — MCP Standards
- Subpart E: §438.330 — Quality Assessment and PIP
- Subpart F: §438.402–§438.424 — Grievance and Appeal System

The audit process involves the EQRO reviewing MCP documentation, conducting interviews with key MCP staff members, and performing a comprehensive file review. Each MCP OSR report provides information that enables the MCP to implement corrective action plans to correct any areas of deficiency found during the OSR. The report also helps DHCF to determine each MCP's compliance with 42 CFR §438 and the District contract and helps identify areas of the contract oversight that need to be modified or strengthened to ensure an MCP complies with the requirements. The MCPs are expected to be 100% compliant with the Medicaid managed care regulations and DHCF-specific contractual requirements.

MCP Corrective Action

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

Intermediate Sanctions

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

- Civil money penalties.

- Appointment of temporary management for an MCP.
- Granting enrollees the right to terminate enrollment without cause.
- Suspension of all new enrollment.
- Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the District is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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

Performance Measure Reporting

Managed Care Program Accountability Set

DHCF plans to move towards a fully managed Medicaid program. This move aims to transform the Managed Care Program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health. As more beneficiaries transition into managed care, a more structured and formalized Managed Care Quality Improvement Program is needed to improve MCP accountability for managing and improving health outcomes. In alignment with the District's Quality Strategy, the Managed Care Quality Improvement Program includes the following components:

- A defined set of standardized performance measures for which MCPs are held accountable.
- Reasonable and achievable performance benchmarks.
- Well-defined criteria for compliance actions when quality improvement benchmarks are not met (e.g., sanctions, corrective action plans, financial withholds).
- Criteria for rewards (e.g., withhold payouts, auto-assignment preferences).

In 2024, DHCF will establish a new Managed Care Program Accountability Set (Accountability Set) — a set of industry-standard quality performance measures including measures in the CMS Adult Core Set Measures and all Child and Behavioral Health Core Set Measures. In order to be in compliance with CMS requirements for reporting, MCPs participating in CASSIP, DCHFP, and DDCP are required to annually report all Accountability Set quality measures for the corresponding measurement year. The measures featured in the Accountability Set include all CMS Child and Behavioral Health Core Set Measures, and most of the Adult Core Set Measures. The Accountability Set is updated annually based on changes made by CMS, the measure data steward (NCQA, AHRQ, NQF, etc.), and changes in the District's quality improvement priorities.

Due to the District's Managed Care reform efforts (which have impacted continuous enrollment) and the ongoing Coronavirus Disease 2019 PHE (which has negatively impacted health service utilization), DHCF has not established a baseline or identified MCP performance benchmarks. Through a collaborative process, the District will begin

conversations with the MCPs, DHCF's contracted Actuary, and other stakeholders to identify a baseline, define benchmarks, and define the criteria for rewards and penalties if the benchmarks are not met.

P4P

The managed care P4P program, also referred to as the Performance-Based Incentive Program in the DCHFP and CASSIP MCP contracts, requires the MCPs to meet the minimum threshold for improvement with several performance measures. P4P may be funded through a withhold of each MCP's capitation payments. DHCF establishes performance goals for the P4P program based on reasonable and attainable improvement thresholds and implemented a scoring system to determine the distribution of payment incentives for the MCPs. The three measures currently planned in the relaunch are — LANE ED utilization, PPAs, and PCRs. The MCP contracts also detail the below methodology and scoring algorithm used to evaluate performance measures.[17]

- LANE and PPA quality metrics are weighted at 33% of the capitation withhold. MCPs have an opportunity to earn back withhold funds as follows:
  - 10% reduction (improvement) in LANE ED utilization and PPAs from the baseline will result in the MCP earning 100% of the 33% withhold attributed to each of these measures.
  - 7.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCP earning 50% of the of the 33% withhold attributed to each of these measures.
  - 5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCP earning 25% of the 33% withhold attributed to each of these measures.
- PCR is weighted at 34% of the capitation withhold. MCPs have an opportunity to earn back withhold funds as follows:
  - 10% reduction (improvement) in PCR from the baseline will result in the MCP earning 100% of the 34% withhold attributed to this measure.
  - 7.5% reduction in PCR from the baseline will result in the MCP earning 50% of the 34% withhold attributed to this measure.
  - 5% reduction in PCR from the baseline will result in the MCP earning 25% of the 34% withhold attributed to this measure.

If reduction is less than the minimum 5% for the metrics, the MCPs do not earn any portion of the withhold funds.

The results of the Managed Care P4P program are published annually in the Managed Care Performance Reports section on DHCF's website.[18]

[17] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCP%20Contract%20PUBLIC.pdf

[18] https://dhcf.dc.gov/page/dhcf-policies-and-publications

VBP

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

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

Section 7
Assessment

Identification of Age, Race, Ethnicity, Sex, Primary Language, and Special Healthcare Needs

Age, Race, Ethnicity, Sex, and Primary Language

At the time of Medicaid enrollment, individuals are asked to report their age, race, ethnicity, and primary language. Disability status is determined based on Supplemental Security Income (SSI) eligibility. These data are shared with the MCPs in order to ensure the delivery of culturally and linguistically appropriate services to members. Each MCP must have written guidelines and procedures to ensure beneficiaries are provided covered services without regard to age, race, ethnicity, sex, primary language, and disability status.

The MCPs provide to beneficiaries and potential beneficiaries free of charge, competent, professional, oral interpretation services utilizing the District's Language Access Line (or comparable services) or through on-site professional interpretation services, regardless of the language spoken, at all points of contact. In addition, MCPs require all Network Providers to follow the requirements of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1974, and other District requirements.[19] All written materials must be made available in any language that the Medicaid enrollee requests.

Enrollees with Special Healthcare Needs

The MCPs are required to have policies and procedures to identify adults and children with special healthcare needs, including utilizing a DHCF-approved screening tool. They are also

[19] The DC Language Access Act at 2–1933 states that a covered entity shall provide translations of vital documents into any non-English language spoken by a limited or non-English proficient population that constitutes 3% or 500 individuals, whichever is fewer, of the population served or encountered, or likely to be served or encountered, by the covered entity in the District.

required to ensure enrollees with special healthcare needs receive care coordination and case management services and have access to a specialist appropriate for the enrollee's condition and identified needs. Adults and children with special healthcare needs are defined as follows:

- Adults who have an illness, condition, or disability that results in limitation of function, activities, or social roles in comparison with accepted adult age-related milestones in general areas of physical, cognitive, emotional, and/or social growth and/or development, or people who have seen a specialist more than three times in the last year. This definition includes, but is not limited to, individuals who self-identify as having a disability or who meet DHCF's standard of limited English proficiency.
- A child with special healthcare needs is defined as a person under 21 years of age with a chronic, physical, developmental, or behavioral condition that requires health and related services of a type or amount beyond that which is required by children generally. This may include a child who receives SSI, a child whose disabilities meet the SSI definition, a child in foster care, and a child with developmental delays or disabilities who needs special education and related services under the Individuals with Disabilities Education Act (IDEA).

EQR and Independent Review of Access, Quality, and Timeliness of Care

In accordance with 42 CFR §438.356, DHCF contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. The EQRO contract duration is four years, with consecutive one-year renewal options. Consistent with CMS guidance, the EQRO conducts the mandatory and optional activities using CMS-published protocols. DHCF publishes the annual technical reports online.

Mandatory Activities

To evaluate the quality, accessibility, and timeliness of healthcare services furnished by the MCPs, the District's EQRO conducts mandatory EQR activities for all MCPs participating in DCHFP, CASSIP, and DDCP. DHCF has determined that the mandatory activities completed by the EQRO do not duplicate activities performed through private accreditation such as NCQA. DHCF has contracted with its EQRO to perform the following mandatory activities:

- **OSR** to assess compliance with the structural and operational standards found in 42 CFR §438 and with DHCF contract requirements.
- **Performance Measure Validation** on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and other required performance measures, including source code validation and medical record overreads.
- **PIP Validation** to ensure the level of confidence DHCF can have in MCP PIP design and methodology, including proper identification of barriers and interventions.
- **Network Adequacy Validation**, including:
  - Define the scope of the validation of quantitative network adequacy standards.
  - Identify data sources for validation.

- Review information systems underlying network adequacy monitoring.
- Validate network adequacy monitoring data, methods, and results.
- Communicate preliminary findings to each MCP.
- Submit the findings to state.

Optional Activities

The EQRO conducts the following optional EQR activities for DHCF:

- Encounter data validation to assess and report on the completeness and accuracy of encounter data.
- Focused study to evaluate the impact of the District's Medicaid Reform Efforts on access to quality of care.
- Calculation of Health Home performance measures.
- BH CAHPS survey.

EQR Annual Technical Report

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report summarizes EQR findings based on the annual MCP audits. The report describes objectives, methodologies, results, and conclusions for each EQR activity. The EQRO 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.

DHCF uses the information obtained from each of the EQR activities, including information highlighted in the EQR Annual Technical Report, to make programmatic changes, and modifications to the Quality Strategy. The EQR Annual Technical Reports are submitted to CMS annually and are posted on the DHCF website.[20]

Non-Duplication of EQR Activities

CMS 438.358(b)(1)(i)–(iii) permits 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 opportunity for non-duplication deeming. DHCF uses information from a Medicare accreditation review of an MCP for the Annual Technical Report, instead of duplicating one or more of the EQR activities.

Non-duplication, as described in EQRO protocols, is intended to reduce 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 opportunity to "deem," or

[20] MCO External Quality Review Annual Technical Reports | dhcf (dc.gov)

consider, the federal regulation as meeting requirements. This process eliminates the need to review the regulation as part of the OSR, reducing 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 in the applicable federal regulation for the last two OSR cycles.
- The MCP must provide evidence of the most recent NCQA audit, which includes a 100% assessment in the applicable standards.

EQR Standards Using Medicare or Private Accreditation Reviews

Using the DHCF deeming criteria and information obtained by the *NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards (Effective July 1, 2020–June 30, 2021)*, the EQRO evaluates whether the MCP qualifies for deeming of federal regulations.

Standards in which DHCF permitted deeming include:

- Subpart D: §438.206–§438.242 MCP 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 PIP
- Subpart F: §438.402–§438.424 Grievance and Appeal System
  - §438.416 Recordkeeping Requirements

The EQRO may refer to the MCP's NCQA accreditation findings when conducting EQR mandatory activities; however, the EQRO does not use NCQA accreditation findings in place of conducting EQR activities. The EQRO reviews the MCP's NCQA accreditation status during the annual OSR activity and documents the finding in the Annual Technical Report.

Section 8
District Standards

Access Standards

DHCF requires the MCPs to meet network adequacy and availability of services standards that fall within the following five domains: availability of services, appointment availability, network capacity, coordination and continuity of care, and coverage and authorization of services.

Availability of Services

The MCPs are required to provide, or arrange for, the delivery of all medically necessary covered health services to enrollees. This includes ensuring they follow provider panel access standards by considering the following:

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

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

For enrollees with special healthcare needs or those who are determined to need a course of treatment or regular care monitoring, DHCF requires MCPs to have mechanisms in place to allow direct access to specialists appropriate for their condition and identified needs.

Women's Health Specialist

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

specialist. Female enrollees are entitled to timely access to family planning (Title X) services, in or out of network.

Second Opinion from a Qualified Health Professional

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

Coverage of Services Not Available In-Network

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

LTSS Coverage

LTSS can be accessed through District government agencies and non-profit organizations that will help identify services available, plan a person's care, and offer information about and recommendations for LTSS. The information will allow people with disabilities and their families to make choices about the LTSS they need to live with dignity in their homes and be fully included in their communities for as long as possible.

Some LTSS have eligibility criteria a person must meet in order to access services, which may include both financial criteria and non-financial criteria. Financial eligibility criteria are based on a person's income and assets. The non-financial eligibility criteria include demographic information such as age and disability, citizenship and residency status, and level of care eligibility. The level of care eligibility is determined through a comprehensive health assessment, which is completed by a registered nurse acting on behalf of the District and which calculates a unique level of care score reflecting an individual's need for LTSS. Individuals seeking services with level of care criteria must participate in this comprehensive assessment process, though not all LTSS require level of care assessments.

LTSS can also be accessed through DDCP. The DDCP D-SNP must ensure network coverage of at least:

- One Medicaid-enrolled Home Health Agency contracted per 150 enrollees authorized to receive personal care services or in-home skilled nursing or therapy, and no fewer than three such providers in total.

- One Medicaid-enrolled chore/homemaker agency contracted per 150 enrollees authorized to receive chore or homemaker services, and no fewer than three such providers in total.
- One Medicaid-enrolled Adult Day Health Program Provider contracted per 150 enrollees authorized to receive adult day health services, and no fewer than three such providers in total.
- One Medicaid-enrolled medical alert devices and services (MADS) Provider contracted per 500 enrollees authorized to receive MADS, and no fewer than three such providers in total.
- One Medicaid-enrolled nursing facility (NF) contracted per 100 enrollees authorized to receive NF services, and no fewer than three such providers in total.
- One Medicaid-enrolled assisted living facility contracted per 50 enrollees authorized to receive assisted living services, and no fewer than three such providers in total.

Appointment Availability

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

Services included in the MCP contract must be available 24 hours a day, 7 days a week, when medically necessary. The District has set timely access standards for non-urgent appointments (see Table 5). In addition, the wait time for a primary care appointment should not be greater than 45 minutes if the enrollee arrived early. All pediatric standards apply to children up to 21 years unless otherwise stated.

MCPs must have written policies and procedures for monitoring and sanctioning providers who are either out of compliance with District standards for timely access to care and services, or have been excluded, suspended, or debarred from participating in any District, state, or federal healthcare benefit program, in accordance with 42 CFR §438.66. The MCP must provide these policies and procedures to their network providers.

Table 5. DC Managed Care Program Timely Access Appointment Standards

Provider Type	Appointment Type	Timely Access for Non-Urgent Appointments
Primary Care	New Enrollee Appointment	45 calendar days from enrollment or 30 calendar days from request, whichever is sooner
	Routine Appointment	30 calendar days from request
	Well-Health for Adults 21+ Years	30 calendar days from request
	Non-Urgent Referrals	30 calendar days from request

Provider Type	Appointment Type	Timely Access for Non-Urgent Appointments
	Diagnosis and Treatment of Health Condition (Non-Urgent)	30 calendar days from request
	Initial Pregnancy	10 calendar days from request
	Family Planning	10 calendar days from request
Specialists	Non-Urgent Referral	30 calendar days from request
	Initial Pregnancy	10 calendar days from request
	Family Planning	10 calendar days from request
Pediatrics Screening	New Enrollee Appointment	60 calendar days from enrollment or sooner to comply with periodicity schedule
	EPSDT Examination	30 calendar days from request
	IDEA Part C Multidisciplinary Evaluation for Children with Disabilities up to 2 Years	30 calendar days from referral
	IDEA Part C Treatment for Children with Disabilities up to 2 Years	25 calendar days from signed Individualized Family Service Plan
Mental Health	Outpatient	• Within 7 calendar days of discharge from a psychiatric inpatient facility or a PRTF • Within 30 calendar days of discharge from an acute care admission

Network Capacity

In order to assess the adequacy of the provider network, MCPs are required to submit a list of all network providers, provide summary reports by specialization, and submit all provider contracts to DHCF. On a weekly basis, the MCPs are sent an electronic file that contains the District's provider panel, allowing for a reconciliation of any discrepancies between the MCP panel and what is contained within DHCF's MMIS.

Time and Distance Requirements

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

- Primary Care, OB/GYN, Specialty Care, Mental Health, Hospital, and Laboratory — five miles or 30 minutes from the beneficiary's residence
- Pharmacy — two miles from the beneficiary's residence

The DDCP requires the following additional standards for the following LTSS provider types:

- Adult Day Health Providers — Travel time by public transportation shall not exceed 30 minutes
- NFs and Assisted Living Facilities — Travel time by public transportation shall not exceed 60 minutes

Cultural Competency

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

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

Coordination and Continuity of Care

Transition of Care Policy

The District's goal is to maintain continuity of care for enrollees especially during transitions between health plans or health systems. This will ensure a seamless transition that is safe, timely, and orderly, and that will maintain effective coordination between responsible entities. MCPs shall develop written policies and procedures to be submitted to DHCF and updated annually. The transition of care (TOC) policy shall include, at a minimum, the requirements in 42 CFR §438.62(b)(1) and 42 CFR §438.208(b)(2)(ii). The MCP transition of new and existing enrollees shall minimize disruption to enrollees' established relationships with providers and existing care treatment plan and ensure medically necessary covered services are provided in a timely manner. To ensure seamless transition, the MCP TOC policy should, at a minimum, include:

- TOC Policies for Enrollees Enrolled in Care Coordination and Case Management
- Enrollees in LTSS for both HCBS and NFs
- TOC for Enrollees in a Health Home
- Health Information Transfer Process Across Contractors
- Process for New Enrollees from FFS or Another Contractor
- Repayment: The Transferring Contractor shall Manage TOCs between Payment Delivery Systems

Coverage and Authorization of Services

MCPs are required to cover and pay for diagnostic, screening, and preventive clinical services that are assigned a grade of A or B (strongly recommended or recommended, respectively) by the United States Preventive Services Task Force; approved vaccines recommended by the Advisory Committee on Immunization Practices; preventive care and screening of infants, children, and adults recommend by the Health Resources and Services Administration's Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine. Preventive services should be recommended by a physician or other licensed practitioner of the healing arts acting within the authorized scope of practice under the Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.), or comparable law in the state where the provider is licensed.

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

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

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

Medical Necessity

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

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

MCPs are allowed to place appropriate limits on services for the purpose of utilization control, provided the services furnished can reasonably achieve their purpose. The services supporting individuals with ongoing or chronic conditions, or who require LTSS, are authorized in a manner that reflects the enrollee's ongoing need for such services and supports. As stated in the MCP contracts, MCPs are responsible for ensuring that Medical Necessity criteria applicable to children under 21 years of age reflect EPSDT guidelines. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.

Authorization of Services

Written UM policies and procedures define a MCP prior authorization process. This process includes the use of review criteria and a utilization review decision algorithm that conforms to managed care industry standards. Specifically, the policies and procedures must:

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

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

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

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

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

- The reason(s) for the adverse benefit determination.

- The enrollee's right to file an Appeal with the MCP.
- The enrollee's right to directly request a District Fair Hearing only after receiving notice that the MCP, Prepaid Inpatient Health Plan, or Prepaid Ambulatory Health Plan is upholding the adverse benefit determination.
- The procedures for exercising the enrollee's Appeal and Fair Hearing rights.
- The enrollee's right to have counsel or another representative in the Appeal and Fair Hearing process.
- The circumstances under which an expedited resolution of the adverse benefit determination is permitted and how to request it.
- The enrollee's right to have his or her benefits continued pending resolution of the Appeal or Fair Hearing if the conditions specified in the contract are met.
- The enrollee's right to receive assistance from the Medicaid Ombudsman and how to contact the Ombudsman.
- The enrollee's right to obtain free copies of certain documents, including the Enrollee's medical records used to make the decision and the medical necessity criteria, referenced in the adverse benefit determination.

Structure and Operation Standards

Credentialing and Re-Credentialing

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

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

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

DHCF prohibits the employment or contracting of providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social

Security Act. MCPs must notify DHCF when credentialing is denied for program integrity reasons.

Enrollee Information

To assist potential enrollees, DHCF maintains current information about the Managed Care Programs on its website.[21] This includes information about the Medicaid Managed Care Benefit Package, links to each of the MCP websites, and, in 2019, a comparison of the District's MCPs on key performance indicators. The District's enrollment broker maintains a phone line and is responsible for providing unbiased education and selection services for the DCHFP and CASSIP MCPs. All informational materials developed by DHCF, the enrollment broker, and the MCPs will be made available in formats and languages that ensure their accessibility and appropriate reading level.

Each MCP is required to produce an enrollee handbook that includes the following information:

- Benefits provided, including the amount, duration, and scope of those benefits, and guidance on how and where to access benefits, including transportation, family planning services, and supplies from out-of-network providers.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP.
- How, and the extent to which, after-hours and emergency coverage are provided.
- Beneficiary rights and responsibilities.
- The process of selecting and changing the enrollee's PCP.
- Grievance, appeal, and District Fair Hearing procedures and timeframes.
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries and how to access auxiliary aids and services, including additional information in alternative formats or languages.
- Information on how to report suspected fraud or abuse.
- MCPs are permitted to provide this information by mail or email (only if beneficiary has expressed consent for email) in addition to posting online.
- MCPs must compile a directory of its network providers in a format specified by DHCF. The directory must be made available to enrollees and potential enrollees and include the following information:
  - Provider names (first, middle, last)
  - Group affiliation(s) (i.e., organization or facility name[s], if applicable)
  - Street address(es) of service location(s)

[21] https://dhcf.dc.gov/

  - Telephone number(s) at each location
  - Website URL(s)
  - Provider specialty
  - Whether provider is accepting new beneficiaries
  - Provider's linguistic capabilities (i.e., languages [including American Sign Language] offered by provider or a skilled medical interpreter at provider's office)
  - Whether provider has completed cultural competency training
  - Office accessibility (i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room[s], and equipment)
  - Telephone number beneficiaries can call to confirm the information in the directory
- This information must be made available in electronic form and, upon request, in paper form. Per 42 CFR §438.10, information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCP receives updated provider information. Provider directories must be posted on the MCP's website.

Confidentiality

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

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

Enrollment and Disenrollment

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

Within 10 business days of the birth of an infant to a woman enrolled in the plan, the MCP shall notify DHCF by completing all fields in the Deemed Newborn forms and log and submit to designated staff at the Department of Human Services' Economic Security Agency, which is responsible for Medicaid eligibility determinations, to ensure newborns are enrolled in a

timely manner. From the time of birth, the newborn must remain an enrollee of the MCP to which they were assigned until a separate Medicaid number is assigned. Upon assignment, the parent can choose to enroll the newborn in a different MCP.

MCPs may only request disenrollment of enrollees when the MCP is notified that the enrollee is ineligible for services or upon suspicions of fraud or deceptive use of MCP services by the enrollee. Consistent with the ADA, DHCF determines whether the individual is a qualified person with a disability and, if so, shall specify the reasonable accommodations that MCP shall make to continue provision of services. Risk-based MCPs may request that DHCF disenroll a Medicaid enrollee who has been admitted to a Medicaid-approved Residential Treatment Center, PRTF, Nursing Home, NF, Skilled Nursing Facility, or other long-term care facility, or is incarcerated and expected to remain in the facility for 30 consecutive days.

CASSIP

CASSIP is a specialized, voluntary managed care program for DC Medicaid or ICP-enrolled children and adolescents aged 20 years old or younger, who either concurrently receive SSI, or have been determined to meet the disability criteria described herein by DHCF, or its authorized agent.

In order to voluntarily enroll in CASSIP, an individual must meet the following criteria:

1. Be actively enrolled in D.C. Medicaid or ICP.
2. Be aged 20 years or under.
3. Be concurrently in receipt of SSI.
4. Be determined by DHCF or its authorized agent to have a qualifying disability.

In addition to the above eligibility criteria, CASSIP enrollees are required to have care coordination and case management services while enrolled in the program. If the newborn is a CASSIP-eligible enrollee, the parent or guardian may choose to enroll the newborn in CASSIP or transition the newborn to FFS. Non-CASSIP newborns shall have the right to remain enrolled in CASSIP from the time of birth and may remain an enrollee up to the age of six years unless the mother ages out of CASSIP or is otherwise disenrolled before that child reaches their sixth birthday. The mother can also choose to enroll her non-CASSIP eligible newborn into a different MCO, as the eligibility warrants and based on the Economic Security Administration assigned program code. CASSIP eligible individuals who do not select the option to enroll in CASSIP will remain in FFS Medicaid.

Once an individual is enrolled in CASSIP, they will remain enrolled until such individual requests disenrollment, is 26 years old or older, the CASSIP contractor is unable to locate the enrollee and/or the enrollee has not utilized covered benefits for a period of at least six months, refuses Care Management services, or is no longer enrolled in DC Medicaid or ICP.

DDCP

DDCP is a voluntary Medicaid managed care program. A beneficiary can enroll in DDCP through D-SNP, 1-800-Medicare, or via Medicare.gov. After verifying Medicare and Medicaid eligibility, D-SNP submits beneficiary enrollment to the District for review. The District responds to D-SNP confirming or rejecting enrollment, based on the District's Medicaid eligibility data. The District allows D-SNPs to effectuate enrollment for members up to seven

days after the start of the month. The District auto-assigns the member's Medicaid managed care benefits to their chosen D-SNP on the same day as their Medicare enrollment date where possible.

DDCP enrollees may choose to disenroll from D-SNP, with or without cause, during special election periods, and once per quarter as prescribed by Medicare regulations. D-SNP must accept an oral or written request for disenrollment from the enrollee. With the exception of any conditions specified under 42 CFR §422 Subpart B, D-SNP may not initiate D-SNP disenrollment and shall refer all requests for disenrollment to DHCF. Consistent with 42 CFR §438.56(b)(2), the contractor may not request disenrollment because of an adverse change in the enrollee's health status, utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when the enrollee's continued enrollment seriously impairs D-SNP's ability to provide services to the enrollee or other enrollees. D-SNP may only request disenrollment of enrollees when D-SNP is notified that the enrollee is ineligible for services, when an enrollee stratified as high-risk affirmatively refuses all Care Management services, or upon suspicions of fraud or deceptive use of D-SNP services by the enrollee.

Grievance and Appeals System[22]

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

The MCP shall issue a written acknowledgement of the receipt of an appeal or a grievance within two business days of receipt. The MCP shall dispose of the grievance and notify the enrollee or the enrollee's designee in writing of the decision no later than 60 calendar days from the date the MCP receives the grievance, or as expeditiously as the enrollee's health condition requires. In handling grievances and appeals, each MCP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers for use by persons with hearing or speech difficulties. DHCF requires MCPs to report monthly on their grievance and appeal processes and outcomes.

Subcontractual Relationships and Delegation

MCPs shall evaluate a prospective subcontractor's ability to perform the activities to be delegated before a written agreement is executed. When an MCP enters into a subcontractual arrangement, all contracts or written arrangements/agreements between the

[22] In addition to meeting the Medicaid Managed Care requirements listed in this section, any D-SNP that operates a plan benefit package that meets the standards of an Applicable Integrated Plan under DDCP shall have in place an internal, integrated Grievance and Appeal System that further meets the standards of 42 CFR §§422.629–422.634.

MCP and any subcontractor must specify that the delegated activities or obligations are: 1) in compliance with the MCP's contract obligations, and 2) either provide for the revocation of the delegation or specify remedies in instances where the subcontractor has not performed satisfactorily.

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

Measurement and Improvement Standards

MCPs are required to implement the following standards for measurement and improvement: clinical practice guidelines, QAPI program, and health information systems.

Clinical Practice Guidelines

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

Pediatric Providers and DC HealthCheck Training

The HealthCheck website (www.dchealthcheck.net) is a training and resource center that provides online training and materials on Medicaid's EPSDT benefit for DC providers, agencies, and families. For a more thorough search of resources, within the Provider Resources section of the website there is a navigation bar (at the left) with resources organized by broad topic: **news**, **HealthCheck resources**, **general pediatric resources**, **Medicaid/EPSDT resources**, and **family resources**.

The HealthCheck Provider Education System is based primarily on information from the following sources:

- The **HealthCheck Periodicity Schedule** developed by DHCF. The manual was developed in collaboration with many organizations and agencies. The content of this manual is based on the information available at time of publication and will be reviewed and updated periodically.
- **Bright Futures** content and philosophy. Bright Futures is cited as an example of recognized and accepted clinical practice guidelines for EPSDT screening. Based on the **Bright Futures Guidelines** and other resources, the Distance Education Project has developed an EPSDT curriculum tailored for providers of pediatric preventive healthcare services. (Form-416 data.)
- **Medicaid and EPSDT** information from CMS. This resource contains information on the EPSDT benefit, including periodicity schedule,

components of an EPSDT visit, District reporting requirements, and CMS' national State Medicaid Manual (Section 5123.2).

Other examples of evidence-based guidelines used by the MCPs include:

- The American College of Physician's clinical practice guidelines on diagnosis and management of stable chronic obstructive pulmonary disease.
- The American Academy of Pediatrics' guidelines for adolescent depression in primary care.
- The American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines' guideline on the management of blood cholesterol.

The practice guidelines are disseminated to all network providers, and are readily available through mail, fax, email, or the MCP's website. Practice guidelines must be made available upon request to enrollees and potential enrollees. The MCP must utilize the application of practice guidelines to assist practitioners and enrollees in decision-making as it pertains to appropriate healthcare UM for specific clinical circumstances and BH care services.

QAPI Program[23]

Each MCP is required to develop, maintain, and operate a QAPI program, which is reviewed and/or revised annually and submitted to DHCF for approval. The MCP must maintain a well-defined QAPI structure that includes a planned, systematic approach to improving clinical and non-clinical processes and enrollee health outcomes.

The MCP is also required to use performance measures, including, but not limited to, HEDIS, CAHPS, provider surveys, and enrollee satisfaction surveys to assess the effectiveness of its QAPI program. The QAPI program must include iterative processes for assessing and monitoring quality performance, including, but not limited to, barrier analysis, identifying opportunities for improvement, implementing targeted and system interventions, and continuous monitoring for effectiveness through the utilization of quality improvement principles. The MCP must also implement clinical and non-clinical initiatives that address performance measures chosen by DHCF and included in the Quality Strategy.

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

The MCP QAPI is required to include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs, including, but not limited to:

- Ensuring each enrollee is assigned a PCP, which may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN, pediatric physician (when appropriate for the enrollee), osteopath, clinic, or Federally Qualified Health Center (FQHC), nurse practitioner, or a subspecialty physician when appropriate to an enrollee's special healthcare needs.

[23] All QAPI information, including requirements, should be located in this Health Disparities section.

- Providing care coordination and case management services.
- Directing access to a specialist as appropriate for the enrollee's condition and identified needs.
- Ensuring the availability of appropriate accommodations.

Finally, each MCPs is required to conduct and submit to DHCF an annual evaluation of its QAPI program, which at a minimum must include:

- Analysis of improvements in access and quality of healthcare services for enrollees due to quality assessment and improvement activities and targeted interventions carried out by the MCP.
- Consideration of trends in service delivery and health outcomes over time, including monitoring of progress on performance goals and objectives.

Health Information Systems

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

MCPs must provide for:

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

MCPs are required to have internal procedures to ensure data reported to DHCF are tested for validity, accuracy, and consistency on a regular basis. At a minimum, MCPs must verify the accuracy and timeliness of reported data and screen the data for completeness, logic, and consistency. They must also collect service information in standardized formats to the extent feasible and appropriate. MCPs must ensure reportable data, when allowed to be reported based on a sample, reflects a sufficient sample size to accurately reflect the enrollee population. MCPs must also agree to cooperate in data validation activities that may

be conducted by DHCF, by making available to DHCF's specifications medical records, claims records, and a sample of any other data.

Health Information Technology

Medicaid Enterprise System

DHCF has created a unique, single-source Medicaid Data Warehouse (MDW) that ensures timely access to claims and encounter data. DHCF migrated 10 years of claims history from its MMIS into an enterprise data warehouse and is now able to create all CMS-required reports and ad hoc reports. The modernized data infrastructure and analytical tools allow for evaluation of MCP performance across financial and utilization metrics. In conjunction with the adoption of the MDW, DHCF has incorporated numerous analytics tools to augment the agency's reporting and analytics capabilities to better serve the District Medicaid population.

DC's Digital Health Initiatives

Within DHCF's HCRIA, the Division of Digital Health is charged with implementing the necessary Health Information Technology (HIT) to support the agency's quality improvement efforts across service delivery areas and programs. Currently, the Division of Digital Health is spearheading initiatives to support adoption of Certified Electronic Health Record Technology (CEHRT) as well as connectivity and enhancements to the District's Health Information Exchange (DC HIE), which is regulated by DHCF.

Since 2019, CRISP DC has served as the Designated DC HIE. The DC HIE aggregates information from multiple sources across regional health system partners, including MCPs, and enables access to that information through six core capabilities listed in DHCF's State Medicaid Health IT Plan (SMHP). Embedded within this infrastructure, the DC HIE has several tools that can help MCPs improve their quality improvement initiatives. For example, MCPs can use Admit Discharge, Transfer (ADT) alerts to monitor emergency department visits, inpatient admissions or discharges, and other care encounters in real-time.

The DC HIE includes an analytics platform, called *PopHealth,* which is intended to support population-level and panel-level management through clinical and administrative data — it is designed with the diverse group of DC HIE users (e.g., providers, DHCF, MCPs, etc.) in mind to support their analyses and interventions. This platform can help MCPs enhance their quality improvement initiatives while also supporting provider readiness for performance monitoring of VBP initiatives. MCPs can use this tool to monitor quality measures using clinical and claims data flowing into the DC HIE, thereby creating a more comprehensive picture of performance, and be better positioned to hold providers accountable.

In addition, the DC HIE includes an aggregation of Health Related Social Needs (HRSN) screening and referral information that is shared from third-party platforms, screening and referral data from provider EHRs (including any ICD-10 social needs z-codes), and other disparate data sources. Also included are HRSN tools that allow users to seamlessly conduct a screening and identify appropriate service providers through a centralized resource

inventory to send and receive referrals (e.g., closed loop). Finally, the DC HIE includes an eConsent tool to facilitate appropriate exchange of 42 CFR §2 data.[24]

Section 9
Delivery System Reforms

BH System Redesign

The District offers a broad array of BH services, ranging from diagnosis and counseling to more intensive interventions for individuals with SMI, SED, or SUD. The District is adding new services, especially evidence-based practices, services for youth, and high-intensity services, such as partial hospitalization and crisis interventions, to continue making BH coverage and access more comprehensive. Transitioning BH services into Managed Care also presents the opportunity for a central point of oversight and supports whole-person, patient-centered care.

Funding sources, and subsequent monitoring and accountability, exist across multiple entities, including DHCF, DBH, and MCPs. In addition, other District agencies provide BH services and touchpoints, including the school system, foster care and child protective services, and the justice system. This shared responsibility has sometimes resulted in data gaps, confusion about referrals, and siloing of beneficiaries' physical and behavioral healthcare.

Medicaid Program Reform

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

DHCF transitioned approximately 17,000 adults without Medicare coverage from the Medicaid FFS program to the DCHFP Medicaid Managed Care Program, effective October 1, 2020. On February 1, 2022, DHCF implemented the District Dual Choice program exclusively for dually eligible beneficiaries to better coordinate their Medicare and Medicaid benefits. Healthcare costs for individuals with FFS coverage are typically four-to-five times greater than persons in managed care, as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays. Previously, these beneficiaries managed their healthcare needs without assistance or care coordination. By joining the Managed Care Program, this population will receive access to much needed care coordination and, as a result, improved health outcomes. The Medicaid Reform Path continued with the implementation of the Program of All-Inclusive Care for the Elderly (PACE) in 2023. PACE is a nationally recognized model of care that integrates Medicare and Medicaid benefits for eligible beneficiaries. Under this model, beneficiaries are eligible for a broader array of benefits than is typically available under either Medicaid or Medicare

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

programs and their care is managed by a comprehensive, inter-disciplinary team of clinical professionals working to deliver high-quality and highly coordinated care.

Section 10

Conclusion and Opportunities

The District's Quality Strategy provides the vision to deliver comprehensive, cost-effective, and quality healthcare services to District Residents with the goal of improving health outcomes. Ensuring access to quality, whole-person care supported by positive provider experience is a focused objective. In addition, supporting health equity and addressing HRSNs are identified opportunities for continuous improvement of member health.

As detailed throughout this document, the District strives to improve the health of its unique members across each of its Managed Care Programs through the implementation of strategic initiatives aligning with the IHI triple aim:

- Improving the patient experience of care.
- Improving the health of District residents.
- Reducing the costs of healthcare.

These strategic initiatives, paired with comprehensive program monitoring, contractual standards, evaluation of performance measures, and other tools, support the District in achieving its goals and objectives. In aligning these initiatives with broader strategies such as disparity initiatives, P4P, and EQR activities, the QS provides a comprehensive approach to continuous quality improvement.

Appendix A

Requirements for the QAPI Program

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

QAPIs must contain, at minimum, the following elements:

1. Description of Quality Management Committee structure — must include:
    A. Quality Improvement Manager.
    B. Key Management Staff.
    C. MCP Network Providers.
2. Designation of individuals/departments responsible for QAPI implementation — MCPs must designate a senior executive with appropriate authority and accountability to oversee QAPI implementation. The Chief Quality Officer is accountable for the administrative success of QAPI program activities. The Chief Medical Officer must have substantial involvement.
3. Description of network provider participation in QAPI — MCPs must involve network providers in QAPI activities by including a requirement in provider contracts securing cooperation.
4. Description of strategy for ensuring all staff responsible for the QAPI program will remain current in the education, experience, and training need for their positions.
5. Integration of quality assurance with other management functions — To be effective, quality assurance must be integrated in all aspects of MCP management and operations. The QAPI must describe the process by which this integration will be achieved.
6. Clinical practice guidelines — MCPs must develop or adopt practice guidelines consistent with current standards of care, as recommended by network practitioners. Include a description of how the MCP will:
    A. Ensure guidelines are based on valid and reliable clinical evidence.
    B. Provide guidelines to providers and members when requested.
    C. Apply the guidelines to UM, member education, coverage of services, and any other appropriate areas.

7. Quality and appropriateness of care — Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.
8. Standards for service accessibility — MCPs must develop written standards for service accessibility.
9. Utilization review procedures — Include mechanisms to detect overutilization and underutilization of services.
10. Annual objectives and/or goals for planned projects or activities, including clinical and non-clinical programs or initiatives and measurement activities; evaluates the effectiveness of clinical and non-clinical initiatives. MCPs should conduct data analysis, including on HRSNs, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees.
11. PIP — MCPs are also required to conduct at least two PIPs each year in a priority topic area of DHCF's choosing. A description of how the MCP intends to address the areas of improvement must be included in the QAPI.
12. Quality indicator measures — MCPs must at least annually collect and submit to DHCF performance measure data, including, but not limited to, HEDIS, CAHPS, provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, and all EQRO activities as part of its QAPI program.
13. QAPI documentation methods — The QAPI must contain a description of the process by which all QAPI activities will be documented, including performance improvement studies, medical record audits, utilization reviews, etc.