Medical Care Advisory Committee

July 26, 2023

Virtual Meeting Processes

To increase engagement, turn on your video

Mute your microphone upon entry, and until you are ready to speak

Use the chat function to introduce yourself: ***Name, Title, Organization*** *(if any)*

If you have comments or questions, please use the '***Raise Hand***' feature and speak clearly

If you are not a member of the Advisory Committee, kindly hold your questions till the end of the meeting or add your questions to the chat!

Agenda

- **Welcome and Introductions**

- **DHCF Program Updates Q&A**
  - Medicaid Renewal
  - Behavioral Health Integration
  - Perinatal Mental Health Task Force
  - Maternal Health Advisory Group

- **MCAC Presentation and Discussion**
  - Annual Technical Report

- **Subcommittee Updates**
  - Access
  - Eligibility and Enrollment
  - Health System Re-design Subcommittee
  - Long-Term Services and Supports

- **Call for nominations and vote for Chair and Vice Chair**

- **Public Announcements**

Medicaid Renewal

Background: Medicaid Beneficiaries Will Have to Renew Their Coverage for the First Time in 3+ Years

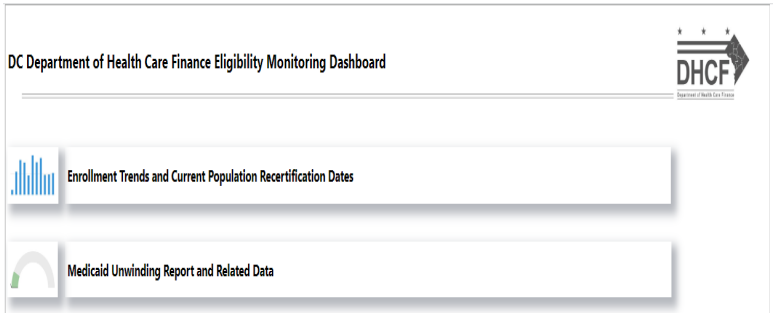
- In March 2020, CMS temporarily waived the need to renew Medicaid coverage and states received a 6.2% financial boost to accommodate the increased enrollment.
- Medicaid enrollment has increased by 20% since the start of the public health emergency – just over 300,000 District residents are now enrolled in Medicaid.
- At the end of 2022, Congress passed legislation ending the continuous eligibility requirement on March 31, 2023.
- The District restarted Medicaid eligibility **renewals beginning April 1, 2023** (Alliance and Immigrant Children's Program renewals started in July 2022), with the first two groups **required to renew coverage before May 31, 2023, or June 30, 2023.**

For Official Government Use Only

DC Medicaid Renewal Data is Publicly Available and Regularly Updated on the DHCF Website

Public data at https://dhcf.dc.gov/eligibilitydashboard is typically updated by the 15th of each month. It currently reflects information as of June 15 for beneficiaries who:

- Previously received a renewal notice (non-disabled children and adults under 65 due in May-June; people with disabilities and those age 65+ due in June-July).
- Newly received a notice in June (non-disabled children and adults under 65 due in July; people with disabilities and those age 65+ due in August).



Data provided in this presentation reflects information as of July 10, beyond what is currently shown in the dashboard linked above. A data update for the general public will be provided during DHCF's next biweekly community meeting on July 19.

- Among beneficiaries **due in May**, more than 80% have renewed or are pending. Most who lost coverage had no response flagged in District Direct.
- Among those **due in June or July**, many currently show as actual or potential coverage loss because there is no renewal response flagged in District Direct. People with disabilities and those age 65+ have received one-month extensions (through July or August) to allow for additional response time.
- Among those **due in July or August**, passive renewals (i.e., coverage automatically extended based on electronic data checks) are low. These are the first months with renewals due for beneficiaries who were kept enrolled during the public health emergency but had income or other changes that made them appear ineligible. Because they are already known to appear ineligible, most are not able to renew based on electronic checks.
- For **all groups** whose renewal is currently due or past due in a 90-day grace period, the number in a renewed, pending, or determined ineligible status can continue to increase as renewals are returned and processed. Similarly, the number in the terminated category will decrease.

Results from First Month of Renewals: More Than 80% of Beneficiaries Are Renewed or Pending

- **Approximately 14,500 beneficiaries were due to recertify by the end of May.** This group largely reflects non-disabled children and adults under age 65 with 60-day notices mailed by April 1.
  - Of that total, 77% (11,200) are **renewed** as of July 10.
    - 66% were renewed passively (extended by DHCF based on electronic checks alone).
    - 12% were renewed non-passively (beneficiary provided information needed to extend their coverage).
  - 4% (600) are **pending** (renewal is flagged in District Direct but requires verification(s) from beneficiary or processing by caseworker).
  - 19% (2,700) are **disenrolled**.
    - Less than 1% (fewer than 100) were determined ineligible (beneficiary provided information indicating they no longer qualify).
    - Remaining 18% (2,600) had no response (renewal not flagged in District Direct). These are referred to as “procedural terminations.”
    - Among the disenrolled, nearly two-thirds are adults aged 21-64 and just over one-third are children (not shown in current dashboard).

Outcomes to Date for Beneficiaries with Medicaid Renewal Initiated, Number by Renewal Due Month

Due month	Renewal initiated	Renewed	Renewed: Passive	Renewed: Non-passive	Pending	Terminated or potential to be	Terminated: Ineligible	Terminated: Non-response
2023-05	14,504	11,230	9,522	1,708	558	2,716	87	2,629
2023-05	100.0%	77.4%	65.7%	11.8%	3.8%	18.7%	0.6%	18.1%

- The **renewed and pending categories will continue to increase** during the 90-day grace period. For example, there were 3,300 terminations from the May group as of June 1. By July 10, this had decreased to 2,700 as additional renewals were processed.

There Are No Substantial Differences in Renewal Rates by Age, Gender, Eligibility Category, and Managed Care Plan for Beneficiaries Due in May

- Among the 14,500 beneficiaries due to recertify by the end of May (largely non-disabled children and adults under 65), there were no substantial differences in renewal rates by age, gender, eligibility category, and managed care plan. For example:
  - 77% of children under age 21 renewed, compared to 78% of those age 21-64.
  - Female beneficiaries were slightly more likely to renew (79%) than male beneficiaries (76%).
  - Childless adults accounted for the largest group due in May, with a 77% renewal rate. Parents and caretaker relatives had a 78% renewal rate. As noted above, 77% of children renewed.
  - Renewal rates for the three managed care plans (Amerigroup, AmeriHealth, MedStar) that enroll nearly all beneficiaries due in May ranged from 76% to 79%.

- Those whose renewal is completed or pending are more likely to have recent service use (e.g., health care provider visit, prescription fill, etc.) than those who lost coverage.
  - Among those who have renewed, 78% used services in the past year.
  - Among those whose renewal is currently pending (not yet determined eligible or ineligible), 88% used services in the past year.
  - Among those who lost coverage, 69% used services in the past year.

- Additional information on beneficiary characteristics by renewal status will be provided as part of DHCF's July update.

Most Beneficiaries Due in May Who Lost Coverage Had No Renewal Response

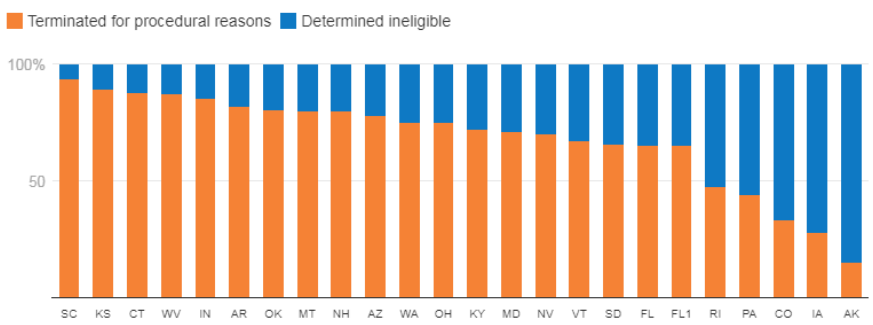
- Among the 2,700 beneficiaries due in May who are disenrolled as of July 10, **reasons for coverage loss**:
  - 2% (fewer than 100) responded and were determined ineligible.
  - 96% (approximately 2,600) had no renewal response flagged in District Direct. This 96% is referred to as a procedural termination rate.

- The District's procedural termination rate is high relative to other states that currently have public data.*
  - This is due in part to the fact that the **District has the highest eligibility levels in the nation** for parents (221% of the federal poverty level) and childless adults (215% FPL).
  - High eligibility levels mean that most people who return a renewal will be found eligible and very few will be determined ineligible. As a result, most of the people losing coverage are those who do not respond, leading to a high procedural termination rate.

Figure 2

Overall, 71% of disenrollments are due to procedural reasons, among states reporting as of July 05, 2023

Of Total Disenrollments, the Share Disenrolled for Procedural Reasons vs. the Share Determined Ineligible:



NOTE: Procedural disenrollments occur when the state cannot verify an individual's ongoing eligibility at renewal. Rates are calculated as procedural disenrollments divided by total disenrollments. Several states report unwinding data without information on reason for disenrollment and are not shown in this figure.

SOURCE: KFF Analysis of State Unwinding Dashboards and Monthly Reports Submitted to CMS • Get the data • PNG

KFF

* https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/

June Renewal Patterns Show Similarities to May - But Changes in Passive Renewal Rate for July, August is a Concern

- **Due in June**
  - Approximately 21,600 beneficiaries were due to recertify by the end of June, including:
    - 19,400 non-disabled children and adults under age 65 with 60-day notices mailed by May 1.
    - 2,200 people with disabilities and adults age 65+ with 90-day notices mailed by April 1.
  - Of those, 72% (15,500) are renewed or pending as of July 10, including:
    - 76% (14,500) of non-disabled children and adults under 65.
    - 42% (900) of people with disabilities and adults age 65+.
  - For most of the remaining 28% (6,100), there is no renewal response currently flagged in District Direct.
    - Among 4,900 non-disabled children and adults in this category, approximately 60% are age 21-64 and 40% are under age 21. These individuals were disenrolled effective July 1.
    - Among 1,200 people with disabilities and adults age 65+ in this category, groups include: home and community-based waiver enrollees (~200); nursing facility residents (~200); other individuals with full Medicaid benefits (~300); and those whose Medicaid coverage is limited to payment of Medicare premiums and cost sharing (~500). These individuals have received a one-month extension of coverage (through July) to allow additional time for a renewal response.

- July and August cohorts represent high number of beneficiaries (approximately 31,000 and 28,000 respectively)
  - July is first month of renewals for the “PHE Group” (individuals that already appear to be ineligible; most are not able to renew passively)

- Issue to Watch: Lower passive renewal rate for July and August compared to May and June

Looking Ahead: On-Going Outreach; Continued Monitoring and Analysis Will Inform DHCF's Renewal Strategy

- On-going direct and indirect **outreach** to Medicaid beneficiaries
  - Media (radio, TV, etc.)
  - Text messaging and automated phone calls
  - Presence at health fairs, other citywide events
  - Bi-weekly stakeholder community calls
  - Managed care organizations efforts

- On-going **data analysis** to understand renewal patterns, demographics
  - Eligibility Renewal Dashboard updates
  - First Medicaid Renewal report to be released by end of July

- Identify / apply **new strategies** to improve response rates
  - New flexibilities announced by CMS in June
    - Renew Medicaid eligibility for individuals with income at or below 100% FPL and no data returned on an ex parte basis (100% income strategy). (under consideration)
    - Permit managed care plans to assist enrollees to complete and submit Medicaid renewal forms. (under consideration)
  - Evening and weekend Beneficiary Town Halls (learn how to check coverage status, update address, renew Medicaid, and open Q&A

Questions and Comments

Learn more about DC Medicaid Renewals:

https://dhcf.dc.gov/medicaid-renewal

Join the Bi-Weekly Community Stakeholder Call

Next Call: August 2nd @ 2:30p

(For call information, email Medicaid.Renewal@dc.gov)

Behavioral Health Integration

Medicaid Behavioral Health Transformation Kicked-Off in 2019 and Continues With Upcoming Major Milestones in October 2023 and April 2024

January 2020

- Implementation of the District's Medicaid 1115 Behavioral Health Transformation Waiver
- In FY21, work on the Waiver continues as the District is transitioning 8 of the 10 Waiver services to permanent State Plan authority, beginning January 1, 2022.

Fiscal Year 2024

- **October 2023: Implement behavioral health services changes**
- **April 2024: Incorporate a full continuum of behavioral health services into Medicaid managed care plans.**

FY25 and Beyond

- Medicaid 1115 Behavioral Health Transformation Renewal
- Focus on additional opportunities to integrate physical and behavioral health for Medicaid beneficiaries.

Phase II Update: As We Approach October, Changes are Happening to Strengthen Behavioral Health System

- DBH Certification now requires **National Accreditati**on from one of the following:
  - (a) The Joint Commission; (b) The Council on Accreditation; or (c) The Commission on Accreditation of Rehabilitation Facilities

- All individuals providing direct services must obtain a **National Provider Identifier** and register with Medicaid.
  - When billing, the billing provider (e.g., Core Service Agency) must include the rendering provider information (e.g., the peer specialist that provided the direct service)

- DBH Participating Providers must utilize an Electronic Health Record certified by the Office of the National Coordinator, independent from DBH-hosted DATA-WITS and iCAMS.

Phase II Update: As We Approach October, Changes are Underway to Strengthen Behavioral Health System

- Comprehensive Rate Study underway to ensure rates reflect provider costs to provide services to fidelity
  - Rate enhancements
  - Scheduled rate adjustments for inflation
  - New services
  - Groundwork for alternative payment models that shift from volume to value

Total of 53 Services under review, fitting into 3 categories:

- Rate Adjustments to Existing Services
- Payment Methodology Changes to Existing Services
- New Medicaid Services

Phase II Update: As We Approach October, Changes are Underway to Strengthen Behavioral Health System

Service Type	Description	Examples
Rate Adjustments to Existing Services	Service definitions and procedure codes stay the same for these existing services, but rates are adjusted based on what it costs to provide the service to fidelity and according to DBH regulations.	***Child-Parent Psychotherapy for Family Violence (CPP-FV)*** Rate Increase
Payment Methodology Changes to Existing Services	Changes in service definitions or service definitions stay the same, but the unit and/or frequency of reimbursement changes.	***Day Rehabilitation*** Rate Increase Moved from Daily rate to Hourly Rate Daily Maximum is 6 hours ***Clubhouse*** Rate Increase Moved from Daily rate to Hourly Rate Daily Maximum is 6 hours ***Assertive Community Treatment (ACT)*** Rate Methodology Change Monthly Rate
New Medicaid Services	Services brand new to the District or services currently reimbursed with local or grant dollars.	***High Fidelity Wrap Around*** *(NEW NAME: Intensive Care Coordination)*

Phase II Update: On-going Support for Provider Readiness

- Monthly provider focused **trainings** (topics include person centered care, clinical documentation, etc.)
  - Support through the Integrated Care DC technical assistance program
    - Managed Care Readiness Workshop held in May 2023; all materials available at: https://www.integratedcaredc.com/resource/integrated-care-dc-managed-care-readiness-workshop/
- Digital Health **Technical Assistance** Program launched HCBS ARPA program
  - Funding to providers to support connectivity to electronic health records (EHRs) and health information exchange (HIE)
- DBH sponsored **grant opportunities** for providers that align with new requirements and service changes

Phase II: Preparing for Upcoming Milestones

OCTOBER 1, 2023:

- ✓ New Services (proposed)
- ✓ Payment Methodology Changes (proposed)
- ✓ Use of Standardized Tools
- ✓ Ongoing Technical Assistance, Training, and Provider Support

October through April 1, 2024:

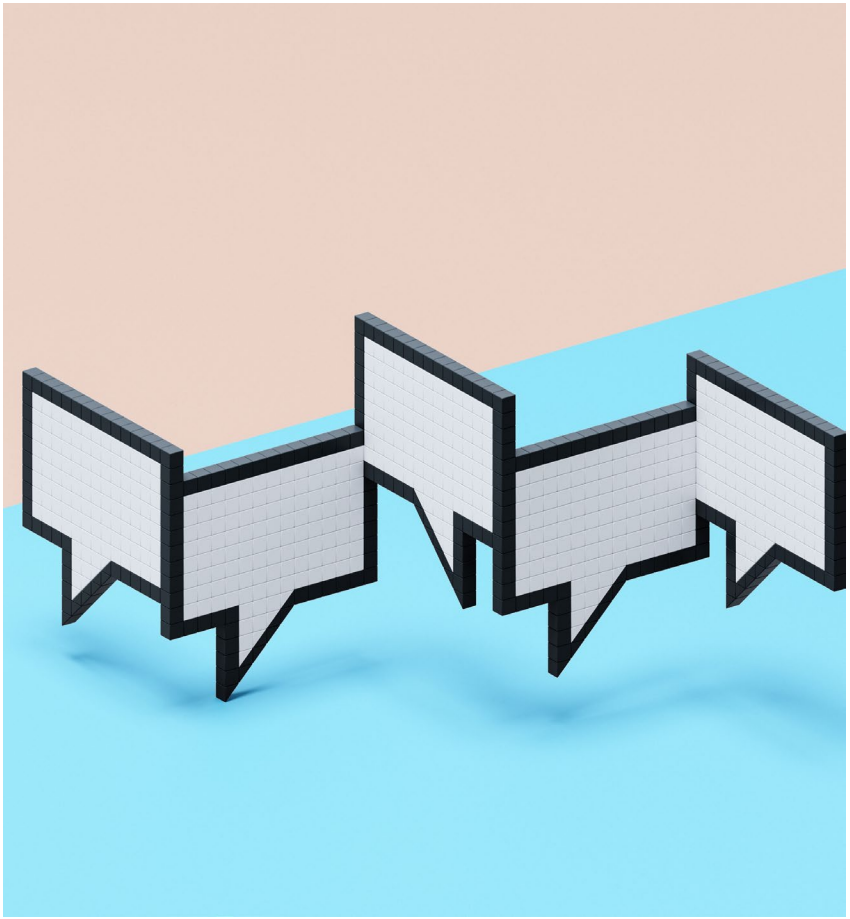
- ✓ DHCF Formal Readiness Activities
- ✓ Provider Enrollment & Contracting with MCOs
- ✓ Claims Testing

Keep Up With Behavioral Health Transformation: Join the Public Forum on Integrated Care (PFIC) Meetings

- **Purpose:** The PFIC will facilitate open communication, discussion, and feedback on key decisions from our Stakeholder Community (Beneficiaries, Families, Advocates, Providers, and Health Plans).

- **Check our webpage for updates and resources:**
  - Public Forum on Integrated Care | dhcf

- **Next PFIC planned for August 30, 2023, at 4pm.**



Perinatal Mental Health Task Force

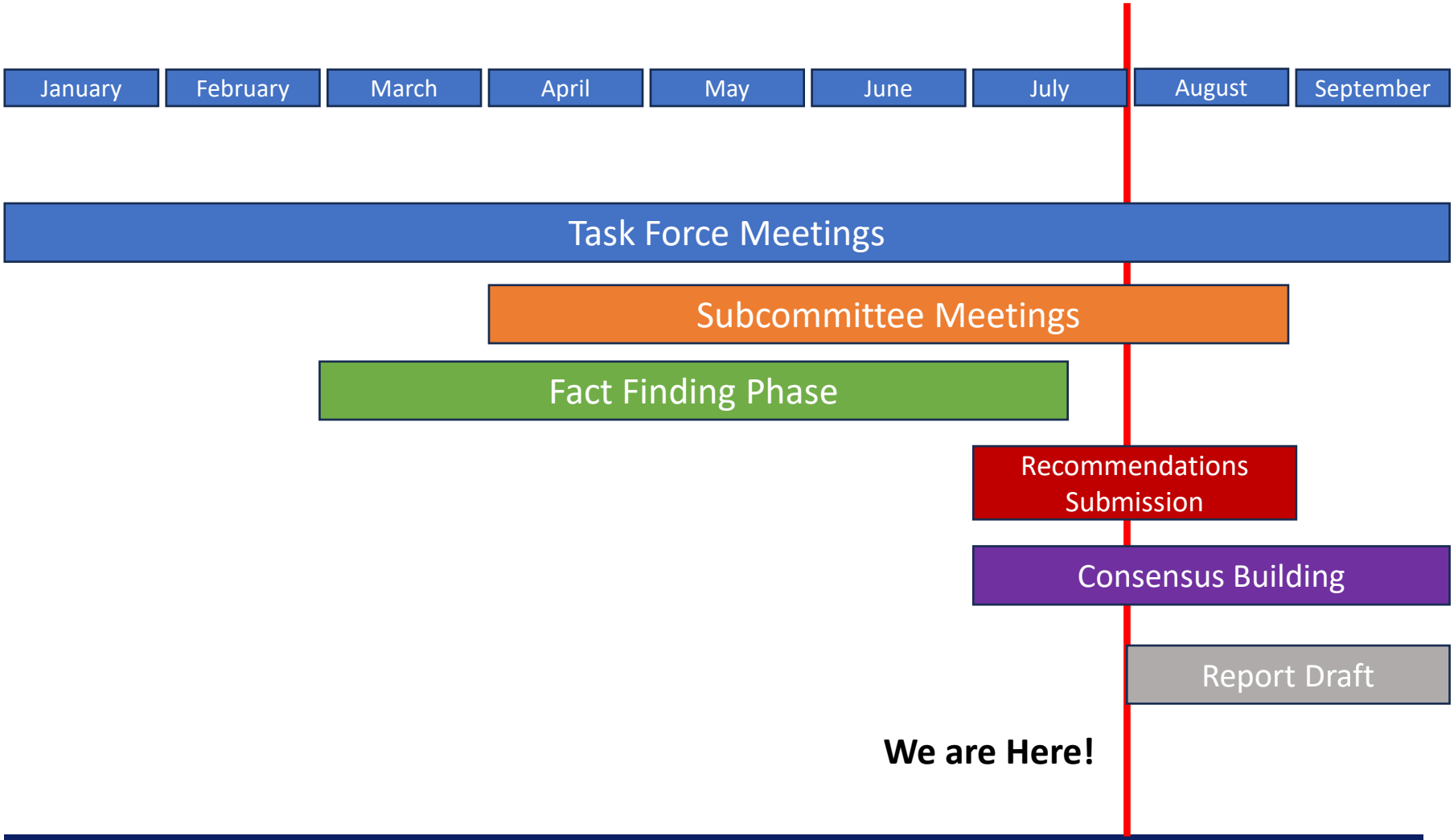
Purpose of the Task Force

- Budget Support Act establishes a Perinatal Mental Health Task Force to provide comprehensive ***policy recommendations for the improvement of perinatal mental health*** in the District. The Task Force shall study and make recommendations to the Council by October 1, 2023 regarding the following:
  - Vulnerable *populations and risk factors* for perinatal mental health disorders
  - *Evidence-based and promising practices* for those with or at risk of perinatal mood and anxiety disorders
  - *Barriers to access to care* during the perinatal period for birthing people and their partners and identifying evidence-based and promising practices for care coordination, systems navigation, and case management services that address and eliminate barriers to accessing care and care utilization for birthing people and their partners;

Purpose, continued

- Evidence-informed practices that are *culturally congruent and accessible to eliminate racial and ethnic disparities* that exist in addressing prevention, screening, diagnosis, intervention and treatment, and recovery from perinatal mood and anxiety disorders;
- National and global models that successfully *promote access to care*, including screening, diagnosis, intervention, treatment, recovery, and prevention services for perinatal mood and anxiety disorders in the pregnant or postpartum person and non-birthing partner; Community-based or multigenerational practices that support individuals and families affected by a maternal mental health condition; *Successful initiatives regarding workforce development* encompassing the hiring, training, and retention of a behavioral health care workforce as it relates to perinatal mental health, including maximizing non-traditional behavioral health supports such as peer support and community health workers; Models for *private and public funding* of perinatal mental health initiatives; and
- *A landscape analysis* of available perinatal mental health programs, treatments, and services, and notable innovations and gaps in care provision and coordination, encompassing the *ability to serve the diversity of perinatal experiences of unique populations*, including Black birthing people, Hispanic birthing people, pregnant and postpartum people of color, perinatal immigrant populations, adolescents who are pregnant and parenting, LGBTQIA+

Task Force Meetings and Recommendation Process



Recommendation Submission

- Recommendation for consideration:
  - Public
    - Will be deferred to the appropriate subcommittee
  - Subcommittee
- Recommendation Form Posted to the Public this Week on the Perinatal Mental Health Task Force Webpage!!
- Can send to networks now!
  - https://app.smartsheet.com/b/form/9b03ee31f3a74e3faa620093a93fd9c4

Maternal Health Advisory Group

DHCF's Stakeholder Approach to Advance Maternal Health

- DHCF formed a Maternal Health Advisory Group to get input from providers, beneficiaries or beneficiary advocates, doulas, and managed care organizations related to Fiscal Year 2022 projects in the following three areas:
  1) Coverage of doula services;
  2) Expansion of postpartum coverage to one year; and
  3) Extension of non-emergency medical transportation benefits to pregnant and postpartum Alliance beneficiaries.

- Input from group members and discussion at meetings shaped the Doula Services benefit and related guidance in several ways.
  - For example, the District's decision to reimburse differently for perinatal and postpartum doula visits came from input from the Maternal Health Advisory Group.
  - In addition, input from the Maternal Health Advisory Group helped determine the total number of doula visits that DHCF would reimburse.

DHCF Reconvened Maternal Health Advisory Group

- June 12th meeting:
  - Update the Advisory Group on maternal health services and discuss how to best outreach, recruit and enroll doulas into the Medicaid program.
  - Special guest Natasha Turner, Doula Program Analyst from the Virginia Department of Medical Assistance Services, shared best practices from Virginia in their state's recruiting efforts of doulas as Medicaid providers.
  - Formation of a future subcommittee to promote doula services and increase enrollment in the Medicaid program.

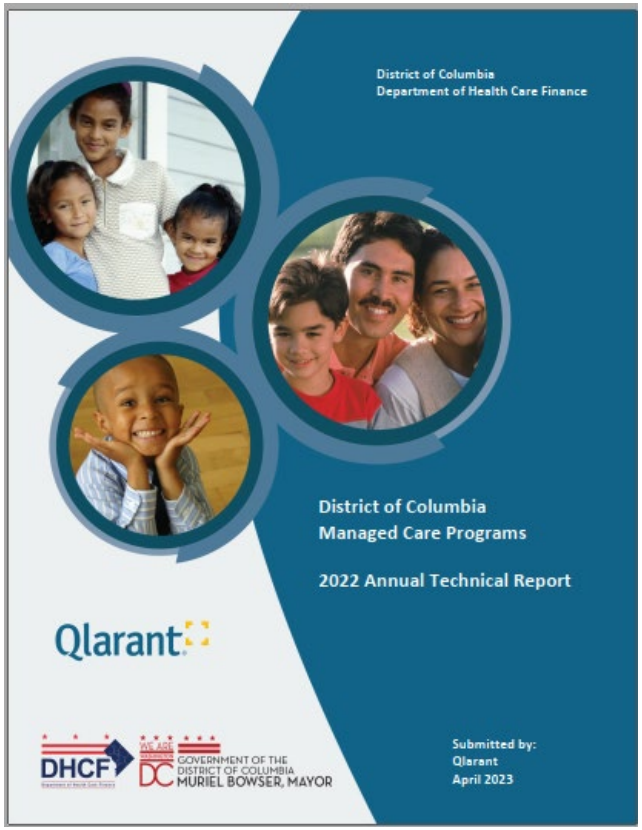
Questions

2022 External Quality Review Annual Technical Report

Fatorma (Fa-Tuh-Mah) Greene, MPH
Management Analyst
07/26/2023

Agenda

- Medicaid Managed Care Quality Strategy
- What is ATR?
  - Quality
  - Access
  - Timeliness
- ATR Results
- Strengths
- Recommendations
- Questions



Medicaid Managed Care Quality Strategy

Medicaid Quality Strategy

The Medicaid Managed Care Quality Strategy is the framework used by the DC 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

Table 49. DHCF Quality Strategy Goals

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

Annual Technical Review (ATR) Basics

Annual Technical Review - Basics

- ATR's are legally required in order to participate as a state/ district/ territory in the Medicaid program.
- ATR's are annual.
- ATR's must have a neutral party reviewing the activities of all parties involved in the management and administration of the program
- Qlarant is the contracted External Quality Review Organization (EQRO) for DC

Key Focus Areas Defined

Quality

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

Access

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

Timeliness

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

ATR Required Activities

Mandatory EQRO Activities

- Compliance Review (OSR)
- Performance Measure Validation (PMV)
- Validation of Performance Improvement Projects (PIP)
- Network Adequacy Validation (NAV)

Optional EQRO Activities

- Validation of Encounter Data (EDV)
- Administration and Validation of Consumer Surveys (Survey)
- Calculation of Performance Measures (CPM)
- Implementation of Additional Performance Improvement Projects (A-PIP)
- Focused Studies (FS)
- Quality Rating System/Consumer Report Card (QRS/CRC)

EQR Annual Technical Report

- Activities for Managed Care Plans (MCP's) noted in the current report include:
  - DC Healthy Families Program (DCHFP)
  - Child and Adolescent Supplemental Security Income Program (CASSIP)
    - Operations System Review/Compliance Review (OSR)
    - Performance Improvement Projects (PIP)
    - Performance Measure Validation (PMV)
      - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
    - Network Adequacy Validation (NAV)
    - Encounter Data Validation (EDV)

- Activities added in this report include:
  - District Dual Choice Program (DDCP)
    - Dual Eligible Special Needs (DSNP)
  - Focus Study – Fee for Service Conversion to Managed Care

Activities to be added in next report include:

Focus Study (FS) – Maternal Health – Methodology Development
Consumer Report Card (CRC) – Methodology Development
Additional Performance Measures (APM) – DC Stratification Measures

Operational Systems Review (OSR)

Operational Systems Review (OSR)

- Standards include:
  - Information Requirements
  - Enrollee Rights and Protections
  - MCP Standards
  - Quality Assessment and Performance Improvement Program
  - Grievance and Appeal System
  - Access and Cultural Consideration
- Standards were updated based on the CMS Final Rule
- Guidance is based on the CMS EQRO Protocols (October 2019, expired October 2022)
- NCQA Deeming – Initiated during 2021 OSR Review

Operational Systems Review - Deeming

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

- Using this information and the latest *NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, Health Plan Standards*, Qlarant evaluated whether the MCP qualified for deeming of federal regulations.

2022 MCP OSR Results: Overall Average Score is 98%

Table 32. MY 2022 MCP OSR Results

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

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

2020 - 2022 MCP OSR Results by Standard

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

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

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

Performance Improvement Projects (PIP)

Performance Improvement Projects (PIPs)

Table 3. Comprehensive Diabetes Care PIP Key Elements

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

MCP Comprehensive Diabetes Care PIP Interventions
Telemedicine program (home visits and video conferences)
Remote blood glucose monitoring
Refill reminder and outreach programs (Rapid Response Outreach Team)
Non-emergent Medical Transportation
Meal delivery based on Food Instability (Social Determinants of Health criteria)
Nutrition classes by dieticians and culinary experts
Staff development

Performance Improvement Projects (PIPs)

Table 9. Maternal Health PIP Key Elements

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

MCP Maternal Health PIP Interventions
Telehealth Program
Interactive applications to assist expectant mothers
In-home post partum visits
Maternity management programs
Pregnancy support program
Early pregnancy identification for all risk levels
Enrollee and provider incentives to participate in care management

Performance Improvement Projects (PIPs)

Table 16. Childhood Obesity Management and Prevention PIP Key Elements

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

Performance Improvement Projects (PIPs)

Table 20. Fall Risk Management PIP Key Elements

2022 PIP (MY 2021)	Fall Risk Management
Program	DDCP
MCP	UHC
Performance Measures	Fall Risk Management— 1. Discussing Fall Risk 2. Managing Fall Risk Screening, Risk Assessment, and Plan of Care to Prevent Future Falls— 3. Falls Screening 4. Falls Risk Assessment 5. Plan of Care
Measure Steward	NCQA (Fall Risk Management – Medicare Health Outcomes Survey) CMS (Screening, Risk Assessment, and Plan of Care to Prevent Future Falls)
Population	Fall Risk Management: The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: Medicaid Managed Long-Term Services and Supports (MLTSS) participants 18 years of age and older
Aim	Will member education on fall prevention decrease the number of falls in enrollees 65 years of age and older during the measurement year? Will implementation of a comprehensive assessment and fall risk management plan decrease the number of falls for enrollees 18 years of age and older with a history of falls during the measurement year?
Phase	Proposal

Performance Measure Validation (PMV)

Performance Measure Validation (PMV)

- Performance Measures (PMs)
  - Monitor each MCP at a point in time,
  - Track performance over time,
  - Compare performance among MCPs.
- Requirements/Protocols:
  - 42 CFR §438.330(c) and *CMS EQR Protocol 2 – Validation of Measures*.
- Evaluation of:
  - Accuracy and reliability of measures produced and reported by the MCP
  - Appropriate utilization of specifications for calculating and reporting the measures.
  - Accuracy and reliability of the reported rates are essential to ascertain whether the MCP's quality improvement efforts resulted in improved health outcomes.
- Validation process allows DHCF to have confidence in MCP measure results.

Performance Measure Validation

Data Obtained.

- Information from several sources were used to satisfy validation requirements.
- Including but not limited to:
  - Information Systems Capabilities Assessment (ISCA)
  - HEDIS Record of Administration, Data Management and Processes (Roadmap)
  - HEDIS Final Audit Report, if available
  - Policies and training materials, as applicable
  - Medical Record Over-read Audits, as applicable

Compliance With PMV Elements

Table 24. PIP and Core Set Measure PMV Results

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

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

Performance Measure Validation – Per MCP

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

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

Performance Measure Validation – Aggregate

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

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Performance Measure

EPSDT Performance Measures

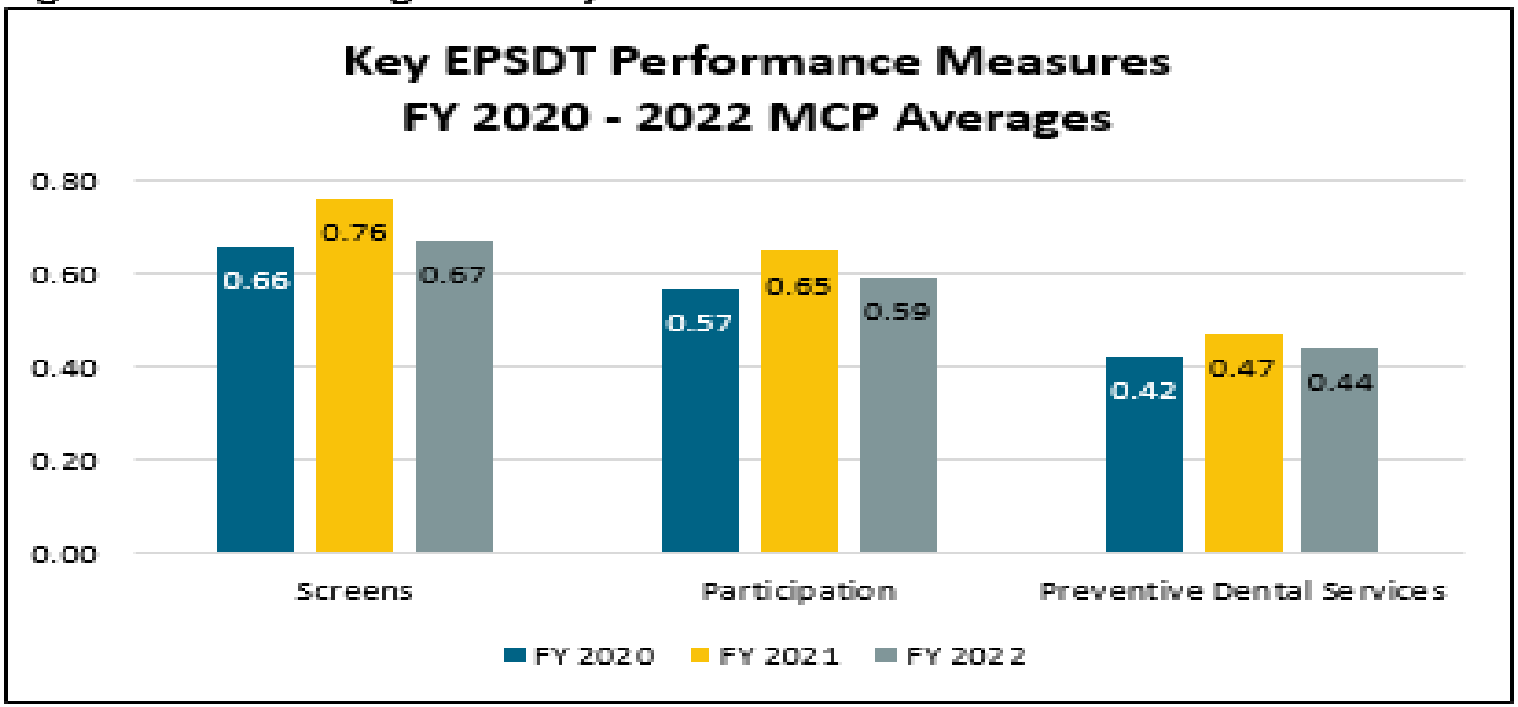
- **EPSDT Screening Ratio.** The calculation uses total screens received compared to the expected number of screens (for eligibles enrolled for 90 continuous days).
- **EPSDT Participation Ratio.** The calculation compares total eligibles who received at least one initial or periodic screen to total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

Table 31. FY 2022 Key EPSDT Performance Measure Results

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

EPSDT Performance Measures – Aggregate

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



Network Adequacy Validation (NAV)

Network Adequacy Validation (NAV)

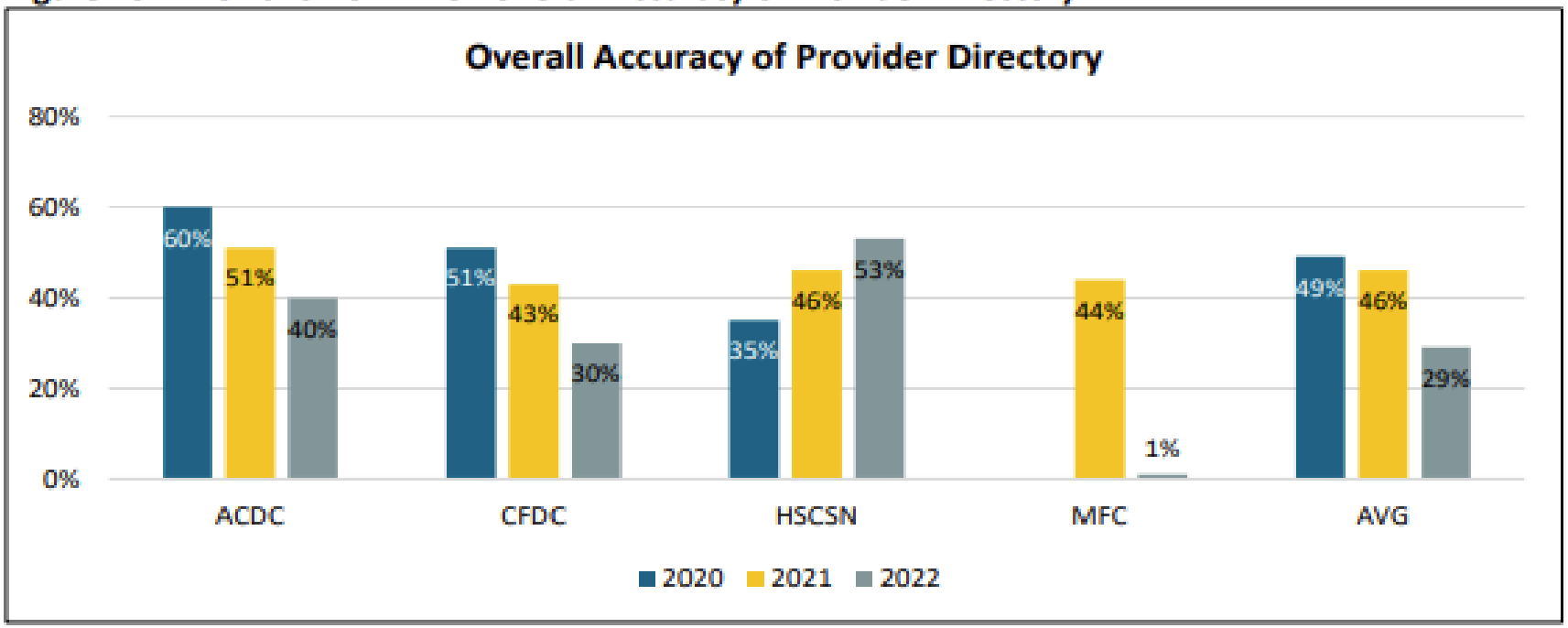
- MCPs must develop and maintain adequate provider networks
  - Network geographic access
  - Provider-to-enrollee ratios
    - Generalist, Specialist and Dental
- NAV results provide a level of confidence in provider network adequacy.
  - MCPs ensure timely access to care and services.
  - NAV evaluates whether MCPs are meeting standards established by DHCF and Federal Regulations
  - Accuracy of MCP online provider directories

DHCF Provider Network Standards

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

NAV Provider Directory Accuracy Trend

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



NAV Provider Appointment Results

Figure 11. MY 2022 MCP Adult PCP Appointment Compliance

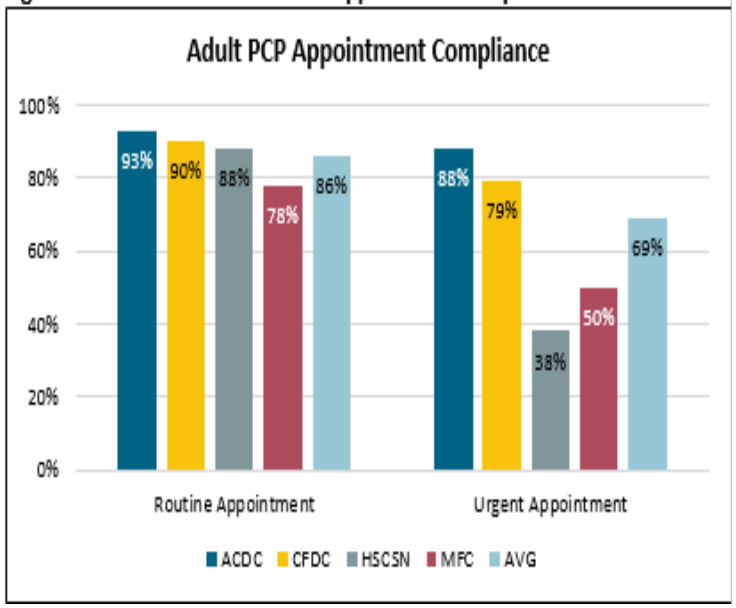
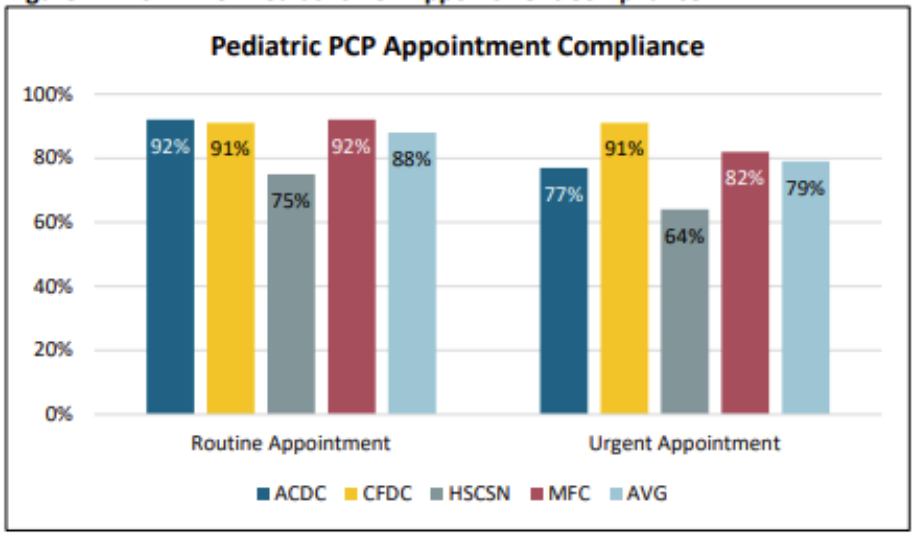


Figure 12. 2022 MCP Pediatric PCP Appointment Compliance



NAV Provider Appointment Trend

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

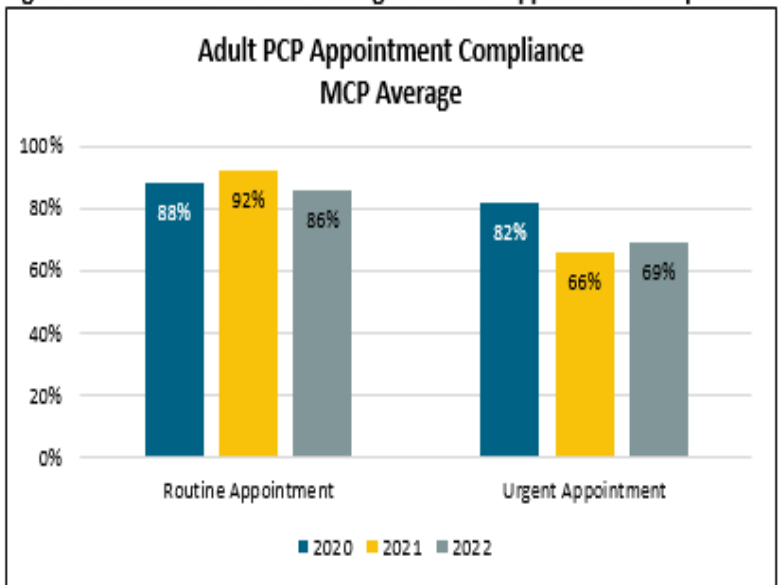
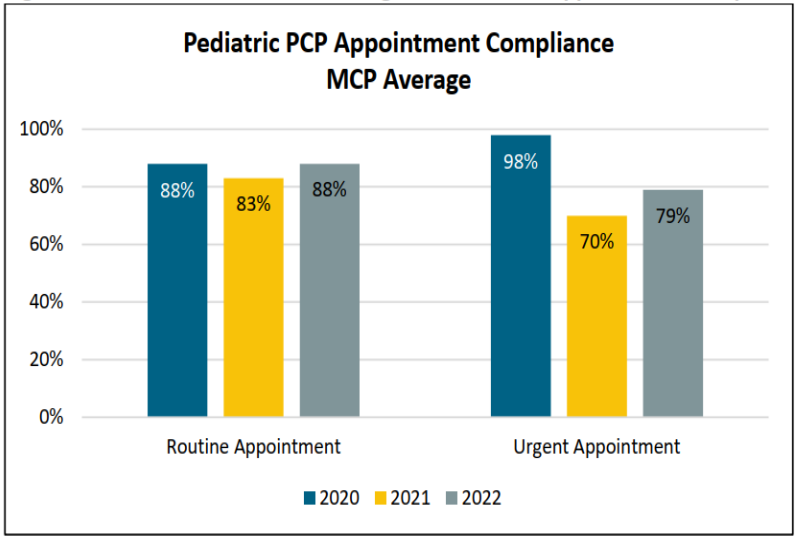


Figure 14. MYs 2020-2022 MCP Average Pediatric PCP Appointment Compliance



Encounter Data Validation (EDV)

Encounter Data Validation (EDV)

- States rely on valid and reliable encounter data submitted by MCPs to make key decisions.
  - For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates.
  - As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical.
  - Results of the EDV study provide DHCF with a level of confidence in the completeness and accuracy of electronic encounter data submitted by the MCPs.
- EDV activities focus on retrospective provider office encounters between July 1 through June 30, of the year prior to the ATR.

Encounter Data Validation (EDV)

- The **EDV study was conducted for the first time in 2021,** therefore, we now have some comparison results. Trending will be able to be added next year when there are 3 sets of data available for some of the plans.
- **EDV is not an activity for the DSNP plan**
- **Description of Data Obtained.** Qlarant obtained the following data to complete the EDV study:
  - Electronic encounter data file from DHCF for the period of review
  - Information Systems Capabilities Assessment (ISCA) and HEDIS Roadmap documentation from the MCPs
  - Medical records from providers through the MCP's
- **Technical Methods of Data Collection and Analysis.**
  - *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.

Encounter Data Validation (EDV)

Table 38. Diagnosis Code Findings

Diagnosis Codes	ACDC	CFDC	HSCSN	MFC	MCP Aggregate
Diagnosis Codes with a Match					
Accuracy or Match Rate	96.0%	96.0%	68.3%	76.8%	88.4%

Table 39. Procedure Code Findings

Procedure Codes	ACDC	CFDC	HSCSN	MFC	MCP Aggregate
Procedure Codes with a Match					
Accuracy or Match Rate	96.2%	96.6%	97.9%	95.2%	96.2%
"No Match" Reasons					
Percentage of diagnosis code elements with coding errors	0.0%	0.0%	0.0%	0.3%	0.1%
Percentage of diagnosis code elements that were not supported by medical record documentation	4.0%	4.0%	31.7%	22.8%	11.5%

Strengths

Strengths - Accountability

- DHCF evaluates MCP progress in meeting quality strategy goals through:
  - Quality and appropriateness of care assessments
  - National performance measures
  - Monitoring and compliance
  - EQR activities

- DHCF also holds MCPs accountable through procedures outlined in its *Managed Care Program Quality Management Manual*.

- DHCF has also implemented a Managed Care Program Accountability Set, which is a newly established program (October 1, 2021)

- DHCF continues to monitor the aftereffects of the public health emergency

Recommendations

Recommendations

DHCF's *Medicaid Managed Care Quality Strategy* identifies objectives and strategies to achieve goals, which are meaningful to DCHFP and CASSIP.

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

Recommendations

DHCF is expanding behavioral health services in its Medicaid managed care program.

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

DHCF is holding MCPs accountable, as previously described, by way of procedures outlined in its *Managed Care Program Quality Management Manual*. This strategy appears to make an impact. The 2022 EQR activities found MCPs fully addressed the majority of recommendations made in 2021—ACDC: 57 percent, CFDC: 67 percent, HSCSN: 64 percent, and MFC: 77 percent.

- ***Qlarant recommends*** DHCF continue to hold MCPs responsible for performance and require corrective actions. These improvements influence performance and advancements in meeting Goals 1-3.

Questions

Next Meeting:

September 27th