Arkansas External Quality Review Organization

April 2022

2021 Annual

EQRO Technical Report

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Qsource

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Acknowledgements, Acronyms, and Initialisms*

ADA ..... Americans with Disabilities Act
ADDT ..... Adult Developmental Day Treatment
ADHD ..... Attention Deficit Hyperactivity Disorder
ADV ..... Annual Dental Visit
AMA ..... American Medical Association
AMM ..... Antidepressant Medication Management
ANA ..... Annual Network Adequacy
AON ..... Area of Noncompliance
APA ..... Arkansas Administrative Procedures Act
ARTC ..... Arkansas Total Care
BH ..... Behavioral Health
C ..... Clinical
CA ..... Compliance Assessment
CAHPS .... Consumer Assessment of Healthcare Providers and Systems
CAP ..... Corrective Action Plan
CASRO .. Council of American Survey Research Organizations
CDT ..... Current Dental Terminology
CEO ..... Chief Executive Officer
CFO ..... Chief Financial Officer
CFR ..... *Code of Federal Regulations*
CHIP ..... Children's Health Insurance Program
CMS ..... Centers for Medicare & Medicaid Services
CMO ..... Chief Medical Officer
COPD ..... Chronic Obstructive Pulmonary Disease
CPT ..... Current Procedural Terminology
DAABHS ... Arkansas Division of Aging, Adults, and Behavioral Health Services
DCFS ..... Arkansas Department of Children & Family Services
DD ..... Developmentally Disabled
DDS ... Arkansas Division of Developmental Disability Services
Delta Dental. ..... Delta Dental of Arkansas
DHS ..... Arkansas Department of Human Services
DME. ..... Durable Medical Equipment
DMO. ..... Dental Managed Care Organization
DMS. ..... Arkansas Division of Medical Services
ED ..... Emergency Department
EDI ..... Electronic Data Interchange
Empower ..... Empower Healthcare Solutions
EONM ..... End of Next Month
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ER ..... Emergency Room
FFS ..... Fee-For-Service
FQHC ..... Federally Qualified Health Center
HCBS ..... Home and Community Based Services
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS ..... U.S. Department of Health and Human Services

* *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

HIPAA.... Health Insurance Portability and Accountability Act of 1996
ICD-10 ..... International Classification of Diseases
ICU ..... Intensive Care Units
ID ..... Identification
IDD ..... Intellectually Developmentally Disabled
IS ..... Information System(s)
ISCA ..... Information Systems Capability Assessment
ISCAT ..... Information Systems Capability Assessment Tool
ISP ..... Interim Service Plan
IT ..... Information Technology
KPI ..... Key Performance Indicator
LTSS ..... Long-Term Services and Supports
MCNA ..... Managed Care of North America, Inc.
MCP ..... Managed Care Plan
MLR ..... Medical Loss Ratio
MMIS ..... Medicaid Management Information System
MRR ..... Medical Record Review
MSA ..... Metropolitan Service Area
MTP ..... Master Treatment Plan
MY ..... Measurement Year
N ..... No/Number
NA ..... Not Applicable (CA)
NA ..... Not Applicable: Denominator Too Small (PMV)
NA ..... Not Assessed (PIP)
NB ..... No Benefit (PMV)
NC ..... Nonclinical
NCCI ..... National Correct Coding Initiative
NCOA ..... National Change of Address
NCPDP ..... National Council for Prescription Drug Programs
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... a trademark of NCQA
NCSS ..... Nonmedical Community Supports and Services
NPI ..... National Provider Identifier
NQ ..... Not Required (PMV)
NQF ..... National Quality Forum
NR ..... Not Reported (PMV)
OB/GYN ..... Obstetrician/Gynecologist
OR ..... Operating Room
P&P ..... Policy and Procedure
PA ..... PASSE Agreement
PAHP ..... Prepaid Ambulatory Health Plan
PAN ..... Patient Account Number
PASSE ..... Provider-Led Arkansas Shared Savings Entity
PCP ..... Primary Care Provider/Physician
PCSP ..... Person-Centered Service Plan
PDP ..... Primary Dental Provider
PDSA ..... Plan-Do-Study-Act
PHI ..... Personal Health Information
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
Q ..... Quarter
QAPI ..... Quality Assessment and Performance Improvement
QIC ..... Quality Improvement Committee
Qsource® ..... EQRO, a registered trademark
R ..... Reportable (PMV)
RFP ..... Request for Proposal
RHC ..... Rural Health Clinic

S ..... Section
SMA ..... State Medicaid Agency
SOC ..... System and Organization Controls
SSA ..... Social Security Administration
SSAE ..... Standards for Attestation Engagements
STP ..... Statewide Transition Plan
Summit ..... Summit Community Care
TIN ..... Tax Identification Number
TPL ..... Third-Party Liability
UB ..... Uniform Bill
USPS ..... United States Postal Service
VAS ..... Value-Added Service
WW ..... Waiver Waitlist
Y ..... Yes

Overview

The State of Arkansas Department of Human Services (DHS) administers the Arkansas Medicaid managed dental care program for Medicaid enrollees and the Provider-Led Arkansas Shared Savings Entity (PASSE) program, a Medicaid Managed Care Waiver program. Qsource serves as DHS's external quality review organization (EQRO) and prepared this *2021 Annual EQRO Technical Report* for DHS to document dental managed care organization (DMO) and PASSE performance in regard to quality, timeliness, and access to care for enrollees, as well as to identify areas for improvement and recommend interventions to improve the process and outcomes of care.

DMOs provide dental care services statewide for Medicaid enrollees. DHS's PASSEs provide medical and ancillary care services for Medicaid enrollees with complex behavioral health conditions, intellectual disabilities, and developmental disabilities. This section provides a brief history of DHS, its Quality Strategy Plan, the guidelines for this report, and external quality review (EQR) activities conducted in 2021. Table 7 presents a detailed list of EQR activities and measurement periods. The majority of the EQR activities were a retrospective review of measurement year 2020.

Background

PASSE

DHS is the sole state agency authorized and responsible for oversight of the Medicaid program in Arkansas, through the Division of Medical Services, which serves as the State Medicaid Agency (SMA). While the Medicaid program was implemented in the state in 1970, a medical care program had been established through two state laws, Section 7 of Act 280 of 1939 and Act 416 of 1977. This program authorized the State to provide medical services for the indigent population of the state. Act 775 of the 2017 Arkansas General Session was signed into law on March 31, 2017. This Act, known as the "Medicaid Provider Led Organized Care Act," was an innovative approach to organizing and managing the delivery of services for Medicaid beneficiaries with high medical needs and allowed for the implementation of the PASSE program. In Phase II, which began on March 1, 2019, all PASSE program vendors began operating under a fully-capitated model with the intent of better integrating services for enrollees across medical, physical health, behavioral health, and specialized development disability service domains. DHS's PASSEs serve Medicaid enrollees with complex behavioral health, developmental, or intellectual disabilities.

DMO

During the 2015 Arkansas Legislative General Session, the General Assembly passed Act 96 which created the Health Care Reform Legislative Task Force in Arkansas. This task force was created to make Medicaid recommendations. The task force along with the Arkansas Dental Association recommended moving to dental managed care in Arkansas. DHS transitioned

the Medicaid dental program to managed care effective January 1, 2018. DMOs administer dental services for almost all children and adults enrolled in Medicaid.

Enrollees

In 2020, three PASSEs and two DMOs operated in Arkansas. The PASSEs included Arkansas Total Care (ARTC), Empower Healthcare Solutions (Empower), and Summit Community Care (Summit). There were 55,935 Arkansans enrolled in the PASSE program at least once, with 15,704 attributed to ARTC, 22,613 attributed to Empower, and 18,773 attributed to Summit. The DMOs included Delta Dental of Arkansas doing business as Delta Dental Smiles (Delta Dental) and Managed Care of North America, Inc. (MCNA). There were 723,310 Arkansans enrolled in the dental managed care program at least once, with 376,988 attributed to Delta Dental and 356,155 attributed to MCNA.

DHS Quality Strategy Beliefs

DHS's vision and mission statements, beliefs, and core values align with the three aims of the National Quality Strategy*: better care, improved health for people and communities, and affordable healthcare. DHS's vision and mission statements serve as a guide for ensuring quality remains a top priority. These statements are a strong foundation for DHS and the services it provides the PASSE and DMO populations:

- **Vision Statement:** "Arkansas citizens are healthy, safe and enjoy a high quality of life."
- **Mission Statement:** "Together we improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence and promoting better health."

Combined with the Division of Medical Services' mission statement, "To ensure that high-quality and accessible healthcare services are provided to citizens of Arkansas who are eligible for Medicaid or Nursing Home Care," the DHS vision and mission statements are the basis of seven beliefs and five core values of DHS. These beliefs and values help shape DHS's approach to improving the quality of healthcare for its enrollees.

Beliefs

- Every person matters.
- Families matter.
- Empowered people help themselves.
- People deserve access to good healthcare.
- We have a responsibility to provide knowledge and services that work.
- Partnering with families and communities is essential to the health and well-being of Arkansans.
- The quality of our services depends upon a knowledgeable and motivated workforce.

* *Agency for Healthcare Research and Quality. n.d. Working for Quality. https://www.ahrq.gov/workingforquality/index.html*

Core Values

- Compassion
- Courage
- Respect
- Integrity
- Action

DHS Quality Strategy Goals and Objectives

The Quality Strategy goals were carefully considered by all stakeholders, including state staff, the PASSEs and DMOs, providers, and families.

The goals align with and support the DHS mission and core beliefs. The goals fall under four areas with specific objectives within them for the PASSEs and DMOs.

Tables 1 and 2 present the DHS Quality Strategy goals and objectives.

Table 1. DHS Quality Strategy Goals and Objectives: PASSEs

Goal 1: Focus on person-centered, coordinated care, and outreach.

- Provide qualified and trained care coordinators.
  - Must provide health education and coaching; coordination with healthcare providers for diagnostic, ambulatory care, and hospital services; assistance with social determinants of health; promotion of activities focused on the health of a patient and their community.
- Develop care coordinator relationships with enrolled members.
- Improve PCSP development for enrolled members.

Table 1. DHS Quality Strategy Goals and Objectives: PASSEs

- Must adhere to 42 CFR § 441.540.
- Include members outlined treatment goals and objectives.
- Contain medical and NCSS services necessary for the member as identified through the assessment of functional need, and crisis plan.

Goal 2: Improve access to needed services and safety for all enrolled members.

- Improve access to appropriate care through network adequacy.
  - Specific provider must be within 40 miles in urban county and 90 miles in a rural county.
  - Must have at least one Provider Type 05 (Acute Inpatient Hospital) within 30 miles in an urban county and 60 miles in a rural county.
- Encourage development of innovative and value-added service models that cross service divisions.
- Ensure safety by monitoring compliance with incident and accident reporting requirements.

Goal 3: Continuously increase member satisfaction with Services.

- Increase satisfaction with the PASSE as reflected on the member surveys.

Goal 4: Continuously advance plan models to improve the health of enrolled members.

- Monitor implementation of performance improvement projects by the PASSEs.
- Develop strategies to increase the number of value-added services being provided to enrolled members.
- Encourage innovative models of value-based services.

Table 2. DHS Quality Strategy Goals and Objectives: DMOs
Goal 1: Focus on person-centered, coordinated care, and outreach.
♦ Make sure every enrolled member has a Primary Care Dentist (PCD).
♦ Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically Necessary dental services.
♦ Shall identify targeted populations and/or service areas for outreach and education activities.
Goal 2: Improve access to needed services and safety for all enrolled members.
♦ Improve access to appropriate dental services through network adequacy.
♦ Improve prevention among clients.
♦ Decrease per capita emergency room (due to dental emergencies) visits.
♦ Internal quality assurance and improvement program that is comprehensive and routinely and systematically monitors access, availability and utilization of services, network adequacy, and customer satisfaction.
Goal 3: Continuously increase member satisfaction with Services.
♦ Increase satisfaction with Healthy Smiles.
Goal 4: Continuously advance plan models to improve the health of enrolled members.
♦ Monitor implementation of performance improvement projects by the DMOs.
♦ Encourage value added services offered by the DMOs at no cost to the member.

Quality metrics and performance targets were the primary mechanisms for assessing DHS's primary goals. Qsource addressed these targets and metrics and how they aligned with the state's quality strategy in the activities in this report, as applicable.

DHS Quality Strategy Evaluation

To fulfill the requirements outlined in 42 CFR 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e), Qsource evaluated the effectiveness of DHS's Quality Strategy and its progress toward the strategy's primary goals and objectives. DHS noted in its Quality Strategy that it set out specific quality metrics and monitoring activities designed to meet the goals and objectives outlined. Therefore, Qsource used the results of those quality metrics to determine the effectiveness of DHS's Quality Strategy and made recommendations for how the State can target goals and objectives to better support improvements in quality, timeliness, and access to care.

PASSE

The evaluation found that, of the performance measures, including all subcategories within the standards which the State outlined for the PASSEs, the PASSEs achieved a high or moderate confidence rating for the majority of them. This means that the PASSEs mostly met or exceeded those metrics set forth for measurement year 2020.

Table 3 presents the validation rating criteria used to evaluate the performance of each PASSE.

Table 3. Quality Strategy Metric Validation Rating Criteria	
Rating	**Criteria**
High Confidence	Met or exceeded DHS target
Moderate Confidence	Within 10 percentage points of DHS target
Low Confidence	Within 20 percentage points of DHS target
No Confidence	Below 20 percentage points of DHS target

Table 4 presents the validation ratings for the performance metrics listed in the Quality Strategy as well as an average validation rating based on the scores achieved in those metrics.

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE						
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**ARTC**	**Empower**	**Summit**
				Validation Rating	**Validation Rating**	**Validation Rating**
Network Adequacy						
Out-of-Network Provider Payment	Starting on January 1, 2020, no greater than twenty percent (20%) of the total dollars paid to the PASSE shall be used to pay for services billed by out-of-network providers.	Quality and Access to Care	High Confidence	High Confidence	High Confidence	High Confidence
Call Center						
Call Center Answer and Abandonment Rates	95% of all calls answered within three rings or 15 seconds	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
	Number of busy signals not exceeding 5% of the total incoming calls	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
	The wait time in queue not longer than two minutes for 95% of the incoming calls	Quality and Timeliness of Care	High Confidence	Moderate Confidence	High Confidence	High Confidence

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE

Metric	Component Definition	Domain	Average Validation Rating	ARTC Validation Rating	Empower Validation Rating	Summit Validation Rating
	The abandoned call rate not to exceed 5% for any month	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Call Center Return Calls	All calls requiring a call back to the enrollee or provider returned within one business day of receipt	Quality, Timeliness, and Access to Care	High* Confidence	PASSE reported there were no calls that required callback	High Confidence	Not Reported
	For calls received during non-business hours, return calls to enrollees and providers made on the next business day	Quality and Timeliness of Care	High* Confidence	High Confidence	High Confidence	Not Reported
Website						
Website and Portal Availability	PASSE's website online at least 99% each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance.	Quality and Access to Care	High Confidence	High Confidence	High Confidence	High Confidence
Grievances						
Investigation and Resolution of Grievances	Acknowledgement in writing within five business days of receipt of each grievance	Quality and Timeliness of Care	No Confidence	Moderate Confidence	No Confidence	Moderate Confidence
	All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with section 4.9.19.c.iii of the PASSE Provider Agreement.	Quality and Timeliness of Care	Low Confidence	Moderate Confidence	No Confidence	High Confidence
	The PASSE must submit a grievance log with its quarterly report.	Quality and Timeliness of Care	Moderate Confidence	High Confidence	No Confidence	High Confidence

**One or more PASSEs was not included in the average due to unavailable data.*

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE

Metric	Component Definition		Domain	Average Validation Rating	ARTC Validation Rating	Empower Validation Rating	Summit Validation Rating
Claims Processing							
Denial, Approval, and Submission of Claims: Processing Clean Claims	The PASSE must process 70% of all clean claims submitted within seven days.		Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
	The PASSE must process 95% of all clean claims submitted within 30 days.		Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
	The PASSE must process 99% of all clean claims submitted within 60 days.		Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Encounter Data							
Accuracy of Encounter Data	No less than 95% of the PASSE's encounter lines submission must pass Medicaid Management Information System (MMIS) system edits, as specified by DHS.		Quality of Care	Moderate Confidence	High Confidence	Moderate Confidence	No Confidence
Timeliness of Encounter Data	All encounter data submitted in accordance with the timeframes established in the Agreement.	Submit encounter claims monthly	Timeliness of Care	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence
		Accurately resubmit 100% of all encounters for which errors can be remedied	Timeliness of Care	No Confidence	No Confidence	No Confidence	No Confidence

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE

Metric	Component Definition		Domain	Average Validation Rating	ARTC Validation Rating	Empower Validation Rating	Summit Validation Rating
		Resubmit remedied encounters within 30 days of notice by DHS	Timeliness of Care	No Confidence	No Confidence	No Confidence	No Confidence
Reporting							
Report Submission	All required reports must be submitted in accordance with timelines established in the Agreement between the PASSE entities and DHS. The reports identified in the PASSE Agreements are listed in the Exhibits.		Timeliness of Care	Moderate Confidence	Moderate Confidence	High Confidence	Moderate Confidence
Key Personnel							
Key Personnel Vacancy	In the event of a key personnel vacancy, the PASSE must propose a suitable replacement to the Contract Monitor within 30 calendar days of the vacancy occurrence or from when the PASSE first knew or should have known the vacancy would be occurring.		Quality of Care	High* Confidence	High Confidence	High Confidence	PASSE reported there were no key personnel vacancies
Person Centered Service Plans							
Person Centered Service Plans	≥90% of enrolled members will have a PCSP or Interim Plan of Care.		Quality of Care	No Confidence	Low Confidence	No Confidence	Low Confidence
Person Centered Service Plans	≥80% of the 90% of enrolled members will have a PCSP that includes all needed HCBS services.		Quality and Access to Care	High Confidence	High Confidence	High Confidence	High Confidence

**One or more PASSEs was not included in the average due to unavailable data.*

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE						
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**ARTC**	**Empower**	**Summit**
				Validation Rating	**Validation Rating**	**Validation Rating**
Care Coordination						
Care Coordinator to Client Caseload	≥90% of care coordinators will have a caseload of ≤50 members	Quality of Care	Moderate Confidence	Low Confidence	High Confidence	High Confidence
Initial Contact of Client	≥75% of members will be contacted by a care coordinator or appropriate PASSE team member within 15 business days after assignment to PASSE	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Monthly Contact of Client	≥75% of members are contacted monthly and in person quarterly by a care coordinator.	Quality of Care	**	**	**	**
Follow-Up Care	≥50% of members with a visit to Emergency room or discharge from hospital or Inpatient Psychiatric Unit/Facility will have a follow up from a PASSE care coordinator or appropriate PASSE team member within seven (7) business days.	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Primary Care Physician Assignment	≥80% of members will have selected a PCP and will be on a PCP's caseload	Access to Care	High Confidence	High Confidence	High Confidence	High Confidence

***DHS Waived Quarterly Contact measure due to the COVID-19 pandemic, thus, no results are reported.*

Table 4. MY 2020 Quality Strategy Metric Ratings: PASSE						
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**ARTC Validation Rating**	**Empower Validation Rating**	**Summit Validation Rating**
Appeals						
Appeals	Unless it is an expedited appeal request, an oral appeal request must be followed with a written, signed appeal within ten (10) calendar days of the oral filing, unless the appellant requests an expedited resolution	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Appeals	The PASSE must acknowledge each PASSE appeal in writing within five (5) business days of receipt of each PASSE appeal, unless the appellant requests an expedited resolution	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence
Appeals	Unless the appellant requests expedited resolution, an appeal must be heard and notice of appeal resolution sent to the member no later than thirty (30) calendar days from the date of receipt of the appeal	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence	High Confidence

**One or more PASSEs were not included in the average due to unavailable data.*
***DHS Waived Quarterly Contact measure due to the COVID-19 pandemic, thus, no results are reported.*

Qsource noted five performance metrics which received an average rating of low or no confidence. Those metrics included:

- Investigate and resolve all Grievances within the following time frames: Acknowledgement in writing within five business days of receipt of each grievance.
- Investigate and resolve all Grievances within the following time frames: All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with 4.9.19.c.iii of the PASSE Provider Agreement.
- Timeliness of Encounter Data: All encounter data submitted in accordance with the timeframes established in the Agreement. Accurately resubmit 100% of all encounters for which errors can be remedied.
- Timeliness of Encounter Data: All encounter data submitted in accordance with the timeframes established in the Agreement. Resubmit remedied encounters within 30 days of notice by DHS.
- ≥90% of enrollees will have a Patient-Centered Service Plan (PCSP) or Interim Plan of Care.

DHS should continue to work with the PASSEs and focus on the standards that consistently receive low to no confidence ratings to ensure quality, timeliness, and access to care for the enrollees. DHS should ensure that the PASSEs review their workflows to ensure timely care and reporting of data. DHS should ensure that the PASSEs are informed of all required timeframes. DHS should have the PASSEs specifically focus on resubmission of encounters metrics as well as investigating and resolving all grievances within timeframe metrics. DHS should continue to focus on PCSPs and ensuring that each enrollee has a PCSP. The PCSPs are an integral piece of quality care for enrollees. Overall, the Quality Strategy was an effective tool for measuring and improving DHS's managed care services, specifically in improving the quality, timeliness, and access to care for the PASSE enrollees. The validation ratings of high to moderate confidence on the majority of the metrics indicated that the PASSEs closely aligned with DHS's Quality Strategy. The PASSEs and the State are making progress towards the Quality Strategy goals and objectives.

DMO

Qsource found that of the Quality Strategy DMO performance measures, including all subcategories within the standards which the State outlined for the DMOs, the DMOs achieved a high or moderate confidence rating on most of them. This means that the DMOs mostly met or exceeded those metrics set forth in the Quality Strategy.

Table 5 presents the validation rating criteria used to evaluate the performance of each DMO.

Table 5. Quality Strategy Metric Validation Rating Criteria

Rating	Criteria
High Confidence	Met or exceeded DHS target
Moderate Confidence	Within 10 percentage points of DHS

Table 5. Quality Strategy Metric Validation Rating Criteria	
Rating	**Criteria**
	target
Low Confidence	Within 20 percentage points of DHS target
No Confidence	Below 20 percentage points of DHS target

Table 6 presents the validation ratings for the performance metrics listed in the Quality Strategy as well as an average validation rating based on the scores achieved in those metrics.

Table 6. MY 2020 Quality Strategy Metric Ratings: DMO					
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**Delta Dental Validation Rating**	**MCNA Validation Rating**
Network Adequacy					
Access to Care: Distance	At least 90% of Beneficiaries have access to two or more Primary Care Dentists who are accepting new patients within 30 miles of the member's residence in urban counties and 60 miles of the member's residence in rural counties	Access to Care	High Confidence	High Confidence	Confidence
	At least 85% of all members have access to at least one specialty provider within 60 miles of the member's residence	Access to Care	High Confidence	High Confidence	Confidence
	At least 90% of pediatric members **must** have access to Pediatric Dental Services through two or more Primary Care Dentist who are accepting new patients within 30 miles of the member's residence in Urban counties and 60 miles of the member's residence in Rural counties	Access to Care	High Confidence	High Confidence	High Confidence
Access to Care – Time	Emergency care provided within 24 hours	Timeliness and Access to Care	Not Reported	Not Reported	Not Reported
	Urgent care, including urgent specialty care, provided within 48 hours	Timeliness and Access to Care	Not Reported	Not Reported	Not Reported
	Therapeutic and diagnostic care provided within 14 days	Timeliness and Access to Care	Not Reported	Not Reported	Not Reported
	Primary care dentists make referrals for specialty care based on the urgency of the enrollee's dental condition, but no later than 30 days.	Timeliness and Access to Care	Not Reported	Not Reported	Not Reported

Table 6. MY 2020 Quality Strategy Metric Ratings: DMO					
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**Delta Dental Validation Rating**	**MCNA Validation Rating**
	Non-urgent specialty care provided within 60 days of authorization	Timeliness and Access to Care	Not Reported	Not Reported	Not Reported
Out-of-Network Provider Billing	No greater than 20% of the total dollars billed to the DMO for outpatient services billed by out-of-network providers	Quality and Access to Care	High Confidence	High Confidence	High Confidence
Call Center					
Call Center Answer and Abandonment Rates	All calls answered within three rings or 15 seconds	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence
	Number of busy signals not exceeding 5% of the total incoming calls	Quality and Timeliness of Care	High* Confidence	High Confidence	Not Reported
	The wait time in queue not longer than two minutes for incoming calls	Quality and Timeliness of Care	Moderate Confidence	High Confidence	Moderate Confidence
	Monthly abandoned call rate	Quality and Timeliness of Care	Moderate Confidence	High Confidence	No Confidence
Call Center Return Calls	All calls requiring a call back to the enrollee or provider returned within one business day of receipt	Quality, Timeliness, and Access to Care	High Confidence	High Confidence	High Confidence

**One DMO was not included in the average due to unavailable data.*

Table 6. MY 2020 Quality Strategy Metric Ratings: DMO					
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**Delta Dental Validation Rating**	**MCNA Validation Rating**
	For calls received during non-business hours, return calls to enrollees and providers made on the next business day	Quality, Timeliness, and Access to Care	High Confidence	High Confidence	High Confidence
Website					
Website and Portal Availability	DMO's website, enrollee portal, and provider portal online each month, except that the DMO may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance	Quality and Access to Care	Moderate Confidence	Moderate Confidence	High Confidence
Grievances					
Investigation and Resolution of Grievances	Investigate and resolve all grievances as expeditiously as the member's health condition requires, but not to exceed ninety (90) calendar days. The timeframe may be extended as allowed in Section 4.3.3 of the Appendix, but the extension must be properly documented and shall not exceed fourteen (14) calendar days	Quality and Timeliness of Care	High Compliance	High Compliance	High Compliance
	Written resolution of the grievance must be sent to the member within two (2) business days of making. The written resolution must conform to the requirements laid out in Section 4.3.3 of the Appendix	Quality and Timeliness of Care	High Compliance	High Compliance	High Compliance
Claims Processing					
Denial, Approval, and Submission of Claims	Deny or approve, and submit for payment: 100% of clean paper claims within 30	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence
	Deny or approve, and submit for payment: 100% of clean electronic claims within 14 calendar days of receipt	Quality and Timeliness of Care	High Confidence	High Confidence	High Confidence

Table 6. MY 2020 Quality Strategy Metric Ratings: DMO					
Metric	**Component Definition**	**Domain**	**Average Validation Rating**	**Delta Dental Validation Rating**	**MCNA Validation Rating**
Encounter Data					
Accuracy of Encounter Data	At least 99% of all encounter data must be accurate	Quality of Care	Moderate Confidence	Moderate Confidence	Low Confidence
Timeliness of Encounter Data	All encounter data submitted in accordance with the timeframes established in the contract	Quality and Timeliness of Care	Moderate Confidence	High Confidence	Low Confidence
Reporting					
Report Submission	All required monthly, quarterly, bi-annual, and annual reports submitted in accordance with the timeframes established in the RFP and the provider enrollment agreement	Quality and Timeliness of Care	Moderate Confidence	Moderate Confidence	High Confidence
Key Persons					
Key Person Vacancy	In the event of a Key Personnel vacancy, propose a suitable replacement to DMS within 15 days of the vacancy occurrence or from when the contractor first knew or should have known the vacancy would be occurring	Quality of Care	Unable to determine due to missing applicable data	Not Reported	DMO reported there were no key person vacancies

**One DMO was not included in the average due to unavailable data.*

While the DMOs achieved a high to moderate rating on most of the metrics, neither of the DMOs reported data on DHS's performance standards regarding emergency or urgent care. The DMOs reported they were unable to bill for urgent or emergent care. These metrics appear to be put in place to address Objective 2.3 of Goal 2: Decrease per capita emergency room (due to dental emergencies) visits. DHS should review this objective and the metric associated with it if the DMOs were unable to track this data. DHS should continue to work with the DMOs and focus on the standards that consistently receive low to no confidence ratings to ensure quality, timeliness, and access to care for the enrollees.

Qsource found that, overall, the Quality Strategy was an effective tool for measuring and improving DHS's managed care services, specifically in improving the quality, timeliness, and access to care for the DMO enrollees. The validation ratings of high to moderate confidence on the majority of the metrics indicated that the DMOs closely aligned with DHS's Quality Strategy. The DMOs and the State are making progress towards the Quality Strategy goals and objectives.

EQR Activities

EQR includes four mandated activities and can include optional activities. Each state agency (in this case, Arkansas DHS) may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for DHS in 2021, in accordance with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocols (released in 2019).

EQR Mandatory Activities

As set forth in Title 42 *Code of Federal Regulations* (CFR) Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, four mandatory EQR activities must be conducted to assess the performance of the PASSEs and DMOs.

In addition to EQR mandatory activities, 42 CFR § 438.358 outlines six optional activities, two of which DHS has elected for Qsource to include in this report.

Table 7 presents the EQR activities conducted in 2021 and the corresponding measurement period for the activity.

Table 7. EQR Activities Conducted in 2021

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	***Validation of Performance Improvement Projects***	Mandatory	January 1, 2020 – December 31, 2020
2	***Validation of Performance Measures***	Mandatory	January 1, 2020 – December 31, 2020
3	***Review of Compliance with Medicaid and CHIP Managed Care Regulations***	Mandatory	January 1, 2021 – December 31, 2021
4	***Validation of Network Adequacy***	Mandatory	Varied (See Below)

Table 7. EQR Activities Conducted in 2021			
Protocol #	**Activity Name**	**Mandatory or Optional**	**Measurement Period**
	Validation of DHS Network Adequacy Analysis		January 1, 2020 – December 31, 2020
	Geographic Network Adequacy Analysis		As of July 2021
	Provider Access to Care Survey		January 1, 2021 – December 31, 2021
	Satisfaction Surveys and Complaints		January 1, 2020 – December 31, 2020
	Person-Centered Service Plans (PCSPs) Assessment		April 1, 2021 – September 30, 2021
	Validation of DHS Person-Centered Service Plan (PCSP) Retrospective Review		January 1, 2020 – December 31, 2020
5	***Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan***	Optional	January 1, 2020 – December 31, 2020
6	***Administration or Validation of Quality of Care Surveys***	Optional	January 1, 2020 – December 31, 2020
7	***Calculation of Additional Performance Measures***	Optional	January 1, 2020 – December 31, 2020
8	***Implementation of Additional Performance Improvement Projects***	Optional	January 1, 2021 – December 31, 2021
9	***Conducting Focus Studies of Health Care Quality***	Optional	January 1, 2020 – December 31, 2020

Qsource followed the CMS Protocols published in October 2019. Qsource provided DHS and the PASSEs and DMOs with technical assistance—an EQR-related activity also defined by 42 CFR § 438.358. The technical assistance provided targeted support through phone calls, webinars, written guides, and trainings. In this capacity, Qsource maintained ongoing, collaborative communication with DHS and supported the PASSEs and DMOs in their EQR activities.

Finally, Qsource provided each PASSE and DMO with an information packet explaining the EQR activities in greater detail and templates for data submission.

Qsource is responsible for the creation and production of this *2021 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by the PASSEs and DMOs.

Qsource performed annual EQR activities to determine each PASSE's and DMO's compliance with federally mandated activities. This report includes the following results of these activities:

- A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities
- A summary of findings from each review
- Comparative information and assessments of the degree to which benefit managers have addressed prior year EQRO recommendations for QI
- Strengths and weaknesses demonstrated by each PASSE and DMO in providing healthcare services to enrollees
- Recommendations for improving the quality of these services, including how DHS can target goals and objectives in achieving the goals of the quality strategy to better support improvement
- Comparative information about all of the PASSEs and DMOs, consistent with CMS EQR Protocols guidance

This *2021 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual EQR activity reports provided to DHS. Comparative analyses from previous measurement years are included in this report where possible.

Quality of Care

While quality of care has numerous applications, CMS described it as the degree to which preferred enrollee health outcomes were likely to be increased through the efforts of the PASSES and the DMOs providing enrollee services, including their organization and operations. The PASSE Agreement with DHS required the PASSEs to conduct performance improvement projects, which included mechanisms to assess the quality and appropriateness of care furnished to the enrollees. DHS's Quality Strategy included the goal of advancing plan models to improve the health of the enrollees by monitoring the implementation of performance improvement projects by the PASSEs and DMOs. Qsource's validation of those PIPs, as well as working with the PASSEs and DMOs to implement a PIP as part of Protocol 8, was part of Qsource's evaluation of quality of care. Each PASSE and DMO was required to report on performance measures related to quality of care to the State. DHS asked the PASSEs and DMOs to meet targets for those performance measures. Qsource conducted Performance Measure Validation as well as Performance Measure Calculation to determine if the PASSEs and DMOs were meeting these quality performance measure targets.

Qsource's Compliance Assessment of each PASSE and DMO evaluated quality of care for enrollees by reviewing Coverage and Authorization of Services, Grievance and Appeals, and Subcontractual Relationships and Delegation.

Enrollee satisfaction was another indicator of quality of care. Enrollee experience of care was evaluated in Protocol 6 by reporting overall satisfaction and composite scores for key areas. Enrollee experience was measured through the Annual Network Adequacy review, encompassing access to and timeliness of care, which were also quality of care measurements.

In addition, encounter data validation served to measure healthcare quality by identifying the degree to which accurate

and complete service utilization data were reported by the PASSEs and DMOs, helping to ensure effective operation and oversight.

Qsource conducted two focus studies this year to evaluate quality of care for specific populations- foster children (PASSEs) and intellectually and/or developmentally disabled (IDD/DD) enrollees (DMOs).

Timeliness of Care

For quality care to be effective, it has to be provided in a timely manner. Thus, various standards for timely care were monitored through PASSE and DMO compliance with federal, state, and contractual regulations. Multiple PIPs, validated by Qsource, addressed the timeliness of care for enrollees. Qsource's validation of performance measures looked at timeliness measures determined by DHS, including timeliness in processing prior authorization requests, claims, grievances, and appeals. This year's Compliance Assessment reviewed the Grievance and Appeals standard looking at the timeliness for of the process for issue resolution. Network adequacy was analyzed to determine if they delivered services timely.

The results of the enrollee and provider satisfaction surveys included questions to evaluate the timeliness of care. Qsource's provider surveys included an evaluation of the providers' perspective on the timeliness of care.

Access to Care

As quality of care was critical for enrollee health outcomes, so was access to care when it was needed. Each PASSE and DMO must attest annually to its ability to provide enrollees with adequate access to the care they need. The provider capacity was also monitored through network adequacy evaluation, which assessed the availability of critical provider specialties by time and distance, and how quickly enrollees could obtain needed appointments. Compliance with applicable federal, state, and contractual regulations regarding credentialing and recredentialing to ensure an adequate network of providers was reviewed in this year's Compliance Assessment. Access to care was also measured with focused efforts through performance improvement projects that addressed the availability of services needed by enrollees and the degree to which enrollees could access those services. PASSE and DMO performance on various quality measures in PMV helped enable monitoring of enrollee access to care as well. These included PCP assignment, follow-up care, out-of-network provider billing/payment, call center return calls, website and portal availability, prior authorizations, preventive dental services, sealant services, dental emergencies, and access to care – time.

In addition, Qsource conducted two focus studies this year to evaluate access to care for specific populations- foster children (PASSEs) and intellectually and/or developmentally disabled (IDD/DD) enrollees (DMOs).

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364 and provided guidelines in the 2012 and 2019 EQR Protocols for this *2021 Annual EQRO Technical Report*, which—in addition to this Overview—includes the following EQR-activity-specific sections and subsections:

- Protocol 1: PIP Validation
- Protocol 2: PMV
- Protocol 3: CA
- Protocol 4: ANA Review
- Protocol 5: EDV (optional EQR activity)
- Protocol 8: Additional PIPs (optional EQR activity)
- Critical Incidents (PASSEs only)
- Utilization Analysis
- Effectiveness Assessment

The Appendices include more detailed, PASSE/DMO-specific results. The assessment tools used to conduct the 2021 EQR activities are available upon request.

The following optional Protocols were conducted, but not included in this report. Links to these optional Protocol reports were included with the submission of this *2021 Annual EQRO Technical Report* to CMS.

- Protocol 6: Validation of Quality of Care Surveys (optional EQR activity)
- Protocol 7: Calculation of Additional Performance Measures (optional EQR activity)
- Protocol 9: Focus Studies of Health Care Quality (optional EQR activity)

DHS Utilization of the EQRO Technical Report

The *2021 Annual EQRO Technical Report* provides DHS with substantive, unbiased data on the PASSEs and DMOs as well as recommendations for action toward far-reaching performance improvement. The data also depict the healthcare landscape for the state's Medicaid managed care population, which assists DHS in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable. DHS can use these data to measure progress toward goals and objectives of its Quality Strategy and better support improvement in the quality, timeliness, and access to healthcare services. Recommendations for how to utilize Qsource's findings can be found in the Conclusions and Recommendations section of this report.

Protocol 1: Performance Improvement Project (PIP) Validation

Objective

The primary objective of PIP validation was to determine the compliance of each PASSE and DMO with the requirements set forth in 42 CFR § 438.330(d). PASSEs and DMOs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease as well as enrollee needs for specific services. Each PIP must be completed within a timeframe that allows PIP success-related data in the aggregate to produce new information on quality of care every year. PIPs are further defined in 42 CFR § 438.330(d) to include all of the following:

- Performance measurement using objective quality indicators
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of intervention effectiveness
- Planning and initiation of activities to increase or sustain improvement

In addition to CFR PIP validation requirements, DHS included the following in its agreement with the PASSEs, which PIPs must address:

- The collection and submission of performance measurement data, including any required by DHS or CMS
- Mechanisms to detect both underutilization and overutilization of services
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports (LTSS), including:
  - an assessment of care between care settings, and
  - a comparison of services and supports received with those set forth in the enrollee's person-centered service plan (PCSP)
- Participation in DHS's efforts to prevent, detect, and remediate critical incidents, consistent with assuring the health and welfare of enrollees, which are based on the requirements for home and community-based waiver programs

Because PIP topics were related to a specific aspect of service or care, not all of the previous items will be applicable. Goal 4 of the State's Quality Strategy is to continuously advance models to improve the health of enrollees. Objective 4.1 of that goal is to monitor the implementation of performance improvement projects by the PASSEs and the DMOs.

The PIP validation process evaluated a minimum of one nonclinical (NC) and one clinical (C) PIP for the two DMOs (Delta Dental and MCNA) and three PASSEs (ARTC, Empower, and Summit). Each PASSE and DMO submitted a continuation of their established PIPs. PIPs are typically conducted over a three year period. Some of the PIPs were in their second measurement year, while some were in the third measurement year. To validate PIPs, Qsource assembled a validation team of experienced staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each PIP's study design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of interventions.

Technical Methods for Data Collection and Analysis

Each PASSE and DMO was contractually required to submit its PIP studies annually to DHS as requested. Submitted PIPs should include the necessary documentation for data collection, data analysis plans, and an interpretation of all results. PASSEs and DMOs should also address threats to validity regarding data analysis and include an interpretation of study results.

The PIP validation was based on CMS's *EQR Protocol 1: Validation of Performance Improvement Projects* (October 2019). Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each PASSE and DMO deliver PIP information to DHS and how that information was assessed. Using Qsource's PIP Summary Form, each PASSE and DMO submitted its PIP studies and supplemental information in July 2021. The measurement year (MY) for this validation was January 1, 2020 through December 31, 2020.

Qsource's scoring methodology was based on the percentage of elements met out of all elements assessed. Each PIP involves nine required steps, and each step consists of elements essential to the successful completion of a PIP. The elements within each step were scored as Met, Not Met, or Not Applicable. The overall validation rating was determined by the percentage score of all elements met, as guided by EQR Protocol 1, and was calculated by dividing the number of elements met by the number of elements assessed. The validation rating indicates Qsource's overall confidence (ranging from No Confidence to High Confidence) that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement—dependent upon how far a particular PIP had progressed. Table 8 presents the rating criteria used in the PIP validation.

Table 8. PIP Validation Rating Criteria	
Rating	**Criteria**
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.

Recent CMS guidance recommended reporting intervention and improvement strategies for PIPs in Remeasurement 1. These are presented in Table 13 based on the information received from the PASSEs and DMOs. Note that the table contains direct quotes from the submitted PIPs.

As part of the validation process, Qsource also notes strengths, suggestions, and areas of noncompliance (AONs) for each PASSE and DMO. When any element of a PIP step receives an AON, Qsource provides technical assistance to help the PASSEs and DMOs follow CMS Protocols and revise the PIP as needed to improve performance and, thereby, the efficacy of the PIP in the following measurement period.

More specific information on validation methodology is available in the individual *2021 PIP Validation Report* for each PASSE and DMO.

Description of Data Obtained

Qsource received PIP summary forms for the following PIPs:

- ARTC
  - Enrollee to Care Coordinator Ratio (Nonclinical)
  - Immunizations for Children and Adolescents (Clinical)
- Empower
  - Care Coordination: Employee Satisfaction (Nonclinical)
  - Improving Enrollee Access to Primary Care Well Visits (Clinical)
- Summit
  - Improving Reportable Incident Notification Timeframes (Nonclinical)
  - Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Clinical)
- Delta Dental
  - Beneficiary Missed Appointments (Nonclinical)
  - Department of Children & Family Services: Foster Care Children with a Preventive Dental Service (Clinical)
- MCNA
  - Annual Dental Visits (Nonclinical)
  - Preventive Dental Visits (Clinical)

A detailed description of each PIP validated is located in Table A-1.

Table 9 lists the nine PIP steps used for assessing the PIP methodology (Activity 1).

Table 9. PIP Steps
1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected PIP Variables and Performance Measures
6. Review the Data Collection Procedures
7. Review Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Findings

Table 10 presents the type, validation status and rating, and overall score for each PIP. The PIP topics, both nonclinical and clinical, were chosen by the PASSEs and DMOs.

For the PIP review, three of the 10 PIP studies received a High Confidence validation rating, while three PIP studies received a Low or No Confidence validation rating. Additional details about each PIP study are provided in Appendix A.

Table 10. MY 2020 PIP Validation Status and Performance Scores

PASSE/ DMO	PIP Type	PIP Validation Status	Overall Score	Validation Rating
ARTC	NC*	Yes	65.1%	No Confidence

Table 10. MY 2020 PIP Validation Status and Performance Scores

PASSE/ DMO	PIP Type	PIP Validation Status	Overall Score	Validation Rating
	C*	Yes	89.1%	Moderate Confidence
Empower	NC	Yes	81.4%	Moderate Confidence
	C	Yes	70.2%	Low Confidence
Summit	NC	Yes	84.1%	Moderate Confidence
	C	Yes	77.8%	Low Confidence
Delta Dental	NC	Yes	100%	High Confidence
	C	Yes	88.9%	Moderate Confidence
MCNA	NC	Yes	100%	High Confidence
	C	Yes	95.5%	High Confidence

** NC=Nonclinical; C=Clinical*

Recent CMS guidance suggested that each PIP should be evaluated for alignment with the State's quality strategy and domain of care. This was the second measurement year for the PASSEs to complete a PIP. While the PASSEs demonstrated improvement for steps one through six, steps seven through nine were new and received low scores which could account for the overall low PIP scores. DHS, along with the PASSEs and DMOs, will determine if these PIPs will be continued in the future. Qsource provided technical assistance to the PASSEs and DMOs for these PIPs and will continue to do so in the future.

Strengths and Weaknesses

Table 11 includes strengths and Table 12 includes weaknesses exhibited by the PASSEs and DMOs for the PIP validation. Strengths for the PIP validation indicate that the PASSEs and DMOs demonstrated particular proficiency on a given activity and can be identified regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming on the part of a PASSE or DMO. AONs, or weaknesses, arise from evaluation elements that receive a Not Met score, indicating that those elements were not in full compliance with CMS Protocols. This information is useful for determining whether to continue or retire a specific PIP.

Qsource also identified suggestions where an element was fully compliant, but a revision or update could further strengthen that element's compliance. The PASSEs and DMOs were not held accountable for addressing suggestions; therefore, suggestions were not monitored or included in this report. Any PIPs not listed had no strengths and/or weaknesses identified.

Table 11. PIP Strengths	
ARTC	
C*	ARTC included multiple detailed attachments to clarify data sources and processes.
Empower	
C	Empower noted the distribution of enrollees in detail, which was informative and helpful.
Summit	
NC*	Summit addressed all elements of this activity comprehensively and clearly.
C	Summit addressed all elements in this activity clearly and comprehensively.
Delta Dental	
NC	Delta Dental provided a very comprehensive analysis with multiple sources.
NC	Delta Dental included a detailed run chart outlining their PDSA activities.
C	Delta Dental included a detailed comprehensive analysis with multiple sources.
C	Delta Dental included a detailed run chart outlining the PDSA activities.
MCNA	
NC	MCNA included a detailed fishbone analysis showing barriers at the enrollee, provider, and system level to enrollees receiving an Annual Dental Visit.
C	MCNA included a detailed fishbone analysis showing barriers at the enrollee, provider, and system level to enrollees accessing preventive services.

** NC=Nonclinical; C=Clinical*

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

Table 12. PIP Weaknesses (AONs)	
ARTC	
NC*	ARTC should include a comprehensive analysis with evidence of how the Care Coordinator to enrollee ratios affect an enrollee's needs, care, and services.
NC	ARTC should specify the PIP population as all enrollees.
NC	ARTC should clearly specify the PIP time period being measured.
NC	ARTC should state a clear goal. If that goal shifts during the PIP, that would be noted in steps 7-9 as factors affecting PIPs and changes for future years. ARTC should align the aim statement with the performance measures being tracked.
NC	ARTC should give one clear and concise aim statement in the form of a question. As stated in the 2021 AR PIP Summary Form Instructions, ARTC should clearly state the PIP aim statement in a question format. For example, "Will ensuring updating and maintaining forecasting models to ensure adequate hiring, the use of a Workforce Analyst, and Care Coordinator Leadership and Compliance monitoring of caseloads ensure at least 90% compliance with Enrollee to Care Coordinator ratios over a 12-month period for the entire enrollee population?"
NC	ARTC should specifically describe the process of how the variable is collected and tracked over time.
NC	ARTC should describe how enrollee to Care Coordinator ratios were an important aspect of care and how the measure will make a difference to enrollees' health status.
NC	ARTC should address clinical knowledge or health services research on which the performance measure may be based.
NC	ARTC should address the importance of enrollee to Care Coordinator ratios to enrollees' care.
NC	ARTC should report the six months of 2019 as the baseline measurement and the 12 months of 2020 as Remeasurement 1 with a discussion of the shortened baseline year, a factor that influences the comparability of initial and repeat measurements.
NC	ARTC should have compared the six months of 2019 to the 12 months of 2020 to determine if there was statistical significance in the findings.
NC	ARTC should use the data collected monthly as part of a rapid-cycle, Plan-Do-Study-Act (PDSA) approach, present the data in a run chart, and clearly implement and describe all components of PDSA activities.
NC	ARTC should address if any major confounding factors could have had an obvious impact on PIP outcomes (i.e., state requirements due to the PHE that halted enrollee terminations from the Medicaid program).
NC	Utilizing a comparison of the six months of 2019 as baseline and the 12 months of 2020 as Remeasurement 1, ARTC should address whether there is quantitative evidence of how the reported improvement in performance, if any, is likely to be the result of the selected improvement strategy.

Table 12. PIP Weaknesses (AONs)	
NC	ARTC should address how the reported improvement in performance, if any, is likely to be the result of the selected improvement strategy.
C*	While ARTC detailed the time period, specific strategies, population, and goals in this step, ARTC should include the details of the aim statement in one concise questions, for example, "Do targeted interventions such as EPSDT program education for enrollees and providers increase the rate of enrollees who have been continuously enrolled for 12 months and who will turn 2 or 13 in the measurement year receiving recommended immunizations to 39.1% an 38.2% respectively?"
C	ARTC should describe its strategy for inter-rater reliability in calculating these hybrid measures.
C	ARTC should include a detailed cause/barrier analysis that supports selection of improvement strategies.
C	ARTC should document all steps taken in the PDSA process.
Empower	
NC	Empower should specify the PIP population. The PASSE should ensure the aim statement is concise and includes the performance being measured and the associated goal.
NC	Empower should ensure the aim statement is concise and includes the performance being measured and the associated goal in one aim statement (question).
NC	Empower should have described numerators, denominators, benchmarks, and the sources for the performance measures.
NC	Empower should discuss the statistical significance of the change between baseline and Remeasurement 1 results.
NC	Empower should address factors that may influence comparability.
NC	Empower should address factors that threaten the internal or external validity of findings.
NC	Empower should specifically address PDSA activities over the measurement period.
C	Empower should update the aim statement (in the form of a question) to include all required components. For example, "Will Care Coordinator assistance with scheduling PCP well visits and provider education on well visit coding increase the utilization of well visits in all enrollees of all ages continuously enrolled over the measurement year to 39.9% by 12/31/2020?
C	Empower should include an estimated degree of data completeness as a percentage of claims.
C	Empower should define the baseline and Remeasurement 1 as consecutive annual periods (2019 and 2020) and include discussion.
C	Empower should complete statistical testing on the significance of variation in the baseline and Remeasurement 1 rates.
C	Empower should note factors that affect comparability of the baseline and Remeasurement 1 rates (abbreviated time period included in the baseline).
C	COVID-19 should have been considered as a factor affecting external validity.
C	Empower should have included lessons learned over the PIP period on sub-optimal performance.

Table 12. PIP Weaknesses (AONs)	
C	Empower should include evidence supporting the likelihood of success of the interventions implemented.
C	Empower should present the causes/barriers to care that resulted in the selection of the interventions.
C	Empower should document the implementation of the interventions for each step in the PDSA cycle.
C	Empower should include a detailed discussion of the success of the interventions and any follow-up planned
C	Empower should address how the reported improvement was likely the result of the selected intervention.
C	Empower should describe statistical significance of improvement results from baseline to remeasurement.
C	Empower should describe the methodology that will be used to assess sustained improvement over time.
Summit	
NC	Summit should phrase the PIP aim statement as a question. For example, "Will targeted provider interventions improve notification timeframes for reportable incidents for all PASSE enrollees during the measurement period (calendar year)?"
NC	Summit should include a discussion of the statistical significance of any differences between baseline and repeat measurements.
NC	Summit should have completed Step 9.
C	Summit should phrase the PIP aim statement as a question. For example, "Will targeted provider interventions improve adherence to antipsychotic medications for all Summit Community Care Medicaid enrollees, 18 years and older with schizophrenia or schizoaffective disorder continuously enrolled during the measurement period to 65.42%?"
C	Summit should include the baseline period of 3/1/19 – 12/31/19 with the Remeasurement 1 period of 1/1/20 – 12/31/20.
C	Summit should calculate the statistical significance of improvement from baseline to remeasurement.
C	Summit should address any factors that could have influenced comparability of initial and repeat measurements (e.g., partial baseline year results) or those that might affect the internal or external validity of findings.
C	Summit should specifically address the success of interventions and follow-up activities.
C	Summit should address whether the baseline and remeasurement methodologies were the same.
C	Summit should address the statistical significance of observed improvement.
C	Summit should address how sustained improvement will be demonstrated with future measurements.
Delta Dental	
C	Delta Dental should have ensured the remeasurement period covered 12 months.
C	Delta Dental should have carried over the baseline timeframe from the previous PIP. The DMO should have recalculated the baseline rate based on the new enrollment criteria and provided detail in further steps.
C	Delta Dental should include a discussion of the baseline measurement and remeasurement of performance measures.

Table 12. PIP Weaknesses (AONs)	
C	Delta Dental should have recalculated the baseline 2019 data using the new enrollment specifications in order to have a full year of data to compare to the Remeasurement 1 data of 2020 with an explanation of the change as an internal factor affecting the PIP.
C	Delta Dental should have included the full 10 months of 2019 data to compare to the full 12 months of 2020 data and specified the change in methodology.
MCNA	
C	MCNA should address whether there was quantitative evidence of improvement in processes or outcomes.
C	MCNA should explain that for future remeasurements, statistically significant improvement in rates over time will be compared to establish if sustained improvement occurred.

** NC=Nonclinical; C=Clinical*

Interventions

Table 13 presents the reported PIP interventions. The table contains direct quotes from the PASSEs and DMOs.

Table 13. PIP Interventions		
PASSE/ DMO	**PIP Name**	**Interventions**
ARTC (Nonclinical)	*Enrollee to Care Coordinator Ratio*	Ensure we have the appropriate number of qualified Care Coordinators hired to meet caseload metric requirement.
		Create Workforce Analyst role within the Care Coordination department who oversees assignments of caseloads and monitors individual and program-wide caseload metric on a daily basis.
		Weekly review of metric data with leadership to ensure progress is on track and being maintained. CAP progress will be tracked as well.
ARTC (Clinical)	*Immunizations for Children and Adolescents*	Notify parent/guardian/member of EPSDT benefit within 60 days of enrollment as well as yearly. Provider education on proper billing, coding, and benefit structure as well as ensuring resources are available. Internal staff education on proper way to discuss the need for EPSDT visits and how to assist with appointment scheduling.
		Increase closure of immunizations measures by claims and medical record review. Provider education piece needs development. State Immunization Registry access is needed to improve numerator by showing higher member compliance. Work with largest provider groups for year-round medical record abstraction.

Table 13. PIP Interventions		
PASSE/ DMO	**PIP Name**	**Interventions**
Empower (Nonclinical)	*Care Coordination: Employee Satisfaction*	Improve the care coordinator training manual.
		Implement team caseload reconciliation meetings.
		Implement self-care supports.
		Redesign the Multidisciplinary form to include a spreadsheet for case load.
		Develop Tools and Resources to help Care Coordinators find resources and information to help members.
Empower (Clinical)	*Improving Enrollee Access to Primary Care Well Visits*	Care Coordinator assistance with scheduling Well Care Visits with a member's assigned PCP.
		Provider Education on appropriate coding to qualify a claim for service as a Well Care Visit.
Summit (Nonclinical)	*Improving Reportable Incident Notification Timeframes*	The incident report tracking tool is utilized to log in 100% of the incident reports reported to the health plan in the category of abuse. The incidents are entered daily, tracked monthly, trended quarterly, and reported to the Quality Management Committee at least semi-annually. The results also allow for year-over-year comparisons, and comparison to the established goal. The incident report tracking tool captures all of the essential elements to determine time frame reporting within established criteria.
Summit (Clinical)	*Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia*	Provider and member medication fail lists and gaps in care lists were produced for enrollees who missed a refill of an antipsychotic medication for at least 80% of the treatment period. The appropriate prescribing providers were faxed lists and/or received provider email blasts, and provider newsletters. The Arkansas Pharmacists Association submitted fax blast newsletter to providers. The health plan quality department communicated with Care Coordinator Team leads to provide member specific gaps in care.
Delta Dental (Nonclinical)	*Beneficiary Missed Appointments*	The work of public health is centered on promoting healthy lifestyles through health education, protecting against environmental hazards, controlling infectious diseases, preparing for and responding to disasters, and promoting healthcare equity, quality, and accessibility. Medicaid is in a special position to bridge public health efforts to the patient level. The Beneficiary Missed Appointments PIP addresses one of the Institute for Healthcare Improvement's Triple Aim Framework: Improving the health of populations. Prevention is the underlying driver of health system transformation. It is what will ultimately lower costs, improve patient care, and improve the health of populations. Annual dental visits play a vital role in diagnosing and preventing dental disease (ASTHO).

Table 13. PIP Interventions		
PASSE/ DMO	**PIP Name**	**Interventions**
		Education is a fundamental social determinant of health and health education is a central tool of public health (Hahn, R.A. & Truman, B.I.). Therefore, we designed our Beneficiary Missed Appointment PIP around educating Delta Dental Smiles members that had been reported as having missed a scheduled dental appointment. We believed that we would see more of these members make and keep a dental appointment with 90 days of outreach efforts, due to the causality between education and health outcomes.
Delta Dental (Clinical)	*Department of Children and Family Services: Foster Care Children with a Preventive Dental Service*	DCFS creates a list of all Foster Children enrolled in Delta Dental Smiles and shares that with DDAR on a monthly basis. We then identify those Foster Children who have and have not had a preventive dental service in our claims/encounter data any time in the most recent 12-month period. DDAR then shares this data back with DCFS staff. DCFS then uses that data to inform regional Health Services workers on Foster Children that need to have dental appointments scheduled. Copies of these reports are available upon request.
MCNA (Nonclinical)	*Annual Dental Visits*	MCNA Member Service Representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a dental visit. The MSR educates the member on their available benefits and the importance of routine dental checkups to prevent gum disease. They also offer to locate a provider if the member does not already have one and perform a three-way call if necessary, with the provider office to schedule an appointment.
		Conduct and/or participate in a minimum of 80 outreach events annually in areas identified as a high-volume opportunity. Education and assistance will be coordinated and members needing additional assistance beyond what can be provided at the event will be referred to the Care Connections team.
		Text messages will be sent once a month to members who have not received a dental checkup within the last six months. Members will continue to receive a text message until an encounter is received or the member “opts out” of text messaging. The text messages will educate the member on preventive care and encourage them to schedule an appointment.
MCNA (Clinical)	*Preventive Dental Visits*	Text messages will be sent once a month to members who have not received a preventive checkup within the last six months. Members will continue to receive a text message until an encounter is received or the member “opts out” of text messaging. The text messages will educate the member on preventive care and encourage them to schedule an appointment.
		Quarterly provider profiling report that shows providers how they are performing against their peers. The report includes a clinical component assessing a provider’s performance against clinical guidelines to that of his/her peers.

Improvements

Table 14 presents a comparison between the PIP scores in measurement year (MY) 2019 and MY 2020. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases in performance are indicated using a downward arrow (↓).

Table 14. PIP Performance Comparison

PASSE/ DMO	PIP Name	MY 2020 Validation Rating	MY 2019 Validation Rating	MY 2020 Overall Score	MY 2019 Overall Score
ARTC	*Enrollee to Care Coordinator Ratio*	No Confidence	Low Confidence	65.1%↓	73.1%
	Immunizations for Children and Adolescents	Moderate Confidence	Low Confidence	89.1%↑	75.9%
Empower	*Care Coordination: Employee Satisfaction*	Moderate Confidence	High Confidence	81.4%↓	92.0%
	Improving Enrollee Access to Primary Care Well Visits	Low Confidence	High Confidence	70.2%↓	96.4%
Summit	*Improving Reportable Incident Notification Timeframes*	Moderate Confidence	High Confidence	84.1%↓	100%
	Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Low Confidence	High Confidence	77.8%↓	100%
Delta Dental	*Beneficiary Missed Appointments*	High Confidence	Low Confidence	100%↑	70.7%
	Department of Children and Family Services: Foster Care Children with a Preventive Dental Service	Moderate Confidence	Low Confidence	88.9%↑	74.1%
MCNA	*Annual Dental Visits*	High Confidence	High Confidence	100%	100%
	Preventive Dental Visits	High Confidence	High Confidence	95.5%↓	100%

Table 15 presents a summary of improvements from the previous measurement year's AONs (MY 2019). Any PIPs not listed had no AONs identified in the previous measurement year. Direct quotes from the PASSEs and DMOs are in italics.

Table 15. PIP Progress Update	
ARTC Nonclinical	
MY 2019 AON	**AON 1: Step 1. Review the Selected PIP Topic** ARTC met one element out of four applicable elements in this step in last year's validation. The AON stated: ARTC should explain the PIP topic, including enrollee demographic characteristics, how care coordinator to enrollee ratios impact health outcomes, and how the care coordinator to enrollee ratio affects an enrollee's care needs as part of its comprehensive analysis. ARTC should describe how it considered feedback from enrollees and providers. ARTC should explain how the PIP topic aligns with HHS and CMS priority areas.
PASSE Response	*We submitted a revised PIP to DHS which better explains the PIP topic, including enrollee demographic characteristics, how care coordinator to enrollee ratios impact health outcomes, and how the care coordinator to enrollee ratio affects an enrollee's care needs. Additionally, the revised PIP describes how we have considered feedback from enrollees and providers and how the PIP topic aligns with DHS and CMS priorities.*
Results from Validation	ARTC met two of three applicable elements in this step in Year 2. ARTC did not include a comprehensive analysis with evidence of how the Care Coordinator to enrollee ratios affect an enrollee's needs, care, and services.
MY 2019 AON	**AON 2: Step 2. Review the PIP Aim Statement** In last year's validation, ARTC met four of the six applicable elements. The AON was: ARTC should clearly specify the PIP improvement strategy. ARTC should specify the time period for the PIP. The PIP should be measured over 12 months.
PASSE Response	Per ARTC, it submitted a revised PIP to DHS and stated that future PIPs will include a timeline. However, the PIPs currently in place exceed the suggested time period.
Results from Validation	In this year's validation, ARTC met two of six applicable elements in this PIP. ARTC failed to specify the PIP population as all enrollees. ARTC did not clearly specify the PIP time period being measured. ARTC did not give one clear and concise aim statement in the form of a question. ARTC did not state a clear goal. If that goal shifts during the PIP, that should be noted in steps 7-9 as factors affecting PIPs and changes for future years. ARTC did not align the aim statement with the performance measures being tracked. In the 2020 validation, there was a suggestion to state the aim statement in a concise question form. However, the 2021 AR PIP Summary Form Instructions indicated that this was now a requirement of this element. ARTC should clearly state the PIP aim statement in a question format. For example, "Will ensuring updating and maintaining forecasting models to ensure adequate hiring, the use of a Workforce Analyst, and Care Coordinator Leadership and Compliance monitoring of caseloads ensure at least 90% compliance with Enrollee to Care Coordinator ratios over a 12-month period for the entire enrollee population?"

Table 15. PIP Progress Update	
MY 2019 AON	**AON 3: Step 5. Review the Selected PIP Variables and Performance Measures** In the previous validation, ARTC met four out of six applicable elements. The AON stated: ARTC should describe how enrollee to care coordinator ratios were an important aspect of care and how the measure will make a difference to enrollees' health status. ARTC should address accepted clinical guidelines relevant to the PIP aim statement and address the importance of enrollee to care coordinator ratios to enrollees' care.
PASSE Response	Per ARTC, it submitted a revised PIP to DHS which includes most of the requested changes. Because this is a non-clinical PIP, ARTC did not add clinical guidelines relevant to the PIP.
Results from Validation	ARTC met three out of seven applicable elements in the current validation. ARTC failed to specifically describe the process of how the variable was collected and tracked over time. Even though there were no clinical guidelines that apply to the PIP, ARTC should describe how enrollee to Care Coordinator ratios were an important aspect of care and how the measure will make a difference to enrollees' health status. ARTC should address clinical knowledge or health services research on which the performance measure may be based. ARTC should address the importance of enrollee to Care Coordinator ratios to enrollees' care.
ARTC Clinical	
MY 2019 AON	**AON 1: Step 1. State the Selected PIO Topic** ARTC met one out of four applicable elements on this step in last year's validation. The AON stated: ARTC should explain the PIP topic, including enrollee demographic characteristics, how immunization status impacts health outcomes, the prevalence of missed immunizations, and why enrollees need immunizations as part of its comprehensive analysis. ARTC should address care of special populations or high-priority services. ARTC should explain how the PIP topic aligns with HHS and CMS priority areas.
PASSE Response	*Please see the attached revised PIP, which includes a better explanation of the PIP topic, demographic characteristics, the impact on health outcomes, the prevalence of missed immunizations, and why enrollees need immunizations. Additionally, the revised PIP addresses care of special populations and how it aligns with DHS and CMS priorities.*
Results from Validation	ARTC met five out of five applicable elements in this year's validation. ARTC included a comprehensive analysis of enrollee needs, care, and services to support the selection of the PIP topic. ARTC detailed demographic characteristics, health risks, and the need for immunizations for children and adolescents. ARTC explained that the PIP topic was included in the current CMS 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. ARTC noted that the PIP topic addresses care of special populations or high-priority services such as preventive care, continuity, and coordination of care from multiple providers and over multiple episodes, and availability of care needs. The PIP aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS including National Quality Strategy to provide better care for patients and families with improved health for communities and populations, CMS priorities including better health, better care, and lower cost through improvement, and CMS initiatives including child quality improvement maternal and infant health, prevention, and patient safety.
MY 2019 AON	**AON 2: Step 2. State the Aim Statement** ARTC met one out of five applicable elements on this step in last year's validation. The AON stated: ARTC should clearly specify the PIP improvement strategy.

Table 15. PIP Progress Update	
PASSE Response	Per ARTC, it submitted a revised PIP to DHS that addressed the AON.
Results from Validation	ARTC met one out of five applicable elements in this year's validation. While ARTC detailed the time period, specific strategies, population, and goals in this step, ARTC should include the details of the aim statement in one concise question, for example, "Do targeted interventions such as EPSDT program education for enrollees and providers increase the rate of enrollees who have been continuously enrolled for 12 months and who will turn 2 or 13 in the measurement year receiving recommended immunizations to 39.1% an 38.2% respectively?"
MY 2019 AON	**AON 3: Step 6. Describe Data Collection Procedures** ARTC met six out of nine applicable elements in this step in 2019. The AON stated: ARTC should address the qualifications of staff responsible for abstracting data, the intra- and inter-rater reliability processes in place, and the guidelines developed for abstraction staff if utilizing hybrid data.
PASSE Response	Per ARTC, it submitted a revised PIP to DHS that addressed the AON.
Results from Validation	ARTC met nine out of nine applicable elements in this year's validation. ARTC included how the data collection instrument Quality Campaign Action Tool (QCAT) was used and allowed for consistent and accurate data collection. ARTC provided their policy on overread and inter-rater reliability processes. The policy also detailed education and staff requirements. ARTC noted that hybrid data was reviewed and audited by a National Committee for Quality Assurance (NCQA)-certified Auditor.
Empower Nonclinical	
MY 2019 AON	**AON 1: Step 1. Review the Selected PIP Topic** Empower met two of the three applicable elements in last year's validation. The AON stated: Empower should include results of a literature review supporting the PIP topic's relevance to enrollee needs, care, and services.
PASSE Response	*Plan of Action to Address Noncompliance: The current, ongoing nonclinical PIP (2020 – 2021) is in compliance with DHS requirements. The population of Care Coordinators surveyed is defined in the PIP program description (i.e., total number of Care Coordinators-318, Median Age of CCs-38, Average length of employment-1.5 years, #Male-25, #Female-293). Literature reviews are available linking employee satisfaction to quality performance outcomes. This can be added into the PIP program description.* ♦ *Ongoing vs. Complete: Ongoing* ♦ *Forecast Implementation/Completion Date: Q3 2021*
Results from Validation	Empower met all applicable elements in this step in this year's validation. Empower noted that the PIP population was a high-risk population with complex behavioral health and intellectual and developmental disabilities, which requires intensive care coordination services. The population served requires coordination of complex health needs and critical linkages to social services. Because of the nature of the Care Coordinator role, Empower explained the risk for job burnout was significant, resulting in staff turnover and enrollee dissatisfaction, with a potential impact on enrollee health outcomes. Improving Care Coordinator satisfaction was predicted to mitigate these negative effects.

Table 15. PIP Progress Update	
MY 2019 AON	**AON 2: Step 2. Review the Aim Statement** Empower met five of the six applicable elements in this step in Year 1. The AON stated: Empower should clearly specify the PIP population.
PASSE Response	*Plan of Action to Address Noncompliance: The current, ongoing nonclinical PIP (2020 – 2021) is in compliance with DHS requirements. The population of Care Coordinators surveyed is defined in the PIP program description (i.e., total number of Care Coordinators-318, Median Age of CCs-38, Average length of employment-1.5 years, #Male-25, #Female-293). Literature reviews are available linking employee satisfaction to quality performance outcomes. This can be added into the PIP program description.* ♦ *Ongoing vs. Complete: Ongoing* ♦ *Forecast Implementation/Completion Date: Q3 2021*
Results from Validation	Empower met three of the six applicable elements in Year 2. The PASSE did not specify the PIP population. While Empower included detail within the step, Empower should ensure the aim statement was concise and includes the performance being measured and the associated goal in one aim statement in the form of a question.
Empower Clinical	
MY 2019 AON	**AON: Step 6. Review the Data Collection Procedures** Empower met six of the seven applicable elements in this step in last year's validation. The AON stated: Empower should describe the process used to determine the estimated degree of data completeness.
PASSE Response	*Plan of Action to Address Noncompliance: The current, ongoing clinical PIP (2020 – 2021) is in compliance with DHS requirements. Empower is currently tracking well care visits via claims (for children/adolescents) and Care Coordinator documentation (for adults).* ♦ *Ongoing vs. Complete: Complete* ♦ *Implementation/Confirmed Date Complete: 12/31/2020* ♦ *How Measured: Claims and Care Coordinator documentation* ♦ *SLA/Target: ~40%*
Results from Validation	In this year's validation, Empower did not meet this element. While Empower indicated a six-week run-off for data completeness, an estimated degree of completeness based on this run-off was not included.
Delta Dental Nonclinical	
MY 2019 AON	**AON 1: Step 1. State the Selected PIP Topic** Delta Dental met three of the five applicable elements in this step. The AON stated: Delta Dental should include a comprehensive analysis that reflects enrollee needs, care, and services. Delta Dental also should address how the topic aligns with the HHS [Department of Health and Human Services] and CMS [Centers for Medicare & Medicaid Services] priority areas.

Table 15. PIP Progress Update	
DMO Response	*This PIP is being modified, with a target completion date of July 2021, to include an analysis that reflects enrollee needs, such as:* ♦ *Demographic characteristics* ♦ *Health risks* ♦ *Prevalence of specific conditions* ♦ *Need of a service by certain demographics* *Additionally, by July 2021, this PIP will be revised to reflect how the strategy aligns with the HHS and CMS priority areas by stating: "The PIP topic aligns with priority areas identified by HHS and CMS by addressing improved health outcomes and preventive service utilization due to the reduction in the number of Delta Dental Smiles members that missed appointments."*
Results from Validation	Delta Dental corrected the AON and met all applicable elements in this step. Delta Dental achieved a strength in this step because Delta Dental provided a very comprehensive analysis with multiple sources. Delta Dental stated that the PIP aligned with the Department of Health and Human Services (HHS) and CMS priority areas improved health outcomes and better oral health.
MY 2019 AON	**AON 2: Step 2. Review the Aim Statement** Delta Dental met five out of six applicable elements in this step in Year 1's validation. The AON stated: Delta Dental should include the specific PIP time period in the aim statement.
DMO Response	*This PIP has been updated to include the time period in the aim statement.*
Results from Validation	Delta Dental met all applicable elements of this step. Delta Dental stated that the time period was until December 2020.
MY 2019 AON	**AON 3: Step 5. Review the Selected PIP Variables and Performance Measures** Delta Dental met four of the seven applicable elements in this step in 2019's validation. The AON stated: Delta Dental should align the variable being measured with the numerator. Delta Dental should address the benchmark rate, along with the source of the benchmark. Delta Dental should identify a measurable and answerable goal. Delta Dental should identify how improvement in the performance measure will improve health outcomes and well-being in the study population. Delta Dental also should include additional detail on how the internally developed measure was selected and was consistent with requirements.
DMO Response	T*his PIP is being modified, with a target completion date of July 2021, to address:* ♦ *Variable measured to align with numerator* ♦ *Benchmark rate and source of benchmark* ♦ *Identify a measurable and answerable goal* ♦ *Identify how improvement in the performance measure will improve health outcomes* ♦ *Include how the internally developed measure was selected consistent with requirements*

Table 15. PIP Progress Update	
Results from Validation	Delta Dental met all applicable elements in this step in 2020's validation. Delta Dental defines the variable as the percentage of enrollees who received a dental service within 90 days of outreach. Delta Dental explained how the variable was measured quarterly by reviewing the dental services (D0100-D9999, excluding D0140) experienced by enrollees who were reported as missing a scheduled dental appointment within 90 days of their respective outreach. Delta Dental described how dental visits were an important aspect of care that will make a difference to enrollees' health or functional status. Delta Dental noted that the data to calculate the measure was readily and routinely available through the primary management information system (claims processing system). Delta Dental referenced the National Institute of Health and the American Dental Association as recommending regular dental visits. Delta Dental described how the performance measure was able to be assessed at a point in time, tracked over time, compared to benchmarks over time, and inform the selection and evaluation of quality improvement strategies. Delta Dental noted that preventive dental services were recognized by CMS as part of the 2020 Child Core Set measures but not as part of the CMS Adult Core Set Measures. Delta Dental explained that since the performance measure was for both children and adults, it was an internally developed measure. As such, Delta Dental detailed the clinical guidelines from the National Institute of Health that influence the measure, how the measure addresses an important aspect of care for enrollees, the data sources used to determine the measure, and the criteria used for the measure.
MY 2019 AON	**AON 4: Step 7. Review the Data Analysis and Interpretation of PIP Results** Delta Dental met four out of seven applicable elements in this step in Year 1. The AON stated: Delta Dental should include a discussion of the baseline and remeasurement of performance. Delta Dental also should include a discussion of the statistical significance of any differences between the baseline and repeat measurements thus far.
DMO Response	*This PIP is being modified, with a target completion date of July 2021, to include a calculated baseline along with recalculations and statistical significance.*
Results from Validation	Delta Dental met all applicable elements of this step in Year 2. Delta Dental included a discussion of baseline and remeasurement of the performance measure. Delta Dental included a discussion of statistical significance including the results of a Chi Square Test analysis and z-test results.
MY 2019 AON	**AON 5: Step 8. Assess the Improvement Strategies** Delta Dental met three of the six applicable elements in last year's validation. The AON stated: Delta Dental should describe an evidence-based improvement strategy. Delta Dental should address the cultural and linguistic appropriateness of the improvement strategy. Delta Dental also should describe the major confounding factors that could have an impact on PIP outcomes.
DMO Response	*By July 2021, this PIP will include more information on why our strategy was chosen, including where applicable evidence or literature that describes how our strategy or one similar has been effective in other areas, or data and detail on the factors that led to our electing the strategy plus why we believe it will succeed. Additionally, we will document cultural or language considerations where appropriate. Lastly, we will document and describe what we believe are the significant and/or confounding factors that may have an impact on the outcome of our strategies.*

Table 15. PIP Progress Update	
Results from Validation	Delta Dental met all applicable elements in this step and achieved a strength because the DMO included a detailed run chart outlining their PDSA activities. Delta Dental described how the Institute for Healthcare Improvement's focus on prevention as the underlying driver of lower costs and improved patient care as well as the finding of education as a fundamental social determinant of health led to the determination of the improvement strategy. While Delta Dental referenced the key-driver diagram that detailed aspects of the improvement strategy, the diagram did not describe causes or barriers to care that led to the determination of the improvement strategy. However, Delta Dental did explain how this intervention should have a long-term change effect, was system-based, and measurable on an ongoing basis. Delta Dental noted that cultural competency training was required for all Delta Dental Smiles staff and that translation services were available to anyone that requested those services in order to meet the cultural and linguistic needs of this population. Delta Dental noted that a major confounding factor could be COVID-19.
Delta Dental Clinical	
MY 2019 AON	**AON 1: Step 1. State the Selected PIP Topic** Delta Dental met two out of four applicable elements in this step in last year's validation. The AON stated: Delta Dental should explain how preventive dental care impacts overall health outcomes as part of its comprehensive analysis. Delta Dental should describe how the study topic aligns with HHS and CMS priority areas.
DMO Response	*We are well versed in how preventive dental care impacts overall health outcomes, and this is being documented in our PIP. Scheduled to be done by July 2021, this PIP is being edited to include an analysis that reflects enrollee needs, such as:* ♦ *Demographic characteristics* ♦ *Health risks* ♦ *Prevalence of specific conditions* ♦ *Need of a service by certain demographics* *Additionally, by July 2021 this PIP will be revised to reflect describe how the strategy aligns with the one or more of the following HHS and CMS priority areas by stating: "The PIP topic aligns with priority areas identified by HHS and CMS by addressing improved health outcomes and better oral health of the Foster child program by increasing the number of Foster children that have received a preventive dental service."*
Results from Validation	In this report Qsource found that Delta Dental included a comprehensive analysis of enrollee needs, care, and services. Delta Dental met all elements in this step and received a strength because it included detailed comprehensive analysis with multiple sources.
MY 2019 AON	**AON 2: Step 2. State the Aim Statement** Delta Dental met one out of five applicable elements in this step in Year 1's validation. The AON stated: Delta Dental should specify the PIP population in the aim statement.
DMO Response	*This PIP has been updated to note the foster children population in the aim statement.*

Table 15. PIP Progress Update	
Results from Validation	In 2020, Delta Dental clearly specified the PIP population as foster children aged 0-21 enrolled for at least nine continuous months. However, there was some discrepancy regarding the time period of the PIP. Delta Dental again met one out of five elements in this step. The AON states: Delta Dental should have ensured the remeasurement period covered 12 months.
MY 2019 AON	**AON 3: Step 3. Review the Identified PIP Population** Delta Dental met one out of three applicable elements on this step in the 2019 validation. The AON stated: Delta Dental should address any age specifications or enrollment requirements applied to the population.
DMO Response	*Delta Dental responded that by July 2021 this PIP will indicate the age range of foster children included in the PIP and the continuous enrollment requirement applied to the population, such as being enrolled in the plan for nine consecutive months with no breaks in coverage periods.*
Results from Validation	In this report, the reviewer found that Delta Dental defined the PIP population as the entire eligible population of all ages enrolled in DCFS care who have nine months of continuous enrollment, with no exclusions. Delta Dental met three out of three on this step.
MY 2019 AON	**AON 4: Step 5: Review the Selected PIP Variables and Performance Measures** In last year's validation, Delta Dental met five of the seven applicable elements. The AON stated: Delta Dental should include the specific performance measure description and source. The numerator for the performance measure should include how the service will be identified (e.g., applicable CDT codes). The benchmark rate should have been addressed, along with the source of the benchmark. Delta Dental should identify the specific performance goal in this step and how improvement in the performance measure will improve health outcomes and well-being in the study population.
DMO Response	*This PIP is being modified, with a target completion date of July 2021, to address:* ♦ *Specific performance measure description and source* ♦ *CDT codes used to determine numerator* ♦ *Benchmark rate and source of benchmark* ♦ *Identify the specific performance goal and how* ♦ *Identify how improvement in the performance measures will improve health outcomes*
Results from Validation	In 2020, Delta Dental corrected the AON and clearly defined the variable as Preventive Dental Visits Percentage Rate for foster children including the CDT codes used to measure the variable. Delta Dental detailed an assessment of how preventive dental services were an important aspect of care that will make a difference to enrollees' health. However, Delta Dental met six of the seven applicable elements in this review because it should have carried over the baseline timeframe from the previous PIP. Delta Dental should have recalculated the baseline rate based on the new enrollment criteria and provided detail in further steps.

Table 15. PIP Progress Update	
MY 2019 AON	**AON 5: Step 6. Review the Data Collection Procedures** Delta Dental met six of the seven applicable elements in last year's validation. The AON stated: Delta Dental should include the CMS-416 PDENT-CH [Percentage of Eligibles Who Received Preventive Dental Services – Child] technical specifications to demonstrate the systematic method of data collection.
DMO Response	*This PIP is being modified, with a target completion date of July 2021, to include the CMS-416 PDENT-CH specification to demonstrate the systematic method of data collection.*
Results from Validation	In this year's PIP, Delta Dental detailed the systematic method for collecting valid and reliable data including the technical specifications for the PDENT-CH measure and met all applicable elements.

Conclusions

ARTC

ARTC received a score of 65.1% (No Confidence) for its nonclinical PIP *Enrollee to Care Coordinator Ratio.* The PIP focused on improving access to care and quality by maintaining the appropriate monthly ratio of care coordinators to enrollees. The PIP aligned with the PASSE Agreement quality metric for Enrollee to Care Coordinator Ratio. By focusing on improving care coordination for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care, and outreach of the State's Quality Strategy. It specifically aligned with the objectives under that goal: Objective 1.1: Provide qualified and trained care coordinators, and Objective 1.2: Develop Care coordinator relationships with enrollees.

The PIP aligned with the State's Quality Strategy quality metric Care Coordinator to Client Caseload and the performance target of ≥90% of care coordinators with a caseload of ≤50 enrollees. The PIP score indicated that, if this PIP continues, ARTC should address the AONs noted by Qsource before the PIP can aid in increasing access and quality of care by maintaining the appropriate monthly ratio of care coordinators to enrollees.

ARTC's clinical PIP was *Immunizations for Children and Adolescents*. The PIP focused on increasing access to care by increasing immunizations for children and adolescents. The PIP aligned with the Healthcare Effectiveness Data and Information Set (HEDIS®) Measures *Childhood Immunization Status (CIS)* and *Immunizations for Adolescents (IMA).* By focusing on increasing immunizations for enrollees, the PIP topic aligned with Goal 2: Improve access to needed services and safety for all enrollees of the State's Quality Strategy.

ARTC received an overall score of 89.1% for this PIP resulting in a Moderate Confidence rating.

Additional details about each PIP study are provided in Appendix A.

Empower

Empower received a score of 81.4% (Moderate Confidence) for its nonclinical PIP *Care Coordination: Employee Satisfaction.* The PIP focused on increasing the quality of care by improving employee satisfaction and ultimately improving care for its enrollees. By focusing on improving care coordination, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care, and outreach of the State's Quality Strategy. It aligned specifically with the objective under that goal: Objective 1.1: Provide qualified and trained care coordinators.

Empower's clinical PIP was *Improving Enrollee Access to Primary Care Well Visits*. The PIP focused on increasing access to care. By focusing on increasing primary care well visits, the PIP topic aligned with Goal 2 of the State's Quality Strategy to improve access to needed services for enrollees.

Empower received an overall score of 70.2% for this PIP resulting in a Low Confidence rating. The PIP score indicated

that, if this PIP continues, Empower should correct the AONs noted by Qsource before the PIP can aid in increasing access to care for its enrollees.

Additional details about each PIP study are provided in Appendix A.

Summit

Summit received a score of 84.1% (Moderate Confidence) for its nonclinical PIP *Improving Reportable Incident Notification Timeframes.* The PIP focused on quality of care by improving abuse reporting. By focusing on critical incidents, the PIP topic aligned with Goal 2: Improve access to needed services and safety for all enrollees of the State's Quality Strategy. It aligned specifically with Objective 2.3 of that goal to ensure safety by monitoring compliance with incident and accident reporting requirements.

Summit's clinical PIP was *Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia*. The PIP focused on increasing the quality of care by improving adherence to medications for adults with schizophrenia or schizoaffective disorder. The PIP aligned with the CMS Adult Core Set Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) measure, and also a HEDIS measure. By focusing on improving adherence to medications for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care, and outreach of the State's Quality Strategy. It aligned specifically to Objective 1.1 of that goal to provide qualified and trained care coordinators to provide health education and coaching; coordination with healthcare providers for diagnostic, ambulatory care, and hospital services; assistance with social determinants of health; promotion of activities focused on the health of a patient and their community. It also aligned with Goal 2: Improve access to needed services and safety for all enrollees.

Summit received an overall score of 77.8% for this PIP resulting in a Low Confidence rating. The PIP score indicated that, if this PIP continues, Summit should correct the AONs noted by Qsource before the PIP can aid in improving quality of care by improving adherence to medications for adults with schizophrenia or schizoaffective disorder.

Additional details about each PIP study are provided in Appendix A.

Delta Dental

Delta Dental received a score of 100% (High Confidence) for its nonclinical PIP *Beneficiary Missed Appointments*. The PIP focused on increasing access to care and timeliness by improving utilization rates of adult and child dental services. By focusing on increasing care for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care and outreach of the State's Quality Strategy. It aligned specifically with the objectives of that goal: Objective 1.2: Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically

Necessary dental services and Objective 1.3: Shall identify targeted populations and/or service areas for outreach and education activities.

The PIP also aligned with Goal 2: Improve access to needed services and safety for all enrollees. It aligned specifically with the objectives of that goal: Objective 2.1: Improve access to appropriate dental services through network adequacy, and Objective 2.2: Improve prevention among clients.

Delta Dental's PIP score indicated that the PIP was written in accordance with instructions. A well-designed PIP can assist the DMO in achieving significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

Delta Dental's clinical PIP was *Department of Children and Family Services: Foster Care Children with a Preventive Dental Service*. The PIP focused on improving access to care by increasing the rate of preventive dental visits in the foster child population. By focusing on increasing care for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care and outreach of the State's Quality Strategy. The topic aligned specifically with the objectives under that goal: Objective 1.2: Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically Necessary dental services, and Objective 1.3: Shall identify targeted populations and/or service areas for outreach and education activities.

The PIP also aligned with Goal 2: Improve access to needed services and safety for all enrollees. It aligned specifically with the objectives of that goal: Objective 2.1: Improve access to appropriate dental services through network adequacy, and Objective 2.2: Improve prevention among clients.

Delta Dental received an overall score of 88.9% for this PIP resulting in a Moderate Confidence rating.

Additional details about each PIP study are provided in Appendix A.

MCNA

MCNA received a score of 100% (High Confidence) for its PIP *Annual Dental Visits*. The PIP focused on increasing access to care by improving the rate of annual dental visits for enrollees ages 1-20 years. By focusing on increasing care for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care and outreach of the State's Quality Strategy. The topic aligned specifically with the objectives under that goal: Objective 1.2: Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically Necessary dental services, and Objective 1.3: Shall identify targeted populations and/or service areas for outreach and education activities.

The PIP also aligned with Goal 2: Improve access to needed services and safety for all enrollees. It aligned specifically with the objectives of that goal: Objective 2.1: Improve access to

appropriate dental services through network adequacy, and Objective 2.2: Improve prevention among clients.

The PIP score indicated that the PIP was written in accordance with instructions. A well-designed PIP can assist the DMO in achieving significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

MCNA's clinical PIP was *Preventive Dental Visits*. The PIP focused on increasing access to care by improving the rate of preventive dental visits for enrollees ages 1-20 years. The PIP aligned with the CMS Child Core Set Measure, Eligibles Receiving Preventive Dental Services (PDENT-CH). By focusing on increasing care for its enrollees, the PIP topic aligned with Goal 1: Focus on person-centered, coordinated care and outreach of the State's Quality Strategy. The topic aligned specifically with the objectives under that goal: Objective 1.2: Take a proactive role in reaching out to clients to ensure that each client has the information necessary to receive Medically Necessary dental services, and Objective 1.3: Shall identify targeted populations and/or service areas for outreach and education activities.

The PIP also aligned with Goal 2: Improve access to needed services and safety for all enrollees. It aligned specifically with the objectives of that goal: Objective 2.1: Improve access to appropriate dental services through network adequacy, and Objective 2.2: Improve prevention among clients.

MCNA received an overall score of 95% for this PIP resulting in a High Confidence rating. This score indicated that the PIP was written in accordance with instructions. A well-designed PIP can assist the DMO to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

Additional details about each PIP study are provided in Appendix A.

Protocol 2: Performance Measure Validation (PMV)

Objectives

To satisfy CMS Protocols for the PASSEs and DMOs and to meet the requirements set forth in 42 CFR § 438.330(c), DHS selected a process for an objective, comparative review of performance measures related to quality-of-care outcomes. The primary aims of PMV are to evaluate the accuracy of PASSE/DMO-reported measures and to determine whether those measures were calculated according to required technical specifications, which enables DHS to monitor performance at a point in time, track performance over time, and compare performance among PASSEs and DMOs.

The PMV included validation of performance measures for the PASSEs and DMOs providing care services for enrollees. The measurement year (MY) for this validation was January 1, 2020 through December 31, 2020 (MY 2020).

Per the protocol, the PASSEs and DMOs should complete an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate information systems, processes, and data. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the PASSE's information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using National Committee for Quality Assurance (NCQA) HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit.

Qsource conducted a virtual systems review for each PASSE and DMO which included interviews with key staff involved in the production of performance measures using questions tailored to the processes for producing performance measures based on findings from the ISCAT. Primary Source Verification was done of data tracking logs that were used to monitor data transfer and ingestion across all facets of data: claims, enrollment, provider, and ancillary vendors. Qsource observed a live demonstration of the data systems and key processes required for performance measure calculation. Qsource assessed the ability to link data from multiple sources and the extent to which they have created processes to ensure the accuracy of the calculated performance measures. A data file review was conducted as well as a review of all systems contributing to the performance measure calculations including:

1. Claims and Encounter Systems
2. Enrollment Systems
3. Medical Record Data, if applicable
4. Ancillary Vendor Data
5. Provider Systems
6. Data Integration
7. Software Integration and Measure Development
8. Communicate Findings and Outstanding Items

Specific findings from the virtual systems reviews and ISCATs for each PASSE and DMO are located in the *2021 Performance Measure Validation Reports*.

Qsource's PMV team consisted of staff selected for their various skill sets, including Certified HEDIS Compliance Auditors, statistics, analysis, managed care operations, clinical expertise, performance measure reporting, information system assessments, and computer programming capabilities.

Activity 2 of the PMV Protocol (October 2019) describes the onsite visit; however, due to the COVID-19 pandemic, the State approved the migration of all onsite reviews to virtual desk validation through data requests to the PASSEs, DMOs, and DHS.

Technical Methods of Data Assessment for PASSEs

Qsource obtained the list of Care Coordination quality measures and technical specifications for the measures from the 2020 PASSE Provider Agreement with DHS as required in Activity 2 of the Protocols. Qsource requested measure numerators, denominators, rates, and source code for the selected Care Coordination measures from the PASSE. The validation team completed line-by-line code review to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any). In addition, Qsource reviewed calculated rates and compared them to target rates for the current measurement period. There was no sampling as mentioned in Activity 2 of the Protocols for the measures validated.

For the HEDIS measures, Qsource requested an attestation from the PASSEs that NCQA-certified software was used to calculate the measures, along with the name of the software vendor. Qsource reviewed calculated rates and compared them to national benchmarks for the current measurement period.

Qsource obtained appropriate PASSE-specific documentation from DHS to validate additional performance standards. Results for each measure were evaluated and compared to defined targets to assess overall compliance with each performance standard. At DHS's request and as required in Activity 1 of the Protocol, this section also includes results for these performance standards, with the exception of network adequacy time and distance requirements for access to care results, which are located in *Protocol 4: Validation of Network Adequacy*.

At the request of DHS, Qsource also performed validation analysis on the State's performance measure calculations. Qsource reviewed the documentation and calculations submitted by the State. If source code was provided, then Qsource validated the numerators, denominators, and rates. If only numerators and denominators were provided, Qsource validated the rates. Where there were instances of data from multiple timeframes (i.e., monthly and quarterly) validation was based on the same data set as the State when possible. Any gaps or discrepancies were noted in the key review findings. Variance

was recorded as the absolute difference between State results and Qsource results.

Technical Methods of Data Assessment for DMOs

Qsource obtained the list of dental quality metrics selected by DHS for validation as required in Activity 2 of the protocols. CMS-416 measure technical specifications were secured from the CMS website. Qsource requested self-reported metric numerators, denominators, rates, and source code for the selected dental quality measures from the DMO to satisfy the validation. Qsource compiled and analyzed the results following the submission. The validation team completed line-by-line code review to ensure compliance with metric technical specifications. Areas of deviation were identified to evaluate the impact on the metric and assess the degree of bias (if any). In addition, Qsource reviewed calculated rates and compared them to target rates for the current measurement period. There was no sampling as mentioned in Activity 2 of the protocols for the measures validated.

Qsource obtained appropriate DMO-specific documentation to validate additional performance standards. Annual 2020 results for each measure were evaluated and compared to defined targets to assess overall compliance with each performance standard.

For both PASSEs and DMOs, all measures reported were calculated from administrative data only and therefore medical record review (MRR), mentioned in Activity 1 of the Protocols, was not applicable. MRR was conducted under *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.

Description of Data Obtained

Table 16 lists the audited measures for PASSEs. The Care Coordination quality measures reviewed were identified by DHS. The Care Coordination measures were collected and reported quarterly by the PASSE. Care Coordination measure technical specifications were based on DHS definitions provided to the PASSEs in the 2020 PASSE Provider Agreement with DHS. DHS's Quality Strategy, Goal 1: Focus on person-centered, coordinated care, and outreach, directly correlates to these care coordination measures. DHS set out these specific quality metrics and targets in order to meet this goal as well as each objective. The measurement year (MY) for this validation was January 1, 2020 through December 31, 2020.

Table 16. PASSE Quality Measures

Care Coordinator Quality Measures	Domain of Care
Care Coordinator Caseload	Quality of Care and Access to Care
Initial Contact with Enrolled Member	Quality of Care, Access to Care, and Timeliness
Monthly Contact with Enrolled Member	Quality of Care, Access to Care, and Timeliness
Quarterly Contact with Enrolled Member	Quality of Care, Access to Care, and Timeliness

Table 16. PASSE Quality Measures	
Care Coordinator Quality Measures	**Domain of Care**
Primary Care Physician (PCP) Assignment	Quality of Care and Access to Care
Follow-Up Care	Quality of Care, Access to Care, and Timeliness

Table 17 lists the additional DHS performance standards for PASSEs. DHS's Quality Strategy, Goal 2: Improve access to needed services and safety for all enrollees and Goal 3: Continuously increase enrollee satisfaction with services, directly correlate to these additional performance measures. DHS set out these specific quality metrics and targets in order to meet these goals as well as each objective. Qsource obtained appropriate PASSE-specific documentation from DHS to validate additional performance standards. Annual 2020 results for each measure were evaluated and compared to defined targets to assess overall compliance with each performance standard.

Table 17. Additional DHS Performance Standards for PASSEs	
Measures	**Domain of Care**
Network Adequacy	
Out-of-Network Provider Payment	Quality of Care and Access to Care
Call Center	
Call Center Answer and Abandonment Rates	Quality of Care and Timeliness
Call Center Return Calls	Quality of Care, Access to Care, and Timeliness
Website	
Website and Portal Availability	Quality of Care and Access to Care
Grievances and Complaints	
Investigation and Resolution of Grievances	Quality of Care and Timeliness
Claims Processing	
Denial, Approval, and Submission of Claims: Timeliness	Timeliness
Denial, Approval, and Submission of Claims: Processing Clean Claims*	Quality of Care and Timeliness
Denial, Approval, and Submission of Claims: Electronically Submitted Claims	Quality of Care and Timeliness
Denial, Approval, and Submission of Claims: Non-Electronically Submitted Claims	Quality of Care and Timeliness
Denial, Approval, and Submission of Claims: Completeness, Logic, and Consistency	Quality of Care
Denial, Approval, and Submission of Claims: Must-Pay Items and Services†	Quality of Care
Denial, Approval, and Submission of Claims: Must-Not-Pay Items and Services**	Quality of Care
Denial, Approval, and Submission of Claims: Provider-Preventable Conditions††	Quality of Care
Encounter Data	
Completeness of Encounter Data	Quality of Care

Table 17. Additional DHS Performance Standards for PASSEs	
Accuracy of Encounter Data	Quality of Care
Reporting	
Report Submission	Quality of Care and Timeliness
Key Personnel	
Key Personnel Vacancy	Quality of Care
Provider Quality Metrics	
Accuracy and Timeliness of Provider-Submitted Data Reports	Quality of Care and Timeliness
Accuracy and Timeliness of Provider Data Reported to DHS	Quality of Care and Timeliness
Prior Authorizations and Utilization Management	
Prior Authorizations	Quality of Care and Access to Care

** "Process" means deny or approve claims and submit for payment within the required timeframes.*
† The PASSE must pay for certain items or services as set forth in more detail in the corresponding sections of the PASSE Provider Agreement.
*** The PASSE must not pay for an item or service (other than an emergency item or service, including items or services furnished in an emergency room of a hospital) as set forth in more detail in the corresponding sections of the PASSE Provider Agreement.*
†† The PASSE must require all providers to report provider-preventable conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made.

In 2020, the PASSEs were instructed by DHS to report on all HEDIS measures. The PASSEs findings included a designation of one of the following:

- R - Reportable: A reportable rate was submitted for the measure.
- NA - Not Applicable: The PASSE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
- NB - No Benefit: The PASSE did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
- NR - Not Reported: The PASSE chose not to report the measure.
- NQ - Not Required: The PASSE was not required to report the measure.
- BR - Biased Rate: The calculated rate was materially biased.

Protocol guidance indicated that the EQRO may review results from a recent comprehensive, independent assessment of the PASSE's information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using NCQA HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit. For the HEDIS measures, Qsource requested an attestation from the PASSE that NCQA-certified software was used to calculate the measures, along with the name of the software vendor. Qsource reviewed calculated rates and compared them to national benchmarks for the current measurement period. HEDIS measures were collected and reported annually. HEDIS measures definitions were based on HEDIS 2020 Technical Specifications. The full list of measures along with the findings for each measure is in Appendix B.

Qsource validated the dental quality metrics identified by DHS, which are listed and defined in **Table 18**. The dental quality metrics selected by DHS help CMS and other stakeholders assess the effectiveness of the provision of dental services to enrollees covered under the Arkansas Medicaid program. DHS's Quality Strategy, Goal 2: Improve access to needed services and safety for all enrollees, directly correlates to these quality metrics. DHS set out these specific quality metrics and targets in order to meet this goal as well as each objective. These metrics were collected and reported by DMOs annually. The measurement year for this validation was January 1, 2020 through December 31, 2020 (MY 2020).

Table 18. DMO Quality Metrics

Measures	Domain of Care
Preventive Dental Services (PDENT): 21 Years and Older	Quality of Care and Access to Care
Preventive Dental Services (PDENT): Under 21 Years	Quality of Care and Access to Care
Sealant Services for Children – with Exclusions (SEA – with Exclusions)	Quality of Care and Access to Care
Dental Emergencies	Quality of Care, Access to Care, and Timeliness

Table 19 lists the additional DHS performance standards for DMOs. DHS's Quality Strategy, Goal 1: Focus on person-centered, coordinated care, and outreach, Goal 2: Improve access to needed services and safety for all enrollees, and Goal 3: Continuously increase enrollee satisfaction with services, directly correlate to these additional performance standards. DHS set out these specific quality metrics and targets in order to meet these goals as well as each objective. Qsource obtained appropriate DMO-specific documentation from DHS to validate additional performance standards. Annual 2020 results for each measure were evaluated and compared to defined targets to assess overall compliance with each performance standard.

Table 19. Additional DHS Performance Standards for DMOs

Measures	Domain of Care
Network Adequacy	
Access to Care – Time	Access to Care and Timeliness
Out-of-Network Provider Billing	Quality of Care and Access to Care
Call Center	
Call Center Answer and Abandonment Rates	Quality of Care and Timeliness
Call Center Return Calls	Quality of Care, Access to Care, and Timeliness
Website	
Website and Portal Availability	Quality of Care and Access to Care
Grievances and Complaints	
Investigation and Resolution of Grievances	Quality of Care and Timeliness
Claims Processing	
Denial, Approval, and Submission of Claims	Quality of Care and Timeliness
Encounter Data	
Accuracy of Encounter Data	Quality of Care
Timeliness of Encounter Data	Access to Care and Timeliness

Table 19. Additional DHS Performance Standards for DMOs	
Reporting	
Report Submission	Quality of Care, Access to Care, and Timeliness
Key Persons	
Voluntary Key Person Replacement	Quality of Care
Key Person Vacancy	Quality of Care

Findings

PASSE Care Coordination Measures

Table 20 presents the validation criteria for Care Coordination Measures and **Table 21** shows the average annual results and validation rating for each Care Coordination measure standard component. A summary with all of the PMV findings is located in the Findings Summary section.

Specific findings, including HEDIS measures, are located in Appendix B.

Table 20. PASSE Care Coordination Validation Rating Criteria

Measure Name	DHS Target	High Confidence	Moderate Confidence	Low Confidence	No Confidence
Care Coordinator Caseload	≥90%	≥90%	81% to <90%	72% to <81%	<72%
Initial Contact with Enrolled Member	≥75%	≥75%	67.5% to <75%	60% to <67.5%	<60%
Monthly Contact with Enrolled Member	≥75%	≥75%	67.5% to <75%	60% to <67.5%	<60%
Quarterly Contact with Enrolled Member	≥75%	≥75%	67.5% to <75%	60% to <67.5%	<60%
Primary Care Physician (PCP) Assignment	≥80%	≥80%	72% to <80%	64% to <72%	<64%
Follow-Up Care	≥50%	≥50%	45% to <50%	40% to <45%	<40%

Table 21. MY 2020 PASSE Care Coordination Measures Annual Results and Validation Ratings

Measure Name	DHS Target	ARTC		Empower		Summit	
		Annual Results	Validation Rating*	Annual Results	Validation Rating	Annual Results	Validation Rating
Care Coordinator Caseload	≥90%	74.2%	Low Confidence	97.0%	High Confidence	98.5%	High Confidence
Initial Contact with Enrolled Member	≥75%	77.8%	High Confidence	83.4%	High Confidence	84.5%	High Confidence

Table 21. MY 2020 PASSE Care Coordination Measures Annual Results and Validation Ratings							
Measure Name	DHS Target	ARTC		Empower		Summit	
		Annual Results	Validation Rating*	Annual Results	Validation Rating	Annual Results	Validation Rating
Monthly Contact with Enrolled Member	≥75%	86.4%	High Confidence	85.9%	High Confidence	86.2%	High Confidence
Quarterly Contact with Enrolled Member	≥75%	*	*	*	*	*	*
Primary Care Physician (PCP) Assignment	≥80%	92.4%	High Confidence	87.3%	High Confidence	99.97%	High Confidence
Follow-Up Care	≥50%	80.3%	High Confidence	84.1%	High Confidence	68.7%	High Confidence

**DHS Waived Quarterly Contact measure due to the COVID-19 pandemic, thus, no results were reported.*

DMO Quality Metrics

Table 22 presents the validation criteria for DMO quality metrics and Table 23 shows the annual results and validation rating for each quality metric standard component. Qsource noted asterisks for both DMOs in the Dental Emergencies measure. Both DMOs reported they do not bill emergencies in their systems and therefore were unable to report the data to Qsource.

Table 22. DMO Quality Metrics Validation Rating Criteria					
Measure Name	DHS Target	High Confidence	Moderate Confidence	Low Confidence	No Confidence
Preventive Dental Services (PDENT): 21 Years and Older	12%	≥12%	10.8% to <12%	9.6% to <10.8%	<9.6%
Preventive Dental Services (PDENT): Under 21 Years	64%	≥64%	57.6% to <64%	51.2% to <57.6%	<51.2%
Sealant Services for Children – with Exclusions (SEA – with Exclusions)	24%	≥24%	21.6% to <24%	19.2% to <21.6%	<19.2%
Dental Emergencies	≤5.5 visits/1,000	*	*	*	*

** Data was not available to the DMO; thus, there were no rating criteria.*

Table 23. MY 2020 DMO Quality Metrics Annual Results and Validation Ratings					
Metric Name	DHS Year 3 Target	Delta Dental		MCNA	
		Annual Results	Validation Rating	Annual Results	Validation Rating
Preventive Dental Services (PDENT): 21 Years and Older	12%	9.8%	Low Confidence	9.1%	No Confidence
Preventive Dental Services (PDENT): Under 21 Years	64%	49.3%	No Confidence	47.7%	No Confidence
Sealant Services for Children – with Exclusions (SEA – with Exclusions)	24%	4.9%	No Confidence	8.9%	No Confidence
Dental Emergencies	≤5.5 visits/1,000	*	*	*	*

** Data were not available to the DMO; thus, no results were reported.*

Additional Performance Measures

Table 24 presents the validation rating criteria for additional performance measures.

Table 24. Additional DHS Performance Measure Validation Rating Criteria	
Rating	Criteria
High Confidence	Met or exceeded DHS target
Moderate Confidence	Within 10 percentage points of DHS target
Low Confidence	Within 20 percentage points of DHS target
No Confidence	Below 20 percentage points of DHS target

Table 25 presents PASSE annual results and validation ratings for each additional performance measure standard component. A summary with all of the PMV findings is located in the Findings Summary section.

Specific findings, including HEDIS measures, are located in Appendix B.

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
Network Adequacy								
Out-of-Network Provider Payment	Starting on January 1, 2020, no greater than twenty percent (20%) of the total dollars paid to the PASSE shall be used to pay for services billed by out-of-network providers.	≤20%	1.2%	High Confidence	1.4%	High Confidence	0.7%	High Confidence
Call Center								
Call Center Answer and Abandonment Rates	All calls answered within three rings or 15 seconds	≥95%	100%	High Confidence	100%	High Confidence	99.3%	High Confidence
	Number of busy signals not exceeding 5% of the total incoming calls	≤5%	0%	High Confidence	0%	High Confidence	0%	High Confidence
	The wait time in queue not longer than two minutes for incoming calls	≥95%	94.4%	Moderate Confidence	97.4%	High Confidence	99.1%	High Confidence
	Monthly abandoned call rate	≤5%	0.8%	High Confidence	1.4%	High Confidence	0.7%	High Confidence
Call Center Return Calls	All calls requiring a call back to the enrollee or provider returned within one business day of receipt	100%	*	*	100%	High Confidence	**	**
	For calls received during non-business hours, return calls to enrollees and providers made on the next business day	100%	100%	High Confidence	100%	High Confidence	**	**

**Denominator was zero.*
*** No data was reported, therefore no results are reported.*

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
Website								
Website and Portal Availability	PASSE's website online each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance	≥99%	99.8%	High Confidence	99.8%	High Confidence	99.7%	High Confidence
Grievances								
Investigation and Resolution of Grievances	Acknowledgement in writing within five business days of receipt of each grievance	100%	93.3%	Moderate Confidence	45.8%	No Confidence	96.7%	Moderate Confidence
	All grievances must be completed and resolved within 30 days of the filing date, unless an extension is granted in accordance with section 4.9.19.c.iii of the PASSE Provider Agreement.	100%	96.7%	Moderate Confidence	70.6%	No Confidence	100%	High Confidence
	The PASSE must submit a grievance log with its quarterly report.	100%	100%	High Confidence	73.9%	No Confidence	100%	High Confidence
Claims Processing								
Denial, Approval, and Submission of Claims: Timeliness	A clean claim must be submitted for payment by the provider, either by mail or electronic submission, within 365 days of the date of service, the date of discharge from an inpatient setting, or the date the provider was furnished with the correct name and address of the PASSE.	100%	99.8%	Moderate Confidence	100%	High Confidence	99.7%	Moderate Confidence
	Claims not submitted within 365 days of the above date may be denied by the PASSE. However, the PASSE must not deny a claim for timeliness if the untimely claim submission results from a provider's reasonable efforts to determine the extent of liability.	100%	84.1%	Low Confidence	100%	High Confidence	23.4%	No Confidence

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
Denial, Approval, and Submission of Claims: Processing Clean Claims	The PASSE must process 70% of all clean claims submitted within seven days.	≥70%	77.2%	High Confidence	77.1%	High Confidence	87.9%	High Confidence
	The PASSE must process 95% of all clean claims submitted within 30 days.	≥95%	98.3%	High Confidence	97.5%	High Confidence	99.4%	High Confidence
	The PASSE must process 99% of all clean claims submitted within 60 days.	≥99%	99.5%	High Confidence	99.5%	High Confidence	99.8%	High Confidence
Denial, Approval, and Submission of Claims: Electronically Submitted Claims	Within 24 hours after the beginning of the next business day after receipt of the claim, the PASSE must provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.	100%	100%	High Confidence	100%	High Confidence	81.4%	Low Confidence
	For contested or "unclean" claims, the PASSE must include in the notice a list of additional information or documents necessary to process the claim.	100%	100%	High Confidence	100%	High Confidence	100%	High Confidence
	The PASSE must pay or deny the claim within 90 calendar days after receipt, whether contested or not.	100%	99.5%	Moderate Confidence	99.9%	Moderate Confidence	99.99%	Moderate Confidence
	Failure to pay or deny the claim within 120 calendar days after receipt of the claim creates an uncontestable obligation of the PASSE to pay the claim.	100%	99.6%	Moderate Confidence	99.95%	Moderate Confidence	99.99%	Moderate Confidence
Denial, Approval, and Submission of Claims: Non-Electronically Submitted Claims	Within 24 hours after the beginning of the next business day after receipt of the claim, the PASSE must provide electronic notice of receipt of the claim. Or, within 15 calendar days after receipt of the claim, the PASSE must provide acknowledgement of receipt of the claim to the provider or designee by mail and with information on how to electronically access the status of the claim.	100%	100%	High Confidence	100%	High Confidence	18.4%	No Confidence

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
	The notification to the provider of a contested or "unclean" claim must include a list of additional information or documents necessary to process the claim.	100%	100%	High Confidence	100%	High Confidence	98.4%	Moderate Confidence
	The PASSE must pay or deny the claim within 120 calendar days after receipt, whether contested or not.	100%	99.2%	Moderate Confidence	94.2%	Moderate Confidence	99.9%	Moderate Confidence
	Failure to pay or deny the claim within 140 calendar days after receipt of the claim creates an uncontestable obligation of the PASSE to pay the claim.	100%	99.3%	Moderate Confidence	95.9%	Moderate Confidence	99.9%	Moderate Confidence
Denial, Approval, and Submission of Claims: Completeness, Logic, and Consistency	The PASSE must screen all claims for completeness, logic, and consistency prior to payment.	100%	100%	High Confidence	100%	High Confidence	100%	High Confidence
Denial, Approval, and Submission of Claims: Must-Pay Items and Services	PASSE Provider Agreement (PA) §5.4: State Plan services	100%	85.8%	Low Confidence	87.9%	Low Confidence	91.7%	Moderate Confidence
	PA §7.1.11: Crossover claims, including Medicare co-insurance and deductibles for specific services	100%	87.8%	Low Confidence	91.1%	Moderate Confidence	90.3%	Moderate Confidence
	PA §7.1.18: Full amount of the claim under the DHS fee-for-service (FFS) schedule or the negotiated contracted rate, and then seek reimbursement, for prenatal care for pregnant women, preventive pediatric services, or services covered by certain third-party liability (TPL) sources	100%	84.4%	Low Confidence	88.6%	Low Confidence	95.1%	Moderate Confidence

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
	PA §7.1.29: Mental Health and Substance Abuse Parity Requirements	100%	88.1%	Low Confidence	91.8%	Moderate Confidence	95.4%	Moderate Confidence
Denial, Approval, and Submission of Claims: Must-Not-Pay Items and Services	PA §7.1.12: (1) Home health care services provided by DHS or another organization, unless DHS provides the state with a surety bond as specified in Section 1861(o)(7) of the Act; (2) Items or services furnished by an individual or entity during a period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless DHS determines that there is good cause not to suspend payments; and (3) Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. PA §7.1.27: Organ transplant except as provided PA §7.1.28: From an excluded person or entity, at the direction of an excluded person or entity, furnished by certain persons or entities not suspended by DHS and for any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 PA §7.1.31: Payment to a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) for less than the amount of payments that would be provided if those services were furnished by a provider that is not an FQHC or RHC	0%	*	*	0.4%	Moderate Confidence	8.7%	Moderate Confidence

**Denominator was zero.*

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE

Standard Component	Component Definition	DHS Target	ARTC		Empower		Summit	
			Annual Results	Validation Rating	Annual Results	Validation Rating	Annual Results	Validation Rating
	PA § 5.8.1: Non-emergency transportation provided through the PAHP, transportation to and from an Early Intervention Day Treatment (EIDT)/Adult Developmental Day Treatment (ADDT), dental benefits in a capitated program, school-based services provided by school employees, skilled nursing facilities, human development centers, AR Choices, AR Independent Choices, abortions							
Denial, Approval, and Submission of Claims: Provider-Preventable Conditions	The PASSE cannot make payments for any provider-preventable conditions in accordance with 42 CFR § 438.3(g).	0%	*	*	*	*	*	*
	The PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions.	100%	*	*	*	*	*	*
Encounter Data								
Completeness of Encounter Data	The PASSE must submit encounters for 100% of the covered services provided by participating and non-participating providers.	100%	98.3%	Moderate Confidence	99.9%	Moderate Confidence	98.4%	Moderate Confidence
Accuracy of Encounter Data	No less than 95% of the PASSE's encounter lines submission must pass Medicaid Management Information System (MMIS) system edits, as specified by DHS.	≥95%	96.6%	High Confidence	89.2%	Moderate Confidence	73.1%	No Confidence
Reporting								
Report Submission	All required reports must be submitted in accordance with timelines established in the Agreement between the PASSE entities and DHS. The reports identified in the PASSE Agreements are listed in the Exhibits.	100%	99.4%	Moderate Confidence	100%	High Confidence	98.0%	Moderate Confidence

**Denominator was zero.*

Table 25. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: PASSE								
Standard Component	**Component Definition**	**DHS Target**	**ARTC**		**Empower**		**Summit**	
			Annual Results	**Validation Rating**	**Annual Results**	**Validation Rating**	**Annual Results**	**Validation Rating**
Key Personnel								
Key Personnel Vacancy	In the event of a key personnel vacancy, the PASSE must propose a suitable replacement to the Contract Monitor within 30 calendar days of the vacancy occurrence or from when the PASSE first knew or should have known the vacancy would be occurring.	100%	100%	High Confidence	100%	High Confidence	*	*
Prior Authorizations and Utilization Management								
Prior Authorizations	The PASSE must honor any authorizations for services issued by DHS or its contractors for newly assigned enrollees. If a provider can submit verification of an authorization issued by DHS or its contractors prior to the effective date of PASSE assignment, the PASSE must provide payment for that service at their negotiated rate.	100%	100%	High Confidence	100%	High Confidence	100%	High Confidence

**Denominator was zero.*

Provider Quality Metrics

Per DHS, each PASSE determined how the Provider Quality Metric was tracked. DHS asked the PASSEs to provide the methodology for tracking Provider Quality Metrics. Qsource combined reported information along with an attestation to ensure that these metrics were being tracked.

The following information is based on a combination of the PASSEs' responses to DHS feedback in Quarter 2, and the submissions for Quarter 3. Metrics which were planned but not currently being tracked are listed in italics.

ARTC

ARTC indicated that these metrics are tracked only for in-network providers. It is likely that the italicized items were already implemented, but they are on an annual schedule therefore no results were available yet.

- Accuracy of claims submission – This metric is tracked monthly. Please note that this appears to refer only to the accuracy of claim payments and not any direct quality of care issue.
- Timeliness of claims submission – The number of claims which are not filed in a timely manner is tracked and reported monthly.
- Provider Education and Outreach – The number of virtual site visits and provider webinars are tracked. The reporting period is not specified.
- *Appointment availability and wait times – Evaluated annually through a survey conducted by Provider Data management*
- *Provider phone call protocol – Evaluated annually through a survey conducted by Provider Data management*
- *Accessibility of PCPs – Evaluated annually through a survey conducted by Provider Data management*
- *QAPI Elements – Evaluated annually by the Quality Department and monitored by a series of committees, including Credentialing, Grievances and Appeals, Utilization Management, Performance Improvement, Provider Advocacy, Member Advisory, HEDIS Steering, and Pharmacy and Therapeutics*

The attestation received from ARTC is in **Table 26**. The attestation indicated that ARTC was tracking metrics except for the QAPI elements. As indicated above, this is something ARTC plans to track. Table 27 presents whether or not ARTC reported its tracking to DHS in each quarter of 2020.

Table 26. MY 2020 Provider Quality Metrics Attestation-ARTC

Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified	Yes	No	NA
Accuracy of claims submission	X		
Timeliness of claims submission	X		
Provider Education and Outreach	X		

Table 26. MY 2020 Provider Quality Metrics Attestation-ARTC			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Appointment Availability and Wait Times	X		
Provider Phone Call Protocol	X		
Accessibility of PCPs	X		
QAPI Elements including Credentialing, Grievances and Appeals, Utilization Management, Performance Improvement, Provider Advocacy, Member Advisory, HEDIS Steering, and Pharmacy and Therapeutics		X	

Table 27. MY 2020 Provider Quality Metrics-ARTC				
Quarter (Q)	**Numerator**	**Denominator**	**Results**	**DHS Target**
(ii) Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	0	1	0%	100%
2020 Q2	1	1	100%	100%
2020 Q3	1	1	100%	100%
2020 Q4	1	1	100%	100%

ARTC met the targets, with the exception of Quarter 1. Quarter 1 was prior to DHS and the PASSEs determining what was required for this metric.

Empower

Empower indicated these metrics were tracked only for in-network providers.

- Provider Preventable Conditions – Empower collects, tracks, and trends PPC reports quarterly.
- Incident Reporting – Empower tracks and trends quality of care incidents in addition to the quarterly reporting they are required to offer to the state. They also escalate "a great number of incidents" for further investigation and clinical review.
- QOC Issue Report – Empower tracks any quality of care issues which are reported to their Quality Department, reviewing, and investigating those cases. Empower has an internal system for ranking these issues according to severity based on a clinical and medical director review. Severe cases are then administrated by the PASSE's peer review committee. These cases are reviewed monthly, reported quarterly, and tracked and trended to identify provider patterns.

The attestation received from Empower is in Table 28. The attestation indicated that Empower was tracking the metrics. Table 29 presents whether or not Empower reported its tracking to DHS in each quarter of 2020.

Table 28. MY 2020 Provider Quality Metrics Attestation-Empower			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Provider Preventable Conditions	X		
Incident Reporting	X		
QOC Issue Report	X		

Table 29. MY 2020 Provider Quality Metrics-Empower				
Quarter (Q)	**Numerator**	**Denominator**	**Results**	**DHS Target**
(ii) Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	1	1	100%	100%
2020 Q2	1	1	100%	100%
2020 Q3	1	1	100%	100%
2020 Q4	1	1	100%	100%

Summit

Summit indicated these metrics were tracked only for in-network providers. It is likely that the italicized items were already implemented, but they were on an annual schedule therefore no results were available yet.

- Over/under utilization and coding compliance – through medical records, ensuring compliance with CMS, NCCI, and NCQA standards
- Claims and authorization metrics – Summit represents these as separate metrics, but they are closely linked. Claims metrics are days to file, percent of claims filed electronically/on paper, and disputes filed electronically/through call center/through other methods. Authorization metrics are the percentage of electronic requests vs facsimile requests.
- Member grievances – Summit tracks and trends grievance data by type and appeal data by service, both broken into categories (i.e., racial discrimination, disability discrimination, etc.).
- *HEDIS Medical Record Review – Monitoring of HEDIS standards through claims data and implementing provider education when needed.*
- *Provider Quality Performance Score Card – A scorecard tracking the provider's compliance with all 55 NCQA HEDIS measures, as well as the PASSE measures laid out in 8.2.g.iii.*

The attestation received from Summit is in Table 30. The attestation indicated that Summit was tracking the metrics. Table 31 presents whether or not Summit reported its tracking to DHS in each quarter of 2020.

Table 30. MY 2020 Provider Quality Metrics Attestation-Summit			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Over/Under Utilization & Coding Compliance	X		
Claims and Authorization Metrics	X		
Member Grievances	X		
HEDIS Medical Record Review	X		
Provider Quality Performance Score Card	X		

Table 31. MY 2020 Provider Quality Metrics-Summit				
Quarter (Q)	**Numerator**	**Denominator**	**Results**	**DHS Target**
(ii) Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	0	1	0%	100%
2020 Q2	1	1	100%	100%
2020 Q3	1	1	100%	100%
2020 Q4	1	1	100%	100%

Summit met the targets, with the exception of Quarter 1. Quarter 1 was prior to DHS and the PASSEs determining what was required for this metric.

Table 32 presents DMO annual results and validation ratings for each additional performance measure standard component. Qsource noted asterisks for both DMOs in the Access to Care – Time component. Both DMOs reported that they do not bill emergencies in their systems and therefore were unable to report the data to Qsource.

Specific findings, including HEDIS measures, are located in Appendix B.

Table 32. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: DMO

Standard Component	Component Definition	DHS Target	Delta Dental		MCNA	
			Annual Results	Validation Rating	Annual Results	Validation Rating
Network Adequacy						
Access to Care – Time	Emergency care provided within 24 hours	100%	*	*	*	*
	Urgent care, including urgent specialty care, provided within 48 hours	100%	*	*	*	*
	Therapeutic and diagnostic care provided within 14 days	100%	*	*	*	*
	Primary care dentists make referrals for specialty care based on the urgency of the enrollee's dental condition, but no later than 30 days.	100%	*	*	*	*
	Non-urgent specialty care provided within 60 days of authorization	100%	*	*	*	*
Out-of-Network Provider Billing	No greater than 20% of the total dollars billed to the DMO for outpatient services billed by out-of-network providers	≤20%	2.1%	High Confidence	0.01%	High Confidence
Call Center						
Call Center Answer and Abandonment Rates	All calls answered within three rings or 15 seconds	95%	100%	High Confidence	96.0%	High Confidence
	Number of busy signals not exceeding 5% of the total incoming calls	≤5%	0%	High Confidence	*	*
	The wait time in queue not longer than two minutes for incoming calls	95%	97.2%	High Confidence	91.4%	Moderate Confidence

** The DMO provided no data; thus, no results were reported.*

Table 32. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: DMO

Standard Component	Component Definition	DHS Target	Delta Dental		MCNA	
			Annual Results	Validation Rating	Annual Results	Validation Rating
	Monthly abandoned call rate	≤3%	0.7%	High Confidence	4.0%	No Confidence
Call Center Return Calls	All calls requiring a call back to the enrollee or provider returned within one business day of receipt	100%	100%	High Confidence	100%	High Confidence
	For calls received during non-business hours, return calls to enrollees and providers made on the next business day	100%	100%	High Confidence	100%	High Confidence
Website						
Website and Portal Availability	DMO's website, enrollee portal, and provider portal online each month, except that the DMO may take the website and portals down from 1:00 am to 5:00 am each Saturday for necessary maintenance	≥99%	96.7%	Moderate Confidence	100%	High Confidence
Grievances						
Investigation and Resolution of Grievances	Emergency or urgent clinical issues: within 24 hours of receipt or by the close of the next business day	100%	*	*	0%	No Confidence
	Non-emergency or non-urgent clinical issues: within five days of receipt	100%	*	*	100%	High Confidence
	Non-clinical issues: within 30 days of receipt	100%	100%	High Confidence	100%	High Confidence
Claims Processing						
Denial, Approval, and Submission of Claims	Clean paper claims within 30 calendar days of receipt	100%	100%	High Confidence	100%	High Confidence
	Clean electronic claims within 14 calendar days of receipt	100%	100%	High Confidence	100%	High Confidence

** The DMO provided no data; thus, no results were reported.*

Table 32. MY 2020 Additional DHS Performance Measures Annual Results and Validation Ratings: DMO						
Standard Component	**Component Definition**	**DHS Target**	**Delta Dental**		**MCNA**	
			Annual Results	**Validation Rating**	**Annual Results**	**Validation Rating**
Encounter Data						
Accuracy of Encounter Data	All encounter data must be accurate.	≥99%	90.1%**	Moderate Confidence	88.3%	Low Confidence
Timeliness of Encounter Data	All encounter data submitted in accordance with the timeframes established in the contract with DHS	100%	100%	High Confidence	83.4%	Low Confidence
Reporting						
Report Submission	All required reports must be submitted in accordance with the timeframes established in the contract. The reports are identified in the managed care provider agreements.	100%	99.5%	Moderate Confidence	100.0%	High Confidence
Key Persons						
Voluntary Key Person Replacement	In the event of a voluntary key person replacement, the DMO must propose a suitable replacement to the Contract Monitor at least 15 days prior to the intended date of change.	≥15 days	*	*	***	***
Key Person Vacancy	In the event of a key person vacancy, the DMO must propose a suitable replacement to the Contract Monitor within 15 days of the vacancy occurrence or from when the DMO first knew or should have known the vacancy would be occurring.	≤15 days	*	*	***	***

** The DMO provided no data; thus, no results were reported.*
***Exclude Quarter 1 data: As explained by Delta Dental for Quarter 1, accepted claims were defined as encounters that resulted in a paid M5 Category of Service status on the received response files.*
****Denominator was zero.*

HEDIS Measures

HEDIS measures are subject to an NCQA HEDIS Compliance Audit that must be conducted by an NCQA-certified HEDIS Compliance Auditor under the auspices of an NCQA-licensed organization. This ensures the integrity of the HEDIS collection and calculation process through an information systems capabilities assessment, followed by an evaluation of the ability to comply with HEDIS specifications. ARTC and Summit underwent this audit. While Empower did not undergo a formal HEDIS Compliance Audit™ during the measurement year, Qsource reviewed the submitted HEDIS Roadmap and ISCAT to support findings.

HEDIS 2020 assesses care across health systems, access to and satisfaction with healthcare services, and specific utilization through a total of 96 measures (Commercial, Medicare, and Medicaid) across six domains of care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Utilization and Risk-Adjusted Utilization
4. Experience of Care
5. Health Plan Descriptive Information
6. Measures Collected Using Electronic Clinical Data Systems (ECDS)

Each of the 96 measures included sub-categories based on age and other specifications. The measures presented in this summary of findings reflect data submitted by the PASSEs from the following two domains of care: Effectiveness of Care and Access/Availability of Care. Data reported by the PASSEs for Utilization and Risk-Adjusted Utilization and Measures Collected Using Electronic Clinical Data Systems (ECDS) are located in the Appendix B. The results in these domains of care do not directly relate to quality, timeliness, or access to care and are included for informational purposes. The Experience of Care and Health Plan Descriptive Information were not reported by the PASSEs.

Only measures having national benchmarks from these categories are presented in this report.

This section is intended to provide an overview of PASSE performance using appropriate and available comparison data. Qsource used these data to determine overall performance in a distribution of statistical values that represent the lowest to highest percentiles achieved. For example, the 50th percentile represents the point at which half of the reported rates are below and half of the reported rates are above that value.

Per NCQA HEDIS Measurement Year 2020 Volume 5; HEDIS Compliance Audit™: Standards, Policies and Procedures, rates are not reported if the denominator is too small (<30).

Qsource requested an attestation from each PASSE that NCQA-certified software was used to calculate the measures, along with the name of the software vendor. Qsource reviewed calculated rates and compared them to national benchmarks for the current measurement period. For this measurement year, DHS asked

each PASSE to report on all HEDIS measures. The number of reportable versus not applicable varied among the PASSEs based on their reported data.

Table 33 presents the number of measures reported by each PASSE.

Table 33. HEDIS Reporting by PASSE

PASSE	Reportable	NA*	NR**	Total number of measures reviewed
Effectiveness				
ARTC	73	43	0	116
Empower	77	39	0	116
Summit	85	31	0	116
Access/Availability of Care				
ARTC	24	6	0	30
Empower	28	0	2	30
Summit	26	4	0	30

** The PASSE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.*
*** The PASSE chose not to report the measure.*

Table 34 presents a summary of the findings for each PASSE. The full results are located in Appendix B.

Table 34. HEDIS Findings Summary by PASSE

PASSE	Number above the 75th Percentile	Number below the 25th Percentile	Number of reportable measures
Effectiveness			
ARTC	20	29	73
Empower	23	41	77
Summit	16	37	85
Access/Availability of Care			
ARTC	14	10	24
Empower	13	8	28
Summit	13	8	26

Validation of State Calculations

Qsource reviewed the State's calculations reported to Qsource for all of the Care Coordination Quality Measures and ten of the Additional Performance Measures. Per DHS, the State's calculations were based on data reported by the PASSEs and DMOs throughout the year. The percentages may be different from the PASSE and DMO reported data to Qsource due to the point in time that the information was pulled or a lack of consistency between the PASSEs/DMOs and DHS in their methodology for counting days. Qsource utilized the data the State provided to validate the calculations.

If source code was provided, then Qsource validated the numerators, denominators, and rates. If only numerators and denominators were provided, Qsource validated the rates. Where there were instances of data from multiple timeframes, i.e., monthly and quarterly, validation was based on the same

data set as the State when possible. Any gaps or discrepancies were noted in the key review findings. Variance was recorded as the absolute difference between State results and Qsource results.

There were 92 applicable data elements validated by Qsource. For ARTC, nine variances were identified between the State's calculations and those conducted by Qsource. For Empower, ten variances were identified between the State's calculations and those conducted by Qsource. For Summit, seven variances were identified between the State's calculations and those conducted by Qsource. Results from the validation of the State's PMV calculations are in Appendix B.

IS Capabilities Assessment

Table 35 presents the criteria used to assign information systems (IS) capabilities ratings.

Table 35. IS Capabilities Rating Criteria

Rating	Criteria
Fully Met	The PASSE or DMO fully met all the criteria necessary for producing accurate and reliable performance metrics with a well-developed and complete data receipt, integration, and reporting process.
Partially Met	The PASSE or DMO partially met the criteria necessary for producing accurate and reliable performance metrics.
Not Met	The PASSE or DMO did not meet the criteria necessary for producing accurate and reliable performance metrics.

Table 36 presents the findings from the IS Capabilities Assessment by plan. Specific findings from the virtual systems reviews and ISCATs for each PASSE and DMO are located in the *2021 Performance Measure Validation Reports*.

Table 36. IS Capabilities Assessment

Plan	IS Capabilities Rating
ARTC	Fully Met
Empower	Fully Met
Summit	Fully Met
Delta Dental	Fully Met
MCNA	Fully Met

Findings Summary

ARTC

ARTC prepared a well-documented ISCAT which greatly facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data made available for review, ARTC met a validation status for performance measures. ARTC has a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting.

ARTC met the targets for most of the Care Coordination Quality Measures, despite the public health emergency declaration, indicating quality and timely access to care. ARTC did not meet the targets for Care Coordinator caseload measure during June 2020 through October 2020 resulting in an average annual result

of 74.2%. However, the remaining care coordinator metrics indicated that ARTC was providing quality access to care.

The number of reportable HEDIS measures was dependent on the PASSE and its population. Therefore, different measures could be applicable to each PASSE. For the HEDIS measures reported by ARTC, Qsource looked specifically at measures that fell into two HEDIS domains of care: Effectiveness of Care and Access/Availability of Care. ARTC met or exceeded the national benchmarks for 58 (approximately 60%) of the 97 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains. ARTC exceeded the national benchmark for 14 of the 24 reportable measures in the Access/Availability of Care domain. ARTC fell below the national benchmarks for 29 of the 73 reportable measures in the Effectiveness of Care domain. The complete measure reporting is located in Appendix B.

ARTC reported that during the measurement period, it had no calls requiring a call back to the enrollee or provider.

ARTC received a rating of low confidence for not denying a claim for timeliness when the untimely claim submission resulted from a provider's reasonable efforts to determine the extent of liability. ARTC did not meet any targets for the must-pay items and services measures. ARTC reported that it had no claims for must-not-pay items. ARTC reported no provider-preventable conditions.

Empower

Empower prepared a well-documented ISCAT which greatly facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data made available for review, Empower met a validation status for performance measures. Empower has a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting.

Empower met the targets for all of the Care Coordination Quality Measures, despite the public health emergency declaration. These results indicated that Empower was providing quality, timeliness, and access to care.

The number of reportable HEDIS measures was dependent on the PASSE and its population. Therefore, different measures could be applicable to each PASSE. For the HEDIS measures reported by Empower, Qsource looked specifically at measures that fell into two HEDIS domains of care: Effectiveness of Care and Access/Availability of Care. Empower met or exceeded the national benchmarks for 56 (approximately 53%) of the 105 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains. Empower exceeded the national benchmark for 13 of the 28 reportable measures in the Access/Availability of Care domain. Empower fell below the national benchmark for 41 of the 77 reportable measures in the Effectiveness of Care domain. The complete measure reporting is located in Appendix B.

Empower achieved a high confidence rating on all call center metrics as well as website and portal availability. Empower did not meet any of the targets for the investigation and resolution of grievances for the measurement year. Empower did not meet any targets for the must-pay items and services. Empower reported no provider preventable conditions.

Summit

Summit prepared a well-documented ISCAT which greatly facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data made available for review, Summit met a validation status for performance measures. Summit has a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting.

Summit met the targets for the Care Coordination Quality Measures, despite the public health emergency declaration. These results indicated that Summit was providing quality, timeliness, and access to care.

The number of reportable HEDIS measures was dependent on the PASSE and its population. Therefore, different measures could be applicable to each PASSE. For the HEDIS measures reported by Summit, Qsource looked specifically at measures that fell into two domains of care: Effectiveness of Care and Access/Availability of Care. In the Effectiveness of Care domain, Summit met or exceeded the national benchmarks for 66 (approximately 60%) of the 111 reportable HEDIS measures. Summit exceeded the national benchmark for 13 of the 26 reportable measures in the Access/Availability of Care domain. Summit fell below the national benchmarks for 37 of the 85 reportable measures in the Effectiveness of Care domain. The complete measure reporting is located in Appendix B.

Summit failed to report data for any of the call center return calls metrics. Summit determined after the last EQR PMV review that its voicemail was not properly set up. An efficient call center and website/portal allow timely access to quality care. Per Summit, the voicemail was set up and effective June 17, 2021. Summit achieved a high confidence rating on the remaining call center metrics and the website and portal availability metric.

Summit did not meet targets for timeliness of denial, approval and submission of claims, with especially low scores for Claims not submitted within 365 days of date of service denied. For electronically and non-electronically submitted claims, Summit did not meet the targets for the electronic acknowledgement. Summit reported no provider preventable conditions. Summit did not report any key personnel vacancies.

Delta Dental

Delta Dental prepared a well-documented ISCAT, which greatly facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data made available for review, Delta Dental met a validation status for performance measures. Provider data were received, entered into the system, and no concerns were identified. Overall, there were processes and procedures in place

to ensure complete data transfer and accuracy as performance measures were produced.

Delta Dental did not meet DHS's Quality Metrics for 2020. The validation ratings of low to no confidence for Preventive Dental Services (PDENT) for both children and adults, as well as Sealant Services for Children, indicated an area of opportunity for Delta Dental to improve quality, timeliness, and access to care. Delta Dental reported that while the participating Dentists provided dental services (including referrals to specialists) in a timely manner to Delta Dental Smiles Enrollees as described in the Delta Dental Smiles Participating Provider Manual, taking into account the urgency of the medical/dental condition, emergencies were not billed through its systems. Therefore, it was unable to report results for the dental emergencies metric. Delta Dental failed to report data for investigation and resolution of grievances in non-emergency or non-urgent clinical issues within five days of receipt.

Delta Dental achieved a high or moderate confidence rating on all reported additional performance measures, including call center and website and portal availability. Delta Dental met or approximated targets for several additional performance measures, including Out-of-Network Billing, Call Center and Abandonment Rates, Call Center Return Calls, Claim Processing, and Reporting.

MCNA

MCNA prepared a well-documented ISCAT, which greatly facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data made available for review, MCNA met a validation status for performance measures. Audit procedures were in place to ensure accuracy and data completeness. Overall, enrollment increased from the prior years. Established processes were in place to ensure receipt of standardized files from DHS. Provider data were received and processed accurately with 100% review conducted. Measures were produced through a single system which contributed to accurate and valid results.

MCNA did not meet DHS's Quality Metrics for 2020. The validation ratings of no confidence for Preventive Dental Services (PDENT) for both children and adults, as well as Sealant Services for Children, indicated an area of opportunity for improving quality, timeliness, and access to care. MCNA reported its enrollees are not required to notify MCNA before seeking Emergency Care, Urgent Care, Therapeutic and Diagnostic Care, Non-urgent Specialty Care and that providers are not currently required to differentiate Emergency Care, Urgent Care, Therapeutic and Diagnostic Care, Non-urgent Specialty Care related services when submitting claims. MCNA does not have access to data related to outpatient hospital emergency dental services data. No Emergency Care, Urgent care, Therapeutic and Diagnostic Care, Primary Care, Non-urgent Specialty Care related access to care grievances were received. Therefore, MCNA was unable to report results for the

dental emergencies metric. Similarly, DHS included emergency and urgent care access in its investigation and resolution of grievances performance standards.

MCNA achieved high or moderate confidence on 11 of the 15 additional performance standards reported. MCNA exceeded targets for calls answered within three rings or 15 seconds for quarters 1 and 2. For the busy signal measure, MCNA failed to submit data, so no results were available. MCNA exceeded targets for the wait time for incoming coming calls in Quarter 2. Results were over the threshold of 3% for the abandoned call rate during the third and fourth quarters of 2020. Resulting in a no confidence rating for call center abandoned call rates. This is an area of opportunity for MCNA to improve quality, timelines, and access to care. MCNA reported only one emergency or urgent clinical issue, which did not meet the target in 2020.

MCNA received a low confidence rating for accuracy and timeliness of encounter data. MCNA met or approximated targets for several of the additional performance measures, including Out-of-Network Billing, Call Center Return Calls, Website and Portal Availability, Grievances, Claim Processing, and Reporting.

Strengths and Weaknesses

Table 37 includes strengths and Table 38 includes opportunities for improvement, or weaknesses, identified in the 2021 PMV.

Table 37. MY 2020 PMV Strengths

ARTC
♦ Receiving the majority of claims electronically provided for greater accuracy and efficiency.
♦ ARTC met the targets for most of the Care Coordination Quality Measures which indicated quality, timeliness, and access to care for enrollees.
♦ ARTC met or exceeded the national benchmarks for 58 (approximately 60%) of the 97 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains.
♦ ARTC exceeded the national benchmark for 14 of the 24 reportable measures in the HEDIS domain of care: Access/Availability of Care.
♦ ARTC met targets for the network adequacy standard, the majority of the Call Center standard measures, the website and portal availability standard which all related directly to access to care.
♦ ARTC met targets for the majority of the grievances standard measures, processing clean claims measure, the electronic acknowledgement and additional information for claims measures, the completeness, logic, and consistency of claims measure, the pharmacy encounter data measures, the reporting standard, the key personnel standard, the provider quality standard, and the prior authorizations and utilization management standard.
Empower
♦ Empower met the targets for most of the Care Coordination Quality Measures which indicated quality, timeliness, and access to care.
♦ Empower met or exceeded the national benchmarks for 56 (approximately 53%) of the 105 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains.

Table 37. MY 2020 PMV Strengths
♦ Empower exceeded the national benchmark for 13 of the 28 reportable measures in the HEDIS Access/Availability of Care domain.
♦ Empower met targets for the network adequacy standard, the Call Center standard measures, the call center return calls standard, the majority of the website and portal availability measures, processing clean claims measure, the electronic acknowledgement and additional information for claims measures, the completeness, logic, and consistency of claims measure, the reporting standard, the key personnel standard, the provider quality standard, and the prior authorizations and utilization management standard.
Summit
♦ Summit met the targets for most of the Care Coordination Quality Measures which indicated quality, timeliness, and access to care for its enrollees.
♦ Summit met or exceeded the national benchmarks for 66 (approximately 60%) of the 111 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains.
♦ Summit exceeded the national benchmark for 13 of the 26 reportable measures in the Access/Availability of Care domain.
♦ Summit met targets for the network adequacy standard, the Call Center standard measures, the website and portal availability standard, the majority of the grievances standard measures, processing clean claims measure, the completeness, logic, and consistency of claims measure, the reporting standard, the provider quality standard, and the prior authorizations and utilization management standard.
Delta Dental
♦ Robust policies and procedures were in place to ensure the validity and accuracy of data.
♦ Delta Dental met targets in all four quarters for the Out-of-Network Billing measure by a significant margin.

Table 37. MY 2020 PMV Strengths
♦ Delta Dental met targets for all Call Center Answer and Abandonment rates indicating timely access to care.
♦ Claims were processed within the required timeframes 100% of the time throughout the measurement period.
♦ Encounter data accuracy and timeliness increased compared to 2019.
MCNA
♦ Robust policies and procedures were in place to ensure the validity and accuracy of data.
♦ MCNA met the targets in all four quarters for the Out-of-Network Billing measure by a significant margin.
♦ Return call rates within the required timeframe were 100% compliant throughout the review period.
♦ Website portal availability met the targets for all four quarters of the review period indicating access to care.
♦ MCNA met the targets for the Clean Paper and Electronic Claims measure at 100% throughout measurement year 2020.

Table 38. MY 2020 PMV Weaknesses (Opportunities)
ARTC
♦ ARTC fell below national benchmarks on 39 of the 97 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains. The measures included antibiotic avoidance, cervical cancer screening, diabetes care, immunizations for adolescents, COPD management, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment.
♦ ARTC fell below the national benchmarks for 29 of the 73 reportable measures in the HEDIS Effectiveness of Care domain.

Table 38. MY 2020 PMV Weaknesses (Opportunities)
♦ ARTC did not meet targets for timeliness of denial, approval and submission of claims, timely paid or denied claims, must-pay items and services measures, institutional encounter data measures, and professional encounter data measures.
Empower
♦ Empower fell below national benchmarks on 49 of the 105 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains. The measures included antibiotic avoidance, cervical cancer screening, diabetes care, chlamydia screening, testing for pharyngitis, follow-up for emergency visits, immunizations for adolescents, COPD management, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment.
♦ Empower fell below the national benchmark for 41 of the 77 reportable measures in the HEDIS Effectiveness of Care domain.
♦ Empower did not meet targets for the investigation and resolution of grievances measures, submitting clean claims within 365 days of service, timely paid or denied electronically and non-electronically submitted claims, must-pay items and services measures, institutional encounter data measures, and professional encounter data measures.
Summit
♦ Summit fell below national benchmarks on 45 of the 111 reportable HEDIS measures across both the Effectiveness and Access/Availability of Care domains. The measures included antibiotic avoidance, follow-up care for ADHD medication prescriptions, breast cancer screening, cervical cancer screening, diabetes care, chlamydia screening, immunizations for adolescents, COPD management, statin therapy, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment.

Table 38. MY 2020 PMV Weaknesses (Opportunities)
♦ Summit fell below the national benchmarks for 37 of the 85 reportable measures in the HEDIS Effectiveness of Care domain.
♦ Summit did not meet targets for call center return calls, timeliness of denial, approval, and submission of claims, electronically and non-electronically submitted claims, must-pay items and services measures, must-not-pay items and services measures, institutional encounter data measures, professional encounter data measures, and pharmacy encounter data measures.
Delta Dental
♦ Delta Dental did not meet targets for any of the Quality Metrics.
♦ The results for each of the Quality Metrics decreased compared to 2019 results.
♦ Website and Portal Availability measure results fell slightly below targets for all four quarters.
♦ While encounter data accuracy improved from 2019, the DMO did not meet targets in all four quarters of 2020.
MCNA
♦ MCNA did not meet the targets for any of the Quality Metrics.
♦ The results for each of the Quality Metrics decreased compared to 2019 results.
♦ MCNA did not meet the targets in three of the four quarters regarding wait times, indicating an opportunity for improvement related to timely care.
♦ While MCNA improved the rate of abandoned calls compared to 2019 in the first two quarters of the measurement year, it exceeded the 2019 rate and did not meet the target in the last two quarters of 2020.
♦ Encounter accuracy and timeliness fell below target in three of the four quarters in 2020.

Improvements

Table 39 presents a summary of improvements from the previous measurement year's AONs (MY 2019). Any performance measures not listed had no AONs identified in the previous measurement year. Direct quotes from the PASSEs and DMOs are in italics.

Table 39. PMV Progress Update	
ARTC	
MY 2019 AON	Care Coordination caseload rates were below the targets for all months except one.
PASSE Response	*ARTC has made many changes to our program since the review period (2019). The first large challenge to meeting caseload metric in 2019 was the late addition of approximately 3,000 Forever Care members one month prior to the start of full risk. The PASSEs were not adequately staffed to accommodate the sudden influx of new members and had to hire, onboard, and train an additional sixty (60) Care Coordinators (CCs) to accommodate the caseload ratio requirement. The need to quickly assign members to CCs to meet the quality metrics requirements led to inefficient caseloads during the first year of the program.* *In October 2019, ARTC redesigned our strategy for assigning members to Care Coordinators. Hiring remote Care Coordinators who live in the areas of the state where our members reside allowed us to begin assigning member based on location and need. Through these changes, ARTC met or nearly met the CC Caseload metric in Q4 2019 and throughout the first half of 2020.* *The Public Health Emergency (PHE) required DHS to suspend member disenrollments from the PASSE program. As ARTC's membership began rising above typical levels, ARTC communicated to DHS the need for flexibility with the caseload metric. With the suspension of face-to-face visits, ARTC believed CCs were easily able to provide CC services to more than 50 members. In June 2020, ARTC's caseload metric began falling below 90%. After DHS issued a Corrective Action Plan (CAP) to ARTC in November 2020, they permitted a relaxed metric for all PASSEs for the remaining duration of the PHE. The relaxed metric requires at least 90% of CCs to maintain a caseload of 60 or fewer members through the remainder of the PHE. DHS denied ARTC's request to retroactively permit the relaxed metric to the entirety of the PHE in lieu of requiring ARTC to complete a CAP. Through meeting the metric from November 2020 forward as shown in the table below, ARTC's CAP was completed at the end of Quarter 1 2021.ARTC does not foresee any barriers to continuing to meet the CC Caseload metric.*
Results from Validation	ARTC did not meet the targets for Care Coordinator caseload measure during June 2020 through October 2020, which was noted in their response above. Per DHS the maximum number of enrollees changed from 50:1 to 60:1 in October 2020.
MY 2019 AON	Initial contact with enrollee rates were significantly below the targets over the entire review period.

Table 39. PMV Progress Update	
PASSE Response	*With the stringent requirements in the 2019 PASSE Agreement, there were many obstacles preventing ARTC from successfully making timely initial contact. Because the 2019 PASSE Agreement required initial contact to be made within 15 business days by an assigned Care Coordinator, ARTC had to immediately assign members to a CC upon receipt of the 834 file to make initial contact timely. The DHS 834 file contains demographic, location, and population (BH/IDD) errors and often lacks adequate contact information. Assigning members to a random CC prior to making contact with the member was an ineffective and inefficient strategy. The requirement changed in the 2020 PASSE Agreement to allow any PASSE staff member to contact the members for the initial contact metric. Upon implementation of the 2020 PASSE Agreement, ARTC adjusted our initial contact strategy and began meeting the initial contact metric in March 2020. ARTC does not foresee any barriers to continuing to meet the initial contact quality metric.*
Results from Validation	ARTC met targets for initial contact with enrollees, except for Quarter 1.
MY 2019 AON	Quarterly contact rates were well below the targets over the measurement period.
PASSE Response	*In October 2019, ARTC made an adjustment to our member assignment strategy, realigning our established members to CCs who reside in their local area and assigning newly enrolled members to CCs after initial contact had been established. A few short months after the realignment was complete, DHS suspended in-person visits for all PASSEs due to the PHE. ARTC voluntarily increased our telephonic contact with members during this time, making as frequent as weekly check-ins with members who desired additional contact. Nonetheless, ARTC believes the restructure of our CC caseload assignments will greatly improve our CCs' ability to efficiently meet face-to-face with members. Assigning CCs caseloads of members primarily all in the same area reduces the amount of time CCs spend traveling between member visits. Additionally, ARTC's Data Analytics team developed preemptive reporting to identify the members who have not yet received an in-person visit. Providing this report on a weekly basis to CCs allows them to develop their schedules accordingly to ensure their members are receiving the needed contact. Though quarterly contact was reported in Q1 2021 based on telephonic communication, ARTC met this metric at 76%. ARTC began conducting in-person visits again on April 12, 2021.*
Results from Validation	Per DHS, the Quarterly Contact Metric was waved for this reporting period due to COVID-19.
MY 2019 AON	Encounter data passing Medicaid Management Information System (MMIS) edits did not meet the targets.

Table 39. PMV Progress Update	
PASSE Response	*ARTC believes the action plan for this area of deficiency must be a collaborative effort between DHS, its agents, and the PASSEs. Encounters processing has been challenging since the inception of the PASSE program. DHS systems were not able to receive encounter data from the PASSEs until July 2019. When the PASSEs began submitting encounters in July, the DHS systems contained many issues preventing smooth encounters submission because they were set up for fee-for-service Medicaid data and were not conducive to receiving data from the PASSEs. Many edits were not compatible with PASSE data and caused unnecessary rejections. ARTC has worked closely with DHS throughout the duration of the review period to work toward appropriate system modifications, to suspend edits that could not be applied to PASSE encounters, and to modify PASSE submissions as necessary.* *In 2020, DHS began working with Gainwell to improve the process and systems. ARTC has continued meeting weekly with DHS and its agents to collaborate on needed adjustments. In June and July 2020, Gainwell reprocessed encounters that had previously incorrectly denied. DHS only recently became able to receive denied encounters for resubmission. The issues below are the currently outstanding known issues comprising the majority of rejections. When calculating ARTC's encounters passing edits without including those rejecting due to the reasons listed below, ARTC believes we would currently meet the metric.* ♦ *Supportive living change from daily to unit rate. DHS agreed for the PASSEs to use H2016 for non-per diem supportive living; however, the encounters are not being accepted. ARTC currently has 160,713 unique claims that have been denied. DHS requested a waiver from CMS that is still pending.* ♦ *Public Health Emergency – ARTC used T2020 to pay providers for checking on members during the PHE. The associated encounters are incorrectly denying. ARTC has $1.8 million incorrectly denied claims for T2020.* ♦ *Provider File discrepancy - The provider file that is sent to the PASSEs does not match what is in the Gainwell system. ARTC does not receive all information needed to allow us to successfully mimic Gainwell's logic.* *DHS, its agents, and the PASSEs continue to meet on a weekly basis, striving toward system compatibility that creates a path for the PASSEs to meet the encounters target.*
Results from Validation	ARTC fell below the targets for encounters passing MMIS system edits for institutional and professional encounter data, with the exception of professional encounters in Quarter 2. ARTC met target for pharmacy encounters. In 2019, Qsource reported on all encounters. In this report Qsource has further broken down those encounters to review Institutional, Professional, and Pharmacy encounters.
MY 2019 AON	None of the provider quality metrics met targets during the review period.
PASSE Response	*In the 2019 PASSE Agreement, the report Exhibit did not include the quarterly submission of Provider Quality Metrics. Though the 2019 PASSE Agreement 8.2.3 (h) did include this requirement, DHS instructed ARTC to only submit reports in accordance with the Exhibit. In Q2 2020, DHS identified their error and requested the Provider Quality Metrics report. ARTC has submitted this report quarterly as directed. ARTC considers this remediated.*

Table 39. PMV Progress Update	
Results from Validation	Per DHS, the Provider Quality Metric was not clear to the PASSEs during Qsource's 2019 review. DHS asked the PASSEs to provide the methodology for how they were tracking Provider Quality Metrics. Each plan submitted its individual metrics that it was utilizing to track Provider Quality. Qsource combined each plan's reported information along with an attestation to ensure that these metrics were being tracked.
Empower	
MY 2019 AON	Care Coordination caseload rates were below the targets for seven of nine months.
PASSE Response	*Empower reported that their plan of action to addresses the deficiency was the creation of a CM Dashboard for daily monitoring of CC Quality Metrics. They reported that this was completed on January 1, 2020. The logic for measuring was created using the PASSE templates and guidance for Quality Metrics. The target was Care Coordination Quality Metrics at 90% for caseloads, 75% for initial contacts, and 75% monthly contacts. Empower sited the Care Coordination Training Manual, CCM 122 Care Coordination, and the CM Program Description. The dashboard will be monitored daily.*
Results from Validation	Empower met the targets for the Care Coordinator caseload measure during 2020.
MY 2019 AON	Quarterly contact rates were below the target over the review period.
PASSE Response	*Empower reported that their plan of action to addresses the deficiency was the creation of a CM Dashboard for daily monitoring of CC Quality Metrics. They reported that this was completed on January 1, 2020. The logic for measuring was created using the PASSE templates and guidance for Quality Metrics. The target was Care Coordination Quality Metrics at 75% for quarterly contacts, 80% assigned PCPs, and 50% for follow up care for members discharging from the hospital, ER, and/or acute psychiatric facility. Empower sited the Care Coordination Training Manual, CCM 122 Care Coordination, and the CM Program Description. The dashboard will be monitored daily.*
Results from Validation	Per DHS, the Quarterly Contact Metric was waved for this reporting period due to COVID-19.
MY 2019 AON	The State asked Empower to address all HEDIS Measures.
PASSE Response	*Empower has now implemented Optum HEDIS measures for both PH and BH metrics. This will allow us to identify and address improvement opportunities. This is forecasted to be complete by 4/29/21. This is measured using the Optum HEDIS tool.*

Table 39. PMV Progress Update	
Results from Validation	Empower met or exceeded the national benchmarks for 56 (approximately 53%) of the 105 reportable HEDIS measures, 13 measures of which fell into the HEDIS Access/Availability of Care domain. Empower fell below national benchmarks on 49 of the 105 applicable HEDIS measures including 41 measures in the HEDIS Effectiveness of Care domain. Comparison from 2019 to 2020 is difficult because Empower reported multiple measures for this report and national benchmarks were used unlike DHS provided targets in 2019 reporting.
MY 2019 AON	The State asked Empower to address call center answer and abandonment rates and call center return calls.
PASSE Response	*Additional staffing level and training for call volume efficiency was completed in the first quarter of 2020. While mitigation steps are complete, monitoring and continued training are ongoing. This was implemented in April 2020. Progress is monitored by call center metrics, weekly work groups, monthly reports, and JOC (monthly).*
Results from Validation	Empower met the targets for the entire year for the calls answered and busy signals measures. Empower met the targets for call wait times during the measurement year. For the monthly abandoned call measure, Empower met the targets for the entire year.
MY 2019 AON	Rates for completion and resolution of grievances within 30 days were below the targets.
PASSE Response	*The Quality Team will ensure all initial acknowledgements and resolutions are provided in writing within the set timeframes in 2021. The forecasted completion date is the first quarter in 2021. This will be measured using a daily grievance tracker and quarterly reports. The target is 100%.*
Results from Validation	Empower did not meet any of the targets for the investigation and resolution of grievances for the measurement year.
MY 2019 AON	The contested claims measure rates were significantly below the targets.
PASSE Response	*Regarding the Claims Processing/Accuracy Corrective Action Plan (CAP); Beacon is working with Evolent to address corrective actions and mitigation strategies. Evolent is focused on resolution strategies including steps to improve auto adjudication, configuration, and system enhancements. Empower's delegation oversight includes multiple status calls, including weekly workgroup discussions/assessments; bi-weekly joint calls including Empower, Beacon, and Evolent leadership; and monthly Joint Operating Committee meetings. Although specific initiative are tracked, these efforts, in and of themselves, do not culminate in a completion date, but reflect an ongoing improvement initiative. This will be measured by our Evolent vendor partner monthly in JOC performance reports. The target is 70% clean claims processed within 7 days, 95% of clean claims processed within 30 days, and 99% clean claims processed within 60 days. Empower lists JOC slide decks as supporting documentation. This will be monitored monthly.*

Table 39. PMV Progress Update	
Results from Validation	Empower met target for both electronically and non-electronically submitted "unclean" claims for the measurement year.
MY 2019 AON	None of the must-pay services met the targets.
PASSE Response	*Regarding the Claims Processing/Accuracy Corrective Action Plan (CAP); Beacon is working with Evolent to address corrective actions and mitigation strategies. Evolent is focused on resolution strategies including steps to improve auto adjudication, configuration, and system enhancements. Empower's delegation oversight includes multiple status calls, including weekly workgroup discussions/assessments; bi-weekly joint calls including Empower, Beacon, and Evolent leadership; and monthly Joint Operating Committee meetings. Although specific initiative are tracked, these efforts, in and of themselves, do not culminate in a completion date, but reflect an ongoing improvement initiative. This will be measured by our Evolent vendor partner monthly in JOC performance reports. The target is 70% clean claims processed within 7 days, 95% of clean claims processed within 30 days, and 99% clean claims processed within 60 days. Empower lists JOC slide decks as supporting documentation. This will be monitored using our Evolent vendor partner's weekly medical encounter dashboard and monthly JOC reports.*
Results from Validation	The response from Empower includes a target for claims measures. These targets do not appear to address this deficiency. Empower did not meet any targets for the Must-Pay Items and Services measures in 2020. Empower program was implemented in March of 2019 and therefore there were no results reported for January through March of that year.
MY 2019 AON	Encounter metrics did not meet the targets.
PASSE Response	*Regarding the Encounters Corrective Action Plan (CAP); Beacon is working with Evolent to address corrective actions and mitigation strategies. Evolent is focused on resolution strategies including remediation steps to improve encounters submissions. In addition, Empower will continue coordination with State on MECM projects/initiatives to improve system edit logic applied to PASSE data. Empower oversight includes multiple status calls, including weekly workgroup discussions/assessments; bi-weekly joint calls including Empower, Beacon, and Evolent leadership; and monthly Joint Operating Committee meetings. Although specific initiative are tracked, these efforts, in and of themselves, do not culminate in a completion date, but reflect an ongoing improvement initiative. In addition, Empower is currently working with DHS to implement new encounter logic at the State level to improve matching of provider master file data which should improve encounter record acceptance. State implementation date is TBD. We will coordinate with DHS to determine more specifics for this area of deficiency to ensure expectations going forward. This will be measured using our Evolent vendor partner monthly performance reports. This will be monitored using our Evolent vendor partner weekly medical encounter dashboard and monthly JOC performance reports.*
Results from Validation	In 2019, Empower did not report data for this measure. In 2020, Empower failed to meet target for institutional and professional encounters. Empower met the targets for pharmacy encounter data submission measures in quarters 2 and 3. Empower met the targets for pharmacy encounter data passing MMIS system edits.

Table 39. PMV Progress Update	
MY 2019 AON	Required report submissions did not meet the targets in quarters 2 or 4.
PASSE Response	*A detailed internal review was conducted of all 2020 DHS responses regarding Empower's report submissions. Elements were categorized as Informational, Clarification, Timeliness, Incomplete, and Correction with 24%, 33%, 2%, 19% and 21% respective distribution. A calendar year report tracking system and dedicated SME manages the report submissions to DHS. The review indicated that the attestation process could have precluded 31% of the DHS responses within incomplete or corrections. This information was shared within the SME team with a specific notation of importance regarding the attestation process. Empower continues to track and review DHS responses and notes mitigation steps when needed. This will be an ongoing review process with no noted completion date. This is measured using internal tracking and assessment of DHS responses regarding report submission.*
Results from Validation	Empower met the targets for the report submission measure in all four quarters.
MY 2019 AON	Honoring prior authorizations for services for newly assigned enrollees was well below the targets.
PASSE Response	*Empower noted that a Transition of Care policy is in draft. The forecasted completion date is 6/30/21. This will be measured using Authorizations identified via TOC policy. There are no specific targets outside of policy development. The policy acts as the supporting documentation. This is monitored using regular updates from admin and clinical staff in response to transition files.*
Results from Validation	Empower met target of 100% for all four quarters in 2020 compared to 5.5% in 2019.
Summit	
MY 2019 AON	Must-pay items services rates for all categories were well below the targets for all three quarters.
PASSE Response	*Summit has implemented a governance committee monitoring state related SLAs and internal operational excellence metrics in order to improve underperforming metrics. Additionally, Summit has implemented a suite of enhancements designed to automate manual processes (e.g. coordination) and reduce manual processing rates on complex claims.* *The governance committee was implemented Q1 2020.*
Results from Validation	Summit did not meet any targets for the Must-Pay Items and Services measures in 2020.

Table 39. PMV Progress Update

<table>
<tr><td>MY 2019 AON</td><td>Encounter line submissions passing MMIS system edits did not meet the targets for any quarter.</td></tr>
<tr><td>PASSE Response</td><td>The State is meeting with all the PASSES on a weekly basis to partner on improvements and align on a remediation strategy for the historical encounters:
<table>
<tr><th>Denial Reason / Denial Code</th><th>Action</th><th># of denials</th><th>% of denials</th></tr>
<tr><td>Missing Rendering Provider (1007)</td><td>This issue was mostly due to outpatient behavioral health clinics that were not billing the Rendering provider. These clinics have been educated to bill correctly and denials have dropped significantly in 2021. State will provide guidance on how to correct these historical denials.</td><td>60,000</td><td>48%</td></tr>
<tr><td>Rendering Provider Not Eligible/Rendering Provider Terminated (1002, 1047)</td><td>Partnering with State to validate NPI rules and educate Providers to reactivate registered credentials with State. State will provide guidance on how to correct these historical denials.</td><td>27,000</td><td>22%</td></tr>
<tr><td>Billing Provider Not Eligible for Date of Service (1048)</td><td>Partnering with State to enhance provider master file for date sensitive NPIs and to enhance our MCE front end edits on provider claims. State will provide guidance on how to correct these historical denials.</td><td>4,000</td><td>3%</td></tr>
<tr><td>Billing Provider Multiple Location (1945)</td><td>Partnering with State to enhance provider master file and apply edit hierarchy. State will provide guidance on how to correct these historical denials.</td><td>3,000</td><td>2%</td></tr>
<tr><td>Edits have moved to Paid Status (4143, 1012)</td><td>State updated the denial list and moved from Deny to Paid status</td><td>4,000</td><td>3%</td></tr>
</table></td></tr>
<tr><td>Results from Validation</td><td>In 2019, Qsource reported on all encounters. In this report, Qsource has further broken down those encounters to review Institutional, Professional, and Pharmacy encounters. Summit did not meet the targets for encounter line submissions passing MMIS edits, except for those in the pharmacy category.</td></tr>
<tr><td>MY 2019 AON</td><td>None of the provider quality metrics met the targets during the review period.</td></tr>
<tr><td>PASSE Response</td><td>After reviewing the EQR technical report and the data submitted for this request; we've determined we misunderstood the ask and inadvertently provided data for providers who use EFT and providers who submitted electronic claims. This data did not represent the measures and requirements for PA 8.2.3 (h) (ii) and (iii). Summit would like to request a meeting with DHS to get clarity on these requirements.</td></tr>
<tr><td>Results from Validation</td><td>Per DHS, the Provider Quality Metric was not clear to the PASSEs during Qsource's 2019 review. DHS asked the plans to provide their methodology for how they were tracking Provider Quality Metrics. Each plan submitted their individual metrics that they were utilizing to track Provider Quality. Qsource combined each plan's reported information along with an attestation that these metrics were being tracked.</td></tr>
<tr><td>MY 2019 AON</td><td>Summit did not submit data for key personnel information or for prior authorization and utilization management requirements.</td></tr>
</table>

Table 39. PMV Progress Update	
PASSE Response	*Summit received the key personnel and PA request from the state on 11/4/2020 (Additional Performance Measures Data Request) with a due date of 12/3/2020. The completed document was submitted to MOVEit on 12/2/2020, with an email to Lindsay Collins noting the submission.*
Results from Validation	With the exception of Quarter 4 of the prior authorizations and utilization management measure, Summit reported denominators of zero for the key personnel measure and the measure prior authorizations and utilization management measure; thus, no results were reported. Summit met target in Quarter 4.
MY 2019 AON	Summit reported no calls received during or outside business hours that required a call back.
PASSE Response	*Summit has determined voicemail was not properly set up. We expect voicemail to be released on 6/17/2021 provided there are no delays in development or testing. Intake process completed 4/29/2021 Scrum team and product owner refining the story on 5/11/2021 Release on 06/17/2021.*
Results from Validation	No data was reported for 2020.
Delta Dental	
MY 2019 AON	Delta Dental did not meet the target for the Sealant Services for Children – with Exclusions measure with a result of 7.9%. In 2019, the target established by DHS was 20%.
DMO Response	*By August of 2021 our Outreach and Education team will modify our 2021 – 2022 Outreach and Education plan to provide an increased emphasis on continuous education efforts highlighting the importance of dental sealants to positive long-term oral health outcomes. Additionally, Delta Dental will work with DHS to evaluate our calculation methodology to ensure alignment in how benchmark rates are calculated across all plans.*
Results from Validation	There appears to be a possibility the metric reported for the review period is understated. The results for this measure in 2020 showed that the rate of Sealant Services decreased to 4.9% while the target increased to 24%.
MY 2019 AON	In 2019, the Website Portal Availability measure results fell slightly below target (≥99%) for all four quarters of the review period, and there was a downward trend from Quarter 2 to Quarter 4.
DMO Response	*The primary issue identified with portal availability is the schedule of regular maintenance. By July 2021, we will work with all parties who support our websites to ensure a consistent understanding and enforcement of allowable downtimes.*
Results from Validation	In 2020, Qsource found that Delta Dental again fell slightly below target in all four quarters. However, there was an increase compared to 2019 in Quarter 3 and Quarter 4 of 2020.

Table 39. PMV Progress Update	
MY 2019 AON	Encounter data accuracy fell below target (99%) for all four quarters. Timeliness of encounter data submissions was below target in quarters 1 and 2 but met target (100%) in quarters 3 and 4.
DMO Response	*As noted in extensive communications with DHS, Delta Dental and DHS's vendors continue to partner to improve encounter data accuracy. Recent reporting results indicate a significant improvement in these metrics. System automation has been put in place to ensure timeliness requirements are met going forward, as reflected in the final two (2) quarters of the review period.*
Results from Validation	This report found that the DMO increased both accuracy and timeliness compared to 2019 but failed to meet targets for accuracy in all four quarters. The DMO met target for timeliness in all four quarters of 2020.
MY 2019 AON	One key person vacancy occurred in February, for which suitable replacement notice was not provided within the required timeframe.
DMO Response	*As noted in our review with Qsource, this issue was a single and isolated incident where we failed to attach the resume of a new employee in our communication to DHS. This was self-identified and reported in our regular performance measure monitoring. We have implemented a secondary review of all Key Person Replacements to ensure requirements are met going forward.*
Results from Validation	In 2020, there were no key person vacancies reported.
MCNA	
MY 2019 AON	The target established by DHS for Preventive Dental Services for children was 60.6%. MCNA did not meet the target with a result of 57.1%. The DHS target for Sealant Services was 20% and MCNA had a rate of 13.8%.
DMO Response	*MCNA has implemented evidence-based improvement strategies to increase preventive services and dental sealants amongst our child population in order to meet our target rates. MCNA's improvement activities such as care gap alerts, preventive text messaging, and Practice Site Performance Summary (PSPS) reports have been ongoing despite the member barrier of access to preventive services that was encountered in 2020 due to COVID-19. In June, MCNA will be implementing a targeted member campaign inclusive of postcard mailings and outbound calls to members who are overdue for a preventive checkup and eligible for sealants. Members will be reassured the dental office is a "safe" place as our providers are following all safety protocols mandated by the CDC and encourage them to schedule an appointment.*
Results from Validation	In 2020, DHS increased the target for Preventive Dental Services for children to 64%. However, MCNA failed to meet that target at 47.7%, which was a decrease from its result in 2019. In similar fashion, while the target increased for Sealant Services to 24% in 2020, the rate decreased to 8.9%.
MY 2019 AON	MCNA did not meet the targets for calls placed to the call center answered timely in any of the four quarters in 2019.

Table 39. PMV Progress Update	
DMO Response	*During an internal review of the EQRO report, it was discovered that MCNA had been inadvertently miscalculating our call center metrics related to answering calls. With the correctly calculated measures, we believe that MCNA met call center metrics, exceeding 95% in all quarters. The call abandonment metric will be immediately addressed by adding staff to the Arkansas member hotline team and increasing the Arkansas priority for agents trained in multiple plans to address higher than normal call volumes that are encountered.*
Results from Validation	In the first two quarters of 2020, the timeliness of answered calls improved and met the target. However, while the last two quarters saw an improvement over 2019, the rate of answered calls within three rings or 15 seconds fell slightly below the target.

Conclusions

ARTC

Overall, the IS capabilities assessment found that ARTC fully met requirements indicating its systems have the capability to provide quality and timely care. Based on ARTC's high confidence rating for four of the five Care Coordinator performance measures, Qsource determined that ARTC aligned with the goals and objectives of DHS's Quality Strategy related to care coordination; specifically, all objectives associated with Goal 1: Focus on person-centered, coordinated care, and outreach. A high confidence rating in call center metrics, website and portal availability, and investigation and resolution of grievances indicated that ARTC had strategies in place to align with DHS's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services. Overall, ARTC achieved a validation rating of high or moderate confidence for 28 of the 34 applicable additional performance measures from DHS. These results indicated an overall moderately high confidence in ARTC's ability to provide quality care, timely care, and access to care for its enrollees.

Empower

Overall, the IS capabilities assessment found that Empower fully met requirements indicating its systems have the capability to provide quality and timely care. Based on Empower's high confidence rating for all of the Care Coordinator performance measures, Qsource determined that Empower aligned with the goals and objectives of DHS's Quality Strategy related to care coordination; specifically, all objectives associated with Goal 1: Focus on person-centered, coordinated care, and outreach. Empower's high confidence rating in call center metrics and website and portal availability indicated that Empower had strategies in place to align with DHS's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services. Overall, Empower achieved a validation rating of high or moderate confidence for 31 of the 36 applicable additional performance measures from DHS. These results indicated an overall moderately high confidence in Empower's ability to provide quality care, timely care, and access to care for its enrollees.

Summit

Overall, the IS capabilities assessment found that Summit fully met requirements indicating its systems have the capability to provide quality and timely care. Based on Summit's high confidence rating for all of the Care Coordinator performance measures, Qsource determined that Summit aligned with the goals and objectives of DHS's Quality Strategy related to care coordination; specifically, all objectives associated with Goal 1: Focus on person-centered, coordinated care, and outreach. Summit's high confidence rating for website and portal availability and investigation and resolution of grievance indicated that Summit had strategies in place to align with DHS's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services. Overall, Summit achieved a validation rating of high

or moderate confidence for 28 of the 33 applicable additional performance measures from DHS. These results indicated an overall moderately high confidence in Summit's ability to provide quality care, timely care, and access to care for its enrollees.

Delta Dental

Overall, the IS capabilities assessment found that Delta Dental fully met requirements indicating its systems have the capability to provide quality and timely care. Based on Delta Dental's low to no confidence rating for Preventive Dental Services (PDENT) for both children and adults, as well as Sealant Services for Children quality metrics, Qsource determined that Delta Dental should focus on preventive care for its enrollees to more closely align with the goals and objectives of DHS's Quality Strategy related to access to care; specifically DHS's Goal 1: Focus on person-centered, coordinated care, and outreach and Goal 2: Improve access to needed services and safety for all enrollees. Delta Dental achieved a validation rating of high or moderate confidence for all of the reported additional performance measures from DHS. These results indicated an overall moderately high confidence in Delta Dental's ability to provide quality care, timely care, and access to care for its enrollees.

MCNA

Overall, the IS capabilities assessment found that MCNA fully met requirements indicating its systems have the capability to provide quality and timely care. Based on MCNA's low to no confidence rating for Preventive Dental Services (PDENT) for both children and adults, as well as Sealant Services for Children quality metrics, Qsource determined that MCNA should focus on preventive care for its enrollees to more closely align with the goals and objectives of DHS's Quality Strategy related to access to care; specifically DHS's Goal 1: Focus on person-centered, coordinated care, and outreach and Goal 2: Improve access to needed services and safety for all enrollees. MCNA achieved a validation rating of high or moderate confidence for all of the reported additional performance measures from DHS. These results indicated an overall moderately high confidence in MCNA's ability to provide quality care, timely care, and access to care for its enrollees.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

Overall, DHS should work with the PASSEs to determine specific Provider Quality Metrics. DHS should work towards consistency between monthly and quarterly data for validation as well as consistency in methodology of counting days.

ARTC

ARTC should continue to work with DHS to ensure encounter data passing MMIS edits improves. ARTC should improve timeliness of denial, approval, and submission of claims. ARTC should ascertain the barriers to meeting targets for must pay items and services to ensure access to care for its enrollees as it received a low confidence rating for each of the subcategories of

that performance standard. ARTC should focus on the HEDIS measures that fell below the national benchmark including antibiotic avoidance, cervical cancer screening, diabetes care, immunizations for adolescents, COPD management, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment. Focusing on the measures in these domains of care will aid into ensuring quality, timeliness, and access to care for all enrollees.

Empower

Empower should work to reduce the amount of paper claims received to improve efficiency and accuracy of data and reduce administrative burden. Following Qsource's findings in measurement year 2019, Empower reported that it would implement a tracking system for the investigation and resolution of grievances. Empower should ensure that this system is in place and functioning as intended to aid in improving quality and timely care to its enrollees. Empower should determine why some encounter types are meeting targets and others are not and apply best practices to ensure quality and timeliness of care. Empower should focus on the HEDIS measures that fell below the national benchmark including antibiotic avoidance, cervical cancer screening, diabetes care, chlamydia screening, testing for pharyngitis, follow-up for emergency visits, immunizations for adolescents, COPD management, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment. Focusing on the measures in these domains of care will aid in ensuring quality, timeliness, and access to care for all enrollees. Empower should ascertain the barriers to meeting targets for must-pay items to ensure access to care.

Summit

Summit should continue to work with DHS to improve encounter data passing MMIS edits. Summit should focus on the HEDIS measures that fell below the national benchmark including antibiotic avoidance, follow-up care for ADHD medication prescriptions, breast cancer screening, cervical cancer screening, diabetes care, chlamydia screening, immunizations for adolescents, COPD management, statin therapy, weight/nutrition counseling, drug and alcohol treatment initiation, timely pre- and postnatal care, and opioid misuse risk assessment. Focusing on the measures in these domains of care will aid in ensuring quality, timeliness, and access to care for all enrollees. Summit should ascertain the barriers to meeting targets for must-pay and must-not-pay items. Summit should ensure that the voicemail scheduled to be in place in June 2021, is in place and functioning appropriately to address call center metrics and quality of care. Summit should evaluate its systems and processes to determine why claims were not being submitted and acknowledged timely. Summit should review processes and workflows to determine why encounter data did not meet targets.

Delta Dental

Delta Dental should work to reduce the volume of paper claims. It should track the impact of the COVID-19 pandemic on access

to care. Delta Dental should increase outreach regarding sealant services and preventive care to ensure quality of care. Delta Dental shouldreview processes and workflows to resolve issues with encounter data submission accuracy. Delta Dental should ensure access to care by continuing to improve website and portal availability. DHS should review the objectives and the metrics associated with emergency care if the DMOs were unable to track this data.

MCNA

MCNA should track the impact of the COVID-19 pandemic on access to care. MCNA should evaluate past successes in call center and abandonment rates to ensure continued access to timely care and apply those best practices. MCNA should determine the cause of a decrease in encounter accuracy and timeliness. MCNA should continue to focus on improving quality and access to care by increasing sealant services and preventive care. DHS should review the objectives and the metrics associated with emergency care if the DMOs were unable to track this data.

Protocol 3: Compliance Assessment (CA)

Objectives

Qsource conducted the Compliance Assessment (CA) pursuant to the requirements in (1) 42 CFR § 438 Subparts D and F, and 42 CFR § 438.330 Subparts D and E, as incorporated by 42 CFR § 457 Subpart L; (2) CMS's *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* (October 2019); and (3) the State of Arkansas Technical and General Services Contract between DHS and the DMOs and the agreement between the PASSEs and DHS. The survey team consisted of staff with expertise in quality improvement.

As required by 42 CFR § 438.358, one of the mandatory EQR activities is a review within the previous three-year period to determine each PASSE's and DMO's compliance with federal and state EQR regulations, as noted in **Table 40**. Qsource reviewed all CA standards in 2020 and those scores are located in Appendix C. The current three-year review cycle is 2021 – 2023.

Table 40. Compliance Assessment Standards Review Schedule

Standard	CFR Citation	Domain of Care
2021		
Coverage and Authorization of Services	42 CFR § 438.210	Access to and Quality of Care
Grievance and Appeals System	42 CFR § 438.228	Quality and Timeliness of Care
Provider Selection (Credentialing/Recredentialing)	42 CFR § 438.214	Access to Care
Subcontractual Relationships and Delegation	42 CFR § 438.230	Quality of Care
2022		
Availability of Services	42 CFR § 438.206	Access to Care
Confidentiality	42 CFR § 438.224	Quality of Care
Health Information Systems	42 CFR § 438.242	Quality of Care
Quality Assessment and Performance Improvement (QAPI)	42 CFR § 438.330	Quality of Care
2023		
Assurances of Adequate Capacity and Services	42 CFR § 438.207	Access to Care
Coordination and Continuity of Care	42 CFR § 438.208	Quality of Care
Practice Guidelines	42 CFR § 438.236	Quality of Care

Also included in the 2021 CA were reviews of random samples of the files for calendar year 2021. The file reviews consisted of complaints, grievances, appeals, service denial files, and credentialing/ recredentialing.

In addition, the CA reports included results from the National Correct Coding Initiative (NCCI) coding evaluation of each PASSE's medical data system, per DHS request.

The overall results for the compliance assessment are included for each PASSE and DMO in the Findings section, where discussion of results from the CA is also provided. More detailed results from the CA are included in Appendix C.

Technical Methods for Data Collection and Analysis

The CA was conducted virtually using online meeting software tools guided by CMS's EQR Protocol 3 (October 2019). The CA was conducted in three phases: pre-virtual review, virtual review, and post-virtual review.

Qsource developed evidence-based oversight tools in consultation with DHS and by referencing the PASSE Agreement, the PASSE Provider Manual, the DMOs' State of Arkansas Technical and General Services Contract, and the requirements included in 42 CFR § 438. Qsource provided a Compliance Assessment Process Overview document, including an agenda for the virtual review, as well as the standard review tools, to explain the process. Throughout the CA process, Qsource worked closely with DHS and the PASSEs and DMOs to ensure a supportive and coordinated process. In addition, Qsource provided technical assistance to the PASSEs and DMOs for the migration from an onsite review to a virtual review environment.

The virtual reviews took place August through September 2021. During the review, PASSE and DMO staff answered questions and provided information to help surveyors determine the degree of compliance with federal and agreement/contract requirements, explore any issues not fully addressed in the document review, and increase overall understanding of the operations. Qsource surveyors used the tools, along with personal observations, interviews with PASSE and DMO staff, virtual system demonstrations, and file/document reviews, to facilitate analyses and compilation of findings. Each PASSE and DMO also provided additional documentation as needed for surveyors during the virtual review.

The compliance rating was determined by the percentage score of all elements met, as guided by EQR Protocol 3, and was calculated by dividing the number of elements met by the number of elements assessed. The compliance rating indicates Qsource's confidence (ranging from No Compliance to High Compliance) that the PASSE or DMO met the elements for the standards reviewed.

Table 41 presents the rating criteria used in the CA validation.

Table 41. Compliance Rating Criteria	
Status	**Criteria**
High Compliance	Of all elements assessed, 90–100% were met.
Moderate Compliance	Of all elements assessed, 80– <90% were met.
Low Compliance	Of all elements assessed, 70– <80% were met.
No Compliance	Less than 70% of the elements were met.

In addition to compliance standards, the CA included reviews of a random sample of complaints, grievances, appeals, service denials cases, and credentialing and recredentialing files. The reviews evaluated how the PASSEs and DMOs applied the processes and procedures required in 42 CFR § 438, Subparts D and F, in operational practice. Qsource asked that the PASSEs and DMOs provide the universe of 2021 complaints, grievances, appeals, service denials files, and credentialing and recredentialing files, from which Qsource abstracted a random sample. Files in this selection included 10 samples and 5 oversample files. The file review tools and tool instructions are available upon request.

Description of Data Obtained

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding the compliance with regulatory and contractual standards through a review of policies and procedures (P&Ps), quality studies, reports, medical records/files, and other related PASSE and DMO documentation. Each standard element has an assigned point value of 1, and Qsource analyzed every element in the survey tools. Qsource determined performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

The number of elements for each standard is provided in **Table 42**. The elements within the standards varied for PASSEs and DMOs based on different requirements.

Table 42. MY 2021 Compliance Assessment Standards		
Standard	**PASSE Elements**	**DMO Elements**
Coverage and Authorization of Services	55	20
Grievance and Appeals System	62	38
Provider Selection (Credentialing/Recredentialing)	20	8
Subcontractual Relationships and Delegation	20	14

Findings

Compliance Standards

Table 43 includes overall compliance scores for all standards evaluated in 2021 for the CA. Additional results and the previous measurement year's results are provided in Appendix C.

Table 43. MY 2021 Compliance Scores and Ratings		
Standards	**Score**	**Compliance Rating**
ARTC		
Coverage and Authorization of Services	98.04%	High Compliance
Grievance and Appeals System	98.39%	High Compliance
Provider Selection (Credentialing/Recredentialing)	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
ARTC Overall Compliance Standard Score	**99.11%**	**High Compliance**
Empower		
Coverage and Authorization of Services	100%	High Compliance
Grievance and Appeals System	100%	High Compliance
Provider Selection (Credentialing/Recredentialing)	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
Empower Overall Compliance Standard Score	**100%**	**High Compliance**
Summit		
Coverage and Authorization of Services	100%	High Compliance
Grievance and Appeals System	100%	High Compliance
Provider Selection (Credentialing/Recredentialing)	95.00%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
Summit Overall Compliance Standard Score	**98.75%**	**High Compliance**
Delta Dental		
Coverage and Authorization of Services	100%	High Compliance
Grievance and Appeals System	100%	High Compliance
Provider Selection (Credentialing/Recredentialing)	100%	High Compliance
Subcontractual Relationships and Delegation	91.67%	High Compliance
Delta Dental Overall Compliance Standard Score	**97.92%**	**High Compliance**
MCNA		
Coverage and Authorization of Services	97.37%	High Compliance
Grievance and Appeals System	100%	High Compliance
Provider Selection (Credentialing/Recredentialing)	100%	High Compliance
Subcontractual Relationships and Delegation	77.27%	Low Compliance
MCNA Overall Compliance Standard Score	**93.66%**	**High Compliance**

File Reviews

Table 44 includes scores for each file review for the CA. These findings support the CA standard scores and compliance ratings assigned to the PASSEs and DMOs.

Table 44. MY 2021 File Review Scores	
File Review	**Score**
ARTC	
Credentialing	100%
Recredentialing	98.98%
Grievances	100%
Appeals	100%
Services Denials	100%
Empower	
Credentialing	100%
Recredentialing	100%
Grievances	100%
Appeals	100%
Services Denials	100%
Summit	
Credentialing	100%
Recredentialing	100%
Grievances	100%
Appeals	100%
Services Denials	98.18%
Delta Dental	
Credentialing	100%
Recredentialing	100%
Grievances	100%
Appeals	100%
Service Denials	100%
MCNA	
Credentialing	100%
Recredentialing	100%
Grievances	100%
Appeals	100%
Service Denials	100%

Strengths and Weaknesses

Table 45 provides strengths by compliance standard for the CA, while the AONs, or weaknesses, identified are in Table 46. Qsource also identified suggestions where an element was fully compliant, but a revision/update could further strengthen that element's compliance. The PASSEs and DMOs were not held accountable for addressing suggestions; therefore, suggestions were not monitored or included in this report. If a PASSE or DMO was not listed, it had no identified strengths or weaknesses in those areas.

Table 45. CA Strengths by Standard	
Standard Title	**Strength**
ARTC	
Coverage and Authorization	**Service Documentation:** ARTC took a proactive approach by giving a live demonstration of the PCSP system.
	Service Authorization Policies and Procedures: ARTC took a proactive approach by giving a live demonstration of the workflow in their system.
	Emergency and Post-Stabilization Coverage: ARTC took a proactive approach by giving a live demonstration of an example of an emergency claim approval.
Grievance and Appeals	**Applicable Requirements:** The documentation submitted as evidence, Member Grievance and Appeals Policy and Procedure is active and current. In addition, ARTC has done a good job updating its documentation to include missed elements and suggested improvements.
Empower	
Coverage and Authorization of Services	**Service Authorization Policies and Procedures:** Empower provided an excellent overview of the authorization of services process.
Provider Selection	**Credentialing and Re-credentialing Documentation:** Empower gave a live demonstration of NetworkConnect Credentialing and Recredentialing System.
	Practice Guidelines: Empower gave a live demonstration of their website.
Grievance and Appeals	**Applicable Requirements:** Empower took a proactive approach by giving a live demonstration of the workflow in the Grievance and Appeal system.
	Decision Makers – Qualified Personnel: The documentation submitted as evidence was active and current. In addition, Empower has done a good job updating its documentation to include missed elements and suggested improvements.
Subcontractual Relationships and Delegation	**PASSE Contract Compliance:** The documentation submitted as evidence was active and current. In addition, Empower has done a good job updating its documentation to include missed elements and suggested improvements.
Summit	
Coverage and Authorization of Services	**Service Coverage:** Summit submitted substantial documentation to meet the elements of this standard.
Provider Selection	**Credentialing and Re-credentialing Documentation:** Summit gave a live demonstration of their credentialing system.

Table 45. CA Strengths by Standard	
Standard Title	**Strength**
	Practice Guidelines: Summit submitted excellent examples to meet this element including a newsletter and screenshots from their website.
Grievance and Appeals	**Applicable Requirements:** Summit gave a comprehensive and informative live demonstration of the NextGen Grievance and Appeals system.
Delta Dental	
Coverage and Authorization of Services	**Adverse Benefit Determination Requirements-1:** Delta Dental took a proactive approach to respond to this element by demonstrating an example live during the virtual review.
	Adverse Benefit Determination Requirements-2: Delta Dental took a proactive approach to respond to this element by demonstrating an example live during the virtual review.
Grievance and Appeals	**Grievance and Appeal – General Requirements:** The revision history on submitted documentation is helpful, up-to-date, and an improvement over the previous measurement period.
	Grievance or Appeal Enrollee Assistance: The Desktop Procedure Manual and grievance and appeal documentation were detailed and presented clearly.
Subcontractual Relationships and Delegation	**DMO Monitoring Plan:** Delta Dental submitted evidence demonstrating that the Program Integrity Plan was updated on an annual schedule and discussed the committee meetings for review in the compliance assessment.
MCNA	
Coverage and Authorization	**Service Authorization Policies and Procedures:** MCNA gave a comprehensive and informative live demonstration of the DentalTrac system from the receipt of the prior authorizations request to an approval and denial.
Provider Selection	**Credentialing and Recredentialing Documentation:** MCNA performed an informative live demonstration of the credentialing and recredentialing system and process from provider application through approval.
Grievance and Appeals	**Grievance and Appeal – General Requirements:** The documentation submitted for this standard was thorough and well written. In addition, the audit trail and revision history were present and complete.
	Enrollee Authority to File: In the documentation, the responsible party was listed and procedures were listed for each task. The workflow in the procedures was easy to follow and comprehensive.
Subcontractual Relationships and Delegation	**DMO Contract Compliance:** The documentation submitted was active with the review and the history of updates was easy to understand.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

Table 46. CA Weaknesses (AONs) by Standard

Standard Title	Weakness
ARTC	
Coverage and Authorization of Services	**Custom Drug File:** ARTC should include that the PASSE must update its pharmacy claims system within one business day of receipt regardless of on- or off-cycle updates in the policy.
Grievance and Appeals	**Fair Hearing Timeframes:** The verbiage within the Member Grievance and Appeals System Description did not include that ARTC will provide to DHS Office of Appeals and Hearings the Notice of Adverse Benefits Determination and Notice of Appeal Resolution. ARTC should include this requirement in the documentation.
Summit	
Provider Selection	**HCBS Providers:** While Summit has a policy in place, it is not currently credentialing HCBS providers. Summit should work with DHS to clarify questions regarding HCBS provider classification in order to begin credentialing and recredentialing HCBS providers.
Delta Dental	
Subcontractual Relationships and Delegation	**DMO Subcontracts:** Delta Dental maintains a fully executed original and electronic copy of all subcontracts; however, Delta Dental did not have the timeframe of five business days written within any policy and procedure.
MCNA	
Coverage and Authorization	**Prior Authorization:** MCNA should either make available the list of services requiring prior authorization or provide a way to access that list to potential enrollees in either the Member Handbook or on the Member Portal.
Subcontractual Relationships and Delegation	**DMO Monitoring Plan:** The verbiage, "The DMO must submit to DHS a monitoring plan for each subcontract or delegation" was missing from the Policy.
	Subcontract Confidentiality: Confidentiality was addressed in the Dental Administrative Services Agreement; however, sub-element (a) was not in the Policy.
	DMO Subcontracts: This element criteria were not captured in any policy or procedure. MCNA should include these criteria.

Improvements

Table 47 presents a comparison between the CA scores in measurement year 2021 and measurement year 2020. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases in performance are indicated using a downward arrow (↓).

Table 47. Progress Update for Compliance Scores

Standards	MY 2021 Score	MY 2020 Score
ARTC		
Coverage and Authorization of Services	98.04%↑	85.71%
Grievance and Appeals System	98.39%↑	90.33%
Provider Selection (Credentialing/Recredentialing)	100%	100%
Subcontractual Relationships and Delegation	100%↑	87.97%
Empower		
Coverage and Authorization of Services	100%↑	91.84%
Grievance and Appeals System	100%↑	95.16%
Provider Selection (Credentialing/Recredentialing)	100%	100%
Subcontractual Relationships and Delegation	100%↑	56.08%
Summit		
Coverage and Authorization of Services	100%	100%
Grievance and Appeals System	100%	100%
Provider Selection (Credentialing/Recredentialing)	95.00%↓	100%
Subcontractual Relationships and Delegation	100%↑	89.47%
Delta Dental		
Coverage and Authorization of Services	100%↑	72.72%
Grievance and Appeals System	100%↑	98.68%
Provider Selection (Credentialing/Recredentialing)	100%	100%
Subcontractual Relationships and Delegation	91.67%↓	100%
MCNA		
Coverage and Authorization of Services	97.37%↓	100%
Grievance and Appeals System	100%	100%
Provider Selection (Credentialing/Recredentialing)	100%	100%
Subcontractual Relationships and Delegation	77.27%↓	100%

Table 48 presents a comparison between the CA file review scores in measurement year 2021 and measurement year 2020. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases in performance are indicated using a downward arrow (↓).

Table 48. Progress Update for File Review Scores		
File Type	**MY 2021 Score**	**MY 2020 Score**
ARTC		
Credentialing	100%	NA*
Recredentialing	98.98%	NA
Grievances	100%	100%
Appeals	100%	100%
Services Denials	100%	100%
Empower		
Credentialing	100%	NA
Recredentialing	100%	NA
Grievances	100%↑	97.50%
Appeals	100%	100%
Services Denials	100%	100%
Summit		
Credentialing	100%	NA
Recredentialing	100%	NA
Grievances	100%↑	97.50%
Appeals	100%	100%
Services Denials	98.18%↑	91.38%
Delta Dental		
Credentialing	100%↑	85.71%
Recredentialing	100%↑	98.75%
Grievances	100%	100%
Appeals	100%	100%
Services Denials	100%	100%

Table 48. Progress Update for File Review Scores		
File Type	**MY 2021 Score**	**MY 2020 Score**
MCNA		
Credentialing	100%	100%
Recredentialing	100%	100%
Grievances	100%	100%
Appeals	100%	100%
Services Denials	100%↑	98.00%

**Not required by DHS in MY 2020, therefore it was not reviewed.*

Conclusions

ARTC

ARTC improved standard results when comparing MY 2021 to MY 2020 findings. In the Coverage and Authorization of Services standard, ARTC achieved a score of 98.04% up from 85.71% with seven AONs identified in MY 2020. ARTC scored a 98.39% up from 90.33% and seven AONs in the Grievance and Appeals standard and 100% up from an 87.97% with three AONs in the Subcontractual Relationships and Delegation Standard in MY 2020. Not only did ARTC improve scores in MY 2021, but also achieved four strengths compared to one in the reviewed standards in MY 2020. ARTC's rating of high compliance in all four standards demonstrated quality, timeliness, and access to care for its enrollees.

ARTC's compliance rating of high confidence indicated that the PASSE aligned with DHS's Quality Strategy. Specifically, it aligned with Goal 2: Improve access to needed services and safety for enrollees. ARTC's score of 98.39% in the Grievance and Appeals standard demonstrated quality and timely care and indicated that it aligned with the Quality Strategy which stated the PASSEs were responsible for establishing and maintaining a Grievance and Complaint process. ARTC's score of 100% in the Provider Selection standard demonstrated access to care and also indicated that it aligned with Objective 2.1 of Goal 2: Improve access to appropriate care through network adequacy.

Empower

Empower greatly improved standard results when comparing MY 2021 to MY 2020 findings. In the Coverage and Authorization of Services standard, Empower achieved a score of 100% up from 91.84% with four AONs identified in MY 2020. Empower scored a 100% up from 95.16% and three AONs in the Grievance and Appeals standard and 100% up from a 56.08% with eleven AONs in the Subcontractual Relationships and Delegation Standard in MY 2020. Not only did Empower improve scores in MY 2021, but also achieved six strengths compared to none in the reviewed standards in MY 2020. Empower's rating of high compliance in all four standards demonstrated quality, timeliness, and access to care for its enrollees.

Empower's compliance rating of high confidence indicated that it aligned with DHS's Quality Strategy. Specifically, it aligned with Goal 2: Improve access to needed services and safety for enrollees. Empower's score of 100% in the Grievance and Appeals standard indicated that it aligned with the Quality Strategy which stated the PASSEs were responsible for establishing and maintaining a Grievance and Complaint process. Empower's score of 100% in the Provider Selection standard indicated that it also aligned with Objective 2.1 of Goal 2: Improve access to appropriate care through network adequacy.

Summit

Summit improved or maintained most standard results when comparing MY 2021 to MY 2020 findings. In the Provider Selection standard, Summit's score fell slightly compared to MY 2020. In the Subcontractual Relationships and Delegation Standard, Summit's score improved to 100% up from 89.47% with two AONs in MY 2020. Summit improved its file review scores in two categories. Not only did Summit improve scores in MY 2021, but the PASSE also achieved four strengths compared to none in the reviewed standards in MY 2020. Summit's rating of high compliance in all four standards demonstrated quality, timeliness, and access to care for its enrollees.

Summit's compliance rating of high confidence indicated that it aligned with DHS's Quality Strategy. Specifically, it aligned with Goal 2: Improve access to needed services and safety for enrollees. Summit's score of 100% in the Grievance and Appeals standard indicated that it aligned with the Quality Strategy which stated the PASSEs were responsible for establishing and maintaining a Grievance and Complaint process. Summit's score of 95% in the Provider Selection standard indicated that it also aligned with Objective 2.1 of Goal 2: Improve access to appropriate care through network adequacy.

Delta Dental

Delta Dental improved standard results when comparing MY 2021 to MY 2020 findings, except for Subcontractual Relationships and Delegation. In the Coverage and Authorization of Services standard, Delta Dental greatly improved upon its score of 72.72% with three AONs identified in MY 2020 to 91.67%. Delta Dental scored 100% up from 98.68% and one AON in the Grievance and Appeals standard in MY 2020. Delta Dental received a considerably higher score for the credentialing file review in MY 2021. Delta Dental achieved five strengths in this report compared to none in the reviewed standards in MY 2020. Delta Dental's rating of high compliance in all four standards demonstrated quality, timeliness, and access to care for its enrollees.

Delta Dental's AONs in MY 2020 correlated with two of the standards reviewed in MY 2021, Coverage and Authorization of Services and Grievances and Appeals. They were issued because the DMO did not have current policy and procedures in use for the elements. The documents submitted for evidence were not reviewed in MY 2020; however, Delta Dental stated the documents were the most current documents and were currently in use. Qsource instructed Delta Dental to ensure that all documentation, policy, and procedures were up to date and active with a clear audit and review trail.

In the 2021 CA, Delta Dental made noticeable improvements in its documentation and review policy. All documents had a clear and current review and audit trail with upcoming review dates noted.

Delta Dental's compliance rating of high confidence indicated that it aligned with DHS's Quality Strategy. Specifically, it aligned with Goal 2: Improve access to needed services and safety for enrollees. Delta Dental's score of 100% in the Grievance and Appeals standard indicated that it aligned with the Quality Strategy which stated the DMOs were responsible for establishing and maintaining a Grievance and Complaint process. Delta Dental's score of 100% in the Provider Selection standard also indicated that it aligned with Objective 2.1 of Goal 2: Improve access to appropriate dental services through network adequacy.

MCNA

MCNA received lower scores in MY 2021 for the Subcontractual Relationships and Delegation standard and the Coverage and Authorization of Services standard. MCNA received a low compliance rating for Subcontractual Relationships and Delegation by receiving three AONs all relating to missing information from policies or procedures. MCNA maintained scores of 100% in the remaining two standards. MCNA scored 100% on all five file reviews in MY 2021 versus four in MY 2020. MCNA achieved five strengths in this report compared to none in the reviewed standards in MY 2020. MCNA's rating of high compliance in three of the four standards demonstrated quality, timeliness, and access to care for its enrollees.

MCNA's overall compliance rating of high confidence indicated that it aligned with DHS's Quality Strategy. Specifically, it aligned with Goal 2: Improve access to needed services and safety for enrollees. MCNA's score of 100% in the Grievance and Appeals standard indicated that it aligned with the Quality Strategy which stated the DMOs were responsible for establishing and maintaining a Grievance and Complaint process. MCNA's score of 100% in the Provider Selection standard also indicated that it aligned with Objective 2.1 of Goal 2: Improve access to appropriate dental services through network adequacy.

National Correct Coding Initiative (NCCI)

Effective October 1, 2010, CMS incorporated NCCI methodologies into the state Medicaid programs pursuant to the requirements of Section 6507, Mandatory State Use of NCCI, of the *Patient Protection and Affordable Care Act* (P.L. 111-148), as amended by the *Health Care and Education Recovery Act* of 2010 (P.L. 111-152), together referred to as the *Affordable Care Act*, which amended section 1903(r) of the *Social Security Act*.

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment of claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Qsource evaluated the PASSEs' NCCI edits per the National Correct Coding Initiative Policy Manual for Medicaid Services (revised January 1, 2020) for 2020 through 2021 (MY 2021). The PASSEs and DMOs submitted supporting documentation, such as policies and procedures, data files, and audit results. Qsource evaluated the PASSE-reported evidence with NCCI standards.

The NCCI evaluation demonstrated that all three PASSEs were in compliance with national correct coding methodologies. While ARTC reported "No" in the table for Audits in Place or Sample Audit Results Provided, Qsource found during the Virtual Systems Review that ARTC demonstrated sufficient evidence to support these elements. Therefore, results should be considered as in compliance.

Table 49 presents the PASSE-reported evaluation results.

Table 49. MY 2021 NCCI PASSE-Reported Results

ARTC	
Claims Processing System	Amysis
NCCI Edits Updated Quarterly	Yes
NCCI Updates Integrated into the Claims System Edit Functionality	Yes
Audit Processes in Place	No
Sample Audit Results Provided	No
Policy or Procedure Indicating Denial of Payment Due to Medicaid NCCI Edits	Yes
Empower	
Claims Processing System	Aldera
NCCI Edits Updated Quarterly	Yes
NCCI Updates Integrated into the Claims System Edit Functionality	Yes
Audit Processes in Place	Yes
Sample Audit Results Provided	Yes
Policy or Procedure Indicating Denial of Payment Due to Medicaid NCCI Edits	Yes
Summit	
Claims Processing System	Facets
NCCI Edits Updated Quarterly	Yes

Table 49. MY 2021 NCCI PASSE-Reported Results	
NCCI Updates Integrated into the Claims System Edit Functionality	Yes
Audit Processes in Place	Yes
Sample Audit Results Provided	Yes
Policy or Procedure Indicating Denial of Payment Due to Medicaid NCCI Edits	Yes

Protocol 4: Annual Network Adequacy Review (ANA)

Qsource evaluated each PASSE and DMO to determine if it had an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 438.68. The following activities were conducted in order to assess the network adequacy of each PASSE and DMO.

1. Validation of 2020 DHS Network Adequacy Analysis (PASSE only)
2. Geographic Network Adequacy Analysis
3. Provider Access to Care Surveys
4. Satisfaction Surveys and Complaints
5. Person-Centered Service Plan (PCSP) Assessment (PASSE only)
6. Validation of DHS Person-Centered Service Plan (PCSP) Retrospective Review (PASSE only)

Validation of 2020 DHS Network Adequacy Analysis

Objectives

This report includes a validation of the State's calculations for measurement year (MY) 2020 and Qsource's calculation of MY 2021 network adequacy for PASSEs. Qsource accepted network adequacy data provided by DHS and self-reported data from the PASSE as of January 2021. For this report, the findings from the specified point in time were aggregated in the previous 12 months. Qsource compared the reports to network adequacy thresholds in the contract to determine compliance. Results are reported accordingly.

Technical Methods of Data Collection

DHS reported its process for the analysis of network adequacy as of January 2021 (MY 2020).

1. A review of the materials submitted by each PASSE to DHS biannually
2. Entering the data submitted by each PASSE into the data set (PASSE Network Adequacy Data 2-21 (final) for each PASSE)
3. Indexing areas of gaps in coverage and missing elements of each PASSE's submission
4. Sending letters to the PASSEs requesting additional information covering the missing elements
5. Compilation of each PASSE's ANA Chart using the gathered information

Qsource compared DHS-reported network adequacy results to applicable standards to assess compliance.

The basis for the analyses and validation of methodology was the PASSE Network Adequacy Data 2-21 (final).xls file provided by DHS. DHS provided additional documentation that the PASSEs submitted to them as source documentation. This source documentation included, but was not limited to, spreadsheets, narrative documents, checklists with an "X" to

indicate a standard was met, as well as Geo Access reports. Qsource utilized these documents for the DHS ANA methodology validation.

Findings

Qsource was able to validate DHS's data with the PASSE source documentation. Qsource found no differences between the PASSE-reported data and DHS's reported findings.

Geographic Network Adequacy Analysis

Objectives

The PASSE Agreement between DHS and the PASSEs establishes minimum requirements for services to be provided to PASSE enrollees and indicates that a PASSE "must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Agreement for all enrollees." The agreement references the PASSE Medicaid Provider Manual for geographical access distance standards for urban and rural primary care, specialty care, facility, organizational, and ancillary providers.

The State of Arkansas Technical and General Services Contract (hereafter referred to as the contract) between DHS and the DMOs establishes minimum requirements for services to be provided to DMO enrollees and requires that the DMO provider networks "must ensure that all Medically Necessary Covered Services shall be available to Beneficiaries on a timely basis (as defined in this RFP), consistent with appropriate dental guidelines, with generally accepted practice parameters, and with the Contract's requirements." The contract's Attachment C – Performance Standards and section 3.3, Access to Care, reference the geographical access distance standards for urban and rural primary care, specialty care, and pediatric dental services.

Goal 2 of DHS's Quality Strategy was to improve access to needed services and safety for all enrollees. Objective 2.1 of Goal 2 specified improving access to appropriate care through network adequacy.

The calculation of network adequacy involves geomapping at a particular point in time. For this report, the findings from the specified point in time were aggregated in the previous 12 months. The providers included in this review of network adequacy and access to care were currently associated with the PASSEs or DMOs (had at least one claim in the previous six months). In order to review the most up-to-date information and to align with the provider access survey information in this report, Qsource requested data from the PASSEs and DMOs as of July 2021. Qsource contracted with Quest Analytics, LLC to use geomapping to determine if provider networks met quantitative standards, such as distance standards, and calculate provider-to-enrollee ratios by type of provider and geographic area. Qsource evaluated the methods and processes used by the PASSEs and DMOs to meet DHS distance standards. Qsource reviewed and evaluated network adequacy policies and processes as well as network contracting as part of *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care*

Regulations conducted in 2021. The full results can be found in the *2021 Compliance Assessment Reports*.

Qsource conducted an Information Systems Capabilities Assessment (ISCA) during the Virtual Systems Review in 2021. ISCA Tools (ISCATs) were reviewed by Qsource for general information, the integrity of all systems capabilities including administrative data (medical claims), enrollment data systems, provider data, data completeness, integration of data for performance measure calculation, and ancillary data and integration processes. The complete findings from the Virtual Systems Review are located in the *2021 Performance Measure Validation Reports*.

Technical Methods of Data Collection

Qsource contracted with Quest Analytics to assess geographical access to primary and specialty care providers by calculating the travel time and distance between enrollees and providers. The geographical access analyses identified the percentage of enrollees who had access to the various provider types within the travel time and distance standards set by the DHS.

To further evaluate availability of provider services, Qsource reviewed appointment availability standards relative to those required in the contract, as evidenced in policies and procedures (P&Ps), provider manual, and enrollee handbook.

The EQR activities performed by Quest Analytics, as well as the requirements for the performance-based standards were:

- Validation of network adequacy and access to care during the preceding twelve (12) months or as alternatively prescribed by DHS. Network adequacy may include any or all of the following applicable provider types for PASSEs:
  - Primary Care PASSE providers (adult and pediatric)
  - Obstetrics and Gynecology
  - Developmental disability providers
  - Behavioral health
  - Home and Community Based Services providers under PASSE
  - Specialists (adult and pediatric)
  - Hospital
  - Pharmacy
  - All other provider types listed in any governing documents, including Agreements and Provider Manuals
  - Additional provider types when it promotes "the objectives of the Medicaid program for the provider type to be subject to such time and distance standards"

- Validation of network adequacy and access to care during the preceding twelve (12) months or as alternatively prescribed by DHS. Network adequacy may include any or all of the following applicable provider types for DMOs:
  - Primary Care dentists (adult and pediatric)

  - Specialists (adult and pediatric)
  - Additional provider types when it promotes "the objectives of the Medicaid program for the provider type to be subject to such time and distance standards"

- Evaluation of network adequacy should include the following without limitation:
  - Evaluate the methods and process used by the PASSEs and DMOs to meet DHS time and distance standards.
  - Review and evaluate network contracting and processes for meeting network adequacy standards.

The DHS distance, provider-to-enrollee ratio metrics for PASSEs by specialty/provider type, and appointment access metrics for DMOs are included with the results in Appendix D. Quest Analytics provided the 2021 AR Data Template to the PASSEs and DMOs.

Data Collection

Quest Analytics derived the data for quantitative analyses from provider data files as of June 2021, supplied by the PASSEs and DMOs, and enrollment files as of July 1, 2021, provided by DHS.

To be included in the analysis, an enrollee had to have the following:

- Active enrollment as of July 1, 2021
- An address within Arkansas
- A valid address as defined by the Quest Analytics Suite™ during data standardization

To be included in the analysis, a provider had to have the following:

- An active contract with the PASSE or DMO as of June 2021
- Status as a network provider
- A valid address as defined by the Quest Analytics Suite during data standardization

Data Standardization

Provider and enrollee addresses were standardized to the United States Postal Service (USPS) address format. The addresses were then geocoded, or converted into spatial data, associating the exact geographical coordinates for the address. Each enrollee and provider address were assigned a latitude and longitude coordinate. If an exact latitude and longitude coordinate could not be identified, but a valid ZIP Code was available, Quest Analytics used a proprietary assignment for latitude and longitude coordinates in a ZIP-distributive geocoding process. ZIP-distributive geocoding considers the number of such ZIP-only points within a ZIP Code area and assigns latitude and

longitude coordinates based on the population patterns of that ZIP Code.

After geocoding, duplicate provider records were eliminated. Ultimately, the provider data used in the analysis reflected the following:

- A single provider with multiple addresses was counted once for each address.
- Multiple providers at the same address were counted as distinct providers.
- A single provider with more than one specialty was counted for each specialty.
- Providers whose National Provider Identifiers had been deactivated were excluded from the analyses.

Calculations

After the enrollee and provider data were standardized and geocoded, county-level (urban and rural) calculations established the travel time and distance from each enrollee location to each of the provider types. If the enrollee location had at least one provider location within the established criteria, that enrollee was factored into the percentage-with-access category. If not, the enrollee was considered to be without the desired access to care.

The data dictionary used by Quest Analytics is located in the *2021 Annual Network Adequacy Review Reports*. Qsource reviewed an attestation from the PASSEs and DMOs stating they took responsibility for network adequacy, as well as the PASSE/DMO policies for ensuring network adequacy.

Description of Data Obtained

Further details can be found in the *2021 Annual Network Adequacy Review Reports*. Analyses were conducted for the provider and specialty types listed in **Table 50** for the PASSEs and Table 51 for the DMOs.

Table 50. ANA Provider/Specialty Categories for PASSEs

Primary and Specialty Care	
♦ Primary Care	♦ Infectious Diseases
♦ Pediatrics – Routine/ Primary Care	♦ Nephrology
♦ Ambulatory Surgical Center	♦ Neurology
♦ Allergy and Immunology	♦ Neurosurgery
♦ Cardiothoracic Surgery	♦ Oncology
♦ Cardiovascular Disease	♦ Ophthalmology
♦ Dermatology	♦ Optometry
♦ Supportive Living / Respite / Supplemental Support	♦ Orthopedic Surgery
♦ Environmental Modifications / Adaptive Equipment	♦ Orthotics and Prosthetics
♦ Specialized Medical Supplies	♦ Outpatient Dialysis
♦ Supported Employment	♦ Outpatient Infusion/ Chemotherapy
♦ Diagnostic Radiology	♦ Personal Care
♦ Endocrinology	♦ Pharmacy
♦ ENT/Otolaryngology	♦ Physical Medicine and Rehabilitation, Physiatry
	♦ Plastic Surgery
	♦ Podiatry
	♦ Pulmonary
	♦ Rheumatology

Table 50. ANA Provider/Specialty Categories for PASSEs	
♦ Federally Qualified Health Center (FQHC)	♦ Rural Health Clinic (RHC)
♦ Gastroenterology	♦ Therapist (Occupational)
♦ General Surgery	♦ Therapist (Physical)
♦ Gynecology, OB/GYN	♦ Therapist (Speech)
♦ Hematology	♦ Urology
♦ Home Health	♦ Vascular Surgery
♦ Hyperalimentation	♦ Ventilator Equipment
♦ Intermediate Care Facility	
Facility/Group/Organization	
♦ Acute Inpatient Hospital	♦ Durable Medical Equipment (DME)
♦ Adult Developmental Day Treatment (ADDT)	♦ Outpatient Hospital
♦ Critical Care Services – Intensive Care Units	
Behavioral Health	
♦ Independently Licensed Clinician – Master's/ Doctoral	♦ Inpatient Psychiatric Facility for Individuals Under the Age of 21
♦ Board Certified Psychiatrist	♦ Substance Abuse Treatment Provider

Table 51. ANA Provider/Specialty Categories for DMOs
All Enrollees
♦ Primary Care Dentists
♦ Specialty Care Dentist
♦ Orthodontists
♦ Periodontists
♦ Oral Surgeons
♦ Endodontists
Pediatric Enrollees
♦ Pediatric Dental Services

Findings

Qsource analyzed the distance and timeliness standards to assess the network adequacy for each PASSE and DMO. This travel distance analysis evaluates enrollee access to providers based on the standards specified in the PASSE and DMO contracts with DHS for each provider type. The percentage of enrollees by geographical location type with access to the various categories of care within applicable distance standards for the service area is in Appendix D.

Qsource developed the network adequacy rating to present comparative findings from the analysis. In addition to the geographic network adequacy analysis, the ratings include the findings from the Access to Service/Wait Time for Existing Patient Appointments questions from the Provider Access to Care Survey.

Table 52 presents the network adequacy rating criteria for PASSEs.

Table 52. Network Adequacy Rating Criteria: PASSE	
Rating	**Criteria**
High Adequacy	Of all standards assessed, 75% to 100% were met
Moderate Adequacy	Of all standards assessed, 50% to <75% were met
Low Adequacy	Of all standards assessed, 25% to <50% were met
No Adequacy	Below 25% of all standards were met

Table 53 presents the network adequacy rating for PASSEs.

Table 53. MY 2021 Network Adequacy Rating: PASSE				
Standards	**# Of Standards Met**	**# Of Applicable Standards**	**Rate**	**Network Adequacy Rating**
ARTC				
Urban Distance Standards	49	56	87.5%	High Adequacy
Rural Distance Standards	40	56	71.4%	Moderate Adequacy
Statewide Provider-to-Enrollee Ratios	54	55	98.2%	High Adequacy
Access to Service/Wait Time for Existing Patient Appointments	12	23	52.2%	Moderate Adequacy
Empower				
Urban Distance Standards	47	56	83.9%	High Adequacy
Rural Distance Standards	42	56	75.0%	High Adequacy
Statewide Provider-to-Enrollee Ratios	52	55	94.5%	High Adequacy
Access to Service/Wait Time for Existing Patient Appointments	12	23	52.2%	Moderate Adequacy
Summit				
Urban Distance Standards	43	56	76.8%	High Adequacy
Rural Distance Standards	34	56	60.7%	Moderate Adequacy

Table 53. MY 2021 Network Adequacy Rating: PASSE				
Standards	**# Of Standards Met**	**# Of Applicable Standards**	**Rate**	**Network Adequacy Rating**
Statewide Provider-to-Enrollee Ratios	52	55	94.5%	High Adequacy
Access to Service/Wait Time for Existing Patient Appointments	12	23	52.2%	Moderate Adequacy

Table 54 presents the network adequacy rating criteria for DMOs. Qsource developed the network adequacy rating to present comparative findings from the analysis. In addition to the geographic network adequacy analysis, the ratings include the findings from the Access to Service/Wait Time for Existing Patient Appointments questions from the Provider Access to Care Survey.

Table 54. Network Adequacy Rating Criteria: DMO	
Rating	**Criteria**
High Adequacy	Of all standards assessed, 50% to 100% were met
Low Adequacy	Of all standards assessed, 25% to <50% were met
No Adequacy	Of all standards assessed, 0% to <25% were met

Table 55 presents the network adequacy rating for DMOs.

Table 55. Network Adequacy Rating: DMO				
Standards	**# Of Standards Met**	**# Of Applicable Standards**	**Rate**	**Network Adequacy Rating**
Delta Dental				
Urban Distance Standards	5	7	71.4%	High Adequacy
Rural Distance Standards	5	7	71.4%	High Adequacy
Access to Service/Wait Time for Existing Patient Appointments	0	4	0.0%	No Adequacy
MCNA				
Urban Distance Standards	5	7	71.4%	High Adequacy
Rural Distance Standards	5	7	71.4%	High Adequacy
Access to Service/Wait Time for Existing Patient Appointments	0	4	0.0%	No Adequacy

Strengths and Weaknesses

Table 56 presents the strengths identified in the ANA Review, while Table 57 presents the weaknesses.

Table 56. MY 2021 Geographic Network Adequacy Strengths

ARTC

- ARTC met enrollee distance access standards for urban areas at 100% for 49 out of 56 reported provider types/provider specialties.
- ARTC achieved 90%-99.99% enrollee access for six additional urban provider types/specialties.
- For rural counties, ARTC met enrollee distance access standard at 100% for 40 out of 56 reported provider types/provider specialties.
- ARTC achieved 90%-99.99% enrollee access for 14 additional rural provider types/specialties.
- All but one statewide provider-to-enrollee ratios met standards.
- ARTC's network adequacy attestation combined with its policy provided sufficient evidence for its ability to meet network adequacy standards.
- ARTC prepared a well-documented ISCAT, which greatly facilitated the Virtual Systems Review process. Robust policies and procedures were in place to ensure the validity and accuracy of data.

Empower

- Empower met enrollee distance access standards for urban areas at 100% for 47 out of 56 reported provider types/provider specialties.
- Empower achieved 90%-99.9% enrollee access for five additional urban provider types/specialties.
- For rural counties, Empower met enrollee distance access standard at 100% for 42 out of 56 reported provider types/provider specialties.
- Empower achieved 90%-99.9% enrollee access for 11 additional rural provider types/specialties.
- Empower met 53 of 56 statewide provider-to-enrollee ratio standards.
- Empower's network adequacy attestation combined with its policy provided sufficient evidence for its ability to meet network adequacy standards.
- Empower prepared a well-documented ISCAT, which greatly facilitated the Virtual Systems Review process. Adequate policies and procedures were in place to ensure the validity and accuracy of data.

Summit

- Summit met enrollee distance access standards for urban areas at 100% for 43 out of 56 reported provider types/provider specialties.
- Summit achieved 90%-99.9% enrollee access for eight additional urban provider types/specialties.
- For rural counties, Summit met enrollee distance access standard at 100% for 34 out of 56 reported provider types/provider specialties.
- Summit achieved 90%-99.9% enrollee access for 16 additional rural provider types/specialties.
- Summit met 51 of 56 statewide provider-to-enrollee ratio standards.
- Summit's network adequacy attestation combined with its policy provided sufficient evidence for its ability to meet network adequacy standards.
- Summit prepared a well-documented ISCAT, which greatly facilitated the Virtual Systems Review process. Adequate policies and procedures were in place to ensure the validity and accuracy of data.

Delta Dental

- Delta Dental met standards for primary care and pediatric dental services.

Table 56. MY 2021 Geographic Network Adequacy Strengths
♦ Delta Dental met the standard for overall specialty dental care.
♦ The attestation combined with Delta Dental's policy provided sufficient evidence for its ability to meet network adequacy standards.
♦ Delta Dental prepared a well-documented ISCAT. Robust policies and procedures were in place to ensure the validity and accuracy of data.
MCNA
♦ MCNA met standards for primary care and pediatric dental services.
♦ MCNA met the standard for overall specialty dental care.
♦ The attestation combined with MCNA's policy provided sufficient evidence for its ability to meet network adequacy standards.
♦ MCNA prepared a well-documented ISCAT. Robust policies and procedures were in place to ensure the validity and accuracy of data.

Table 57. MY 2021 Geographic Network Adequacy Weaknesses
ARTC
♦ The only provider type/specialty for which urban enrollee access was significantly below standard (<90%) was Plastic Surgery at 54.59%.
♦ Provider types/provider specialties for which rural enrollee access was significantly below standard (<90%) included Outpatient Dialysis (88.55%) and Plastic Surgery (86.48%).
♦ ARTC failed to meet the ratio provider-to-enrollee standard for Inpatient Psychiatric Facility for Individuals Under the Age of 21 with 1 bed to 569.8 enrollees.

Table 57. MY 2021 Geographic Network Adequacy Weaknesses
Empower
♦ Provider types/specialties for which enrollee access was not reported to Qsource included Pharmacy, Board Certified Psychiatrist, and Substance Abuse Treatment Provider. However, provider data was reported to DHS which Qsource validated as part of this report.
Summit
♦ The provider types/specialties for which urban enrollee access was significantly below standard (<90%) were Outpatient Dialysis (2.68%), and Substance Abuse Treatment Provider (11.97%).
♦ Provider types/provider specialties for which rural enrollee access was significantly below standard (<90%) included Outpatient Dialysis (40.42%), Plastic Surgery (83.69%), and Substance Abuse Treatment Provider (84.79%).
♦ The statewide provider-to-enrollee ratios that did not meet standards were Outpatient Dialysis (1:8,251.5 enrollees), Vascular Surgery (1:1,650.3 enrollees), and Inpatient Psychiatric Facility for Individuals Under the Age of 21 (1 bed: 1,375.3 enrollees).
♦ Provider types/provider specialties that were not reported to Qsource for analysis were Diagnostic Radiology, Outpatient Infusion/Chemotherapy, and Pharmacy. However, this provider data was reported to DHS which was validated in this report.
Delta Dental
♦ Delta Dental failed to meet the standard for Periodontists and Endodontists in both urban and rural counties.
MCNA
♦ MCNA failed to meet standards for Periodontists and Endodontists in both urban and rural counties.

Improvements

DHS requested Qsource include areas of non-compliance from the previous measurement year (MY 2019) and the PASSE/DMO responses. **Table 58** presents a summary of improvements from the previous measurement year's AONs. Any standards not listed had no AONs identified in the previous measurement year. Direct quotes from the PASSEs and DMOs are in italics.

Table 58. Geographic Network Adequacy Progress Update

ARTC	
MY 2019 AON	Access to Plastic Surgery was highly deficient in both urban (56.90%) and rural counties (55.50%).
PASSE Response	*ARTC contracts with 100% of Plastic Surgery providers participating in AR Medicaid. There are no potential outreach opportunities for current AR Medicaid providers.*
Results from Analysis	While neither urban nor rural standards were met in the current measurement year, ARTC improved the distance standards for providers in rural areas from 55.50% to 86.48%.
MY 2019 AON	Access to Infectious Diseases specialty was deficient in urban (99.70%) and rural counties (88.10%).
PASSE Response	*ARTC conducted an analysis comparing AR Medicaid's Master Provider File to ARTC's contracted providers and found only one AR Medicaid participating provider entity, located in Greenville, Mississippi, who could potentially improve access to the infectious disease specialty in rural counties for ARTC members. ARTC will conduct outreach to pursue contracting with this location.*
Results from Analysis	ARTC improved network adequacy to meet urban distance standards in the current measurement year from 99.70% to 100%. ARTC improved access in rural areas from 88.10% to 96.95% but did not meet the standard.
MY 2019 AON	Access to Outpatient Dialysis was deficient in urban and rural counties at 91.10% and 88.30%, respectively.
PASSE Response	*ARTC conducted an analysis comparing AR Medicaid's Master Provider File to ARTC's contracted providers and validated that two groups who participate in AR Medicaid declined contracts with ARTC when initially offered. We will outreach to these two groups to discuss contracting again.*
Results from Analysis	ARTC's network remained deficient for both urban and rural distance standards at 91.47% and 88.55%, respectively.
MY 2019 AON	Inpatient Psychiatric Facility for Individuals Under the Age of 21 provider-to-enrollee results did not meet the standard.

Table 58. Geographic Network Adequacy Progress Update	
PASSE Response	Not Available
Results from Analysis	While the results of the Inpatient Psychiatric Facility for Individuals Under the Age of 21 provider-to-enrollee results were not listed as an AON for ARTC in Year 1, it failed to meet this standard in both the Year 1 and Year 2 reports. ARTC reported a ratio of 1 bed: 483.9 enrollees in Year 1 and 1 bed: 569.8 enrollees in Year 2. The standard for this ratio is 1 bed: 300 enrollees.
Empower	
MY 2019 AON	Access to Endocrinology was below standard for urban (92.90%) and rural counties (96.80%).
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop plan to address gaps.*
Results from Analysis	Empower's network remained deficient for both urban and rural Endocrinology distance standards, although some improvement was demonstrated for urban access with an increase from 92.90% to 99.83%.
MY 2019 AON	Access to Rheumatology was below standard for urban and rural counties at 56.90% and 55.50%, respectively.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop plan to address gaps.*
Results from Analysis	Empower improved network adequacy for both rural and urban distance standards in the current measurement year, but still did not meet the standards at 92.90% and 96.21%, respectively.
MY 2019 AON	Access to Outpatient Dialysis was below standard for urban counties at 93.00%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop plan to address gaps.*
Results from Analysis	Empower maintained network adequacy to meet rural distance standards in the current measurement year but was still deficient in urban areas at 93.10%.
MY 2019 AON	Access to Cardiothoracic Surgery was below standard for rural counties at 99.90%.

Table 58. Geographic Network Adequacy Progress Update	
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*
Results from Analysis	Empower's network remained deficient for Cardiothoracic Surgery rural distance standards at 99.67%.
MY 2019 AON	Access to Dermatology was below standard for rural counties at 99.70%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*
Results from Analysis	Empower's network remained deficient for Dermatology rural distance standards at 99.68%.
MY 2019 AON	Access to Infectious Diseases was below standard for rural counties at 99.50%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*
Results from Analysis	Empower improved network adequacy to meet rural distance standards in the current measurement year.
MY 2019 AON	Access to Neurosurgery was below standard for rural counties at 98.90%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*
Results from Analysis	Empower's network remained deficient for Neurosurgery rural distance standards at 95.92%.
MY 2019 AON	Access to Plastic Surgery was below standard for rural counties at 99.70%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*

Table 58. Geographic Network Adequacy Progress Update	
Results from Analysis	Empower's network remained deficient for Plastic Surgery rural distance standards (99.68%) and also became deficient for urban distance standards in the current measurement year (89.88%).
MY 2019 AON	Access to Podiatry was below standard for rural counties at 99.70%.
PASSE Response	*Empower will work with DHS in areas where no providers exist or in which providers exist outside of time and distance standards. Empower's Access and Availability workgroup will meet monthly to develop solutions.*
Results from Analysis	Empower's network remained deficient for Podiatry rural distance standards at 99.67%.
MY 2019 AON	Access to Vascular Surgery was below standard for rural counties at 99.90%.
PASSE Response	*Vascular Surgery standard has been met.*
Results from Analysis	Empower improved network adequacy to meet rural distance standards in the current measurement year.
Summit	
MY 2019 AON	Access to Cardiothoracic Surgery was deficient in urban (94.90%) and rural counties (89.10%).
PASSE Response	*Assisting with the numerous identified gaps, Summit executed agreements with two multi-county integrated delivery networks; (1) Mercy Health, primarily in NW Arkansas, and (2) ALT-PHO, primarily in SW Arkansas – these systems assisted with facility, ancillary, and physician Specialty gaps.* *Assisting with the Hematology, Oncology, and Outpatient Infusion/Chemotherapy gaps, Summit executed agreements with two multi-county cancer treatment providers: (1) American Oncology Centers, and (2) CARTI. In addition, Summit executed agreements with Mercy Health and ALT-PHO.*
Results from Analysis	Summit's network remained deficient for urban distance standards, although there was some improvement for the percentage of enrollees with access from 94.90% to 99.95%. Summit improved access in rural counties to meet distance standards.
MY 2019 AON	Access to Cardiovascular Disease specialty was deficient in rural counties at 90.20%.

Table 58. Geographic Network Adequacy Progress Update	
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Summit improved access in rural and urban counties to meet distance standards.
MY 2019 AON	Access to Dermatology was deficient in rural counties at 99.50%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in rural areas remained deficient in the current measurement year at 99.77%.
MY 2019 AON	Access to ENT/Otolaryngology was deficient in rural counties at 97.0%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in rural areas remained deficient in the current measurement year at 96.09%.
MY 2019 AON	Access to Gastroenterology was deficient in rural counties at 99.10%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in rural areas remained deficient in the current measurement year at 99.78%.
MY 2019 AON	Access to Gynecology, OB/GYN was deficient in rural counties at 83.70%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.

Table 58. Geographic Network Adequacy Progress Update	
Results from Analysis	Summit improved network adequacy in rural counties to meet distance standards.
MY 2019 AON	Access to Hematology was deficient in urban counties at 91.0%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Summit improved network adequacy in urban counties to meet distance standards.
MY 2019 AON	Access to Infectious Diseases specialty was deficient in urban (99.80%) and rural counties (88.30%).
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in urban and rural areas remained deficient in the current measurement year, although there was significant improvement in rural counties from 88.30% to 99.19%.
MY 2019 AON	Access to Nephrology was deficient in rural counties at 99.60%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Summit improved network adequacy in rural counties to meet distance standards.
MY 2019 AON	Access to Neurosurgery was deficient in urban (99.90%) and rural counties (89.30%).
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.

Table 58. Geographic Network Adequacy Progress Update	
Results from Analysis	Access in urban and rural areas remained deficient in the current measurement year, although there was significant improvement in rural counties from 89.30% to 98.26%.
MY 2019 AON	Access to Oncology was deficient in urban counties at 91.30%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Summit improved network adequacy in urban counties to meet distance standards.
MY 2019 AON	Access to Ophthalmology was deficient in rural counties at 99.20%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Summit improved network adequacy in rural counties to meet distance standards.
MY 2019 AON	Access to Outpatient Infusion/Chemotherapy was deficient in urban counties at 74.60%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in urban and rural areas was not reported to Qsource for analysis. Summit reported this data to DHS which was validated by Qsource. Summit reported meeting this standard.
MY 2019 AON	Access to Pulmonary was deficient in rural counties at 99.10%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.

Table 58. Geographic Network Adequacy Progress Update	
Results from Analysis	Summit improved network adequacy in rural counties to meet distance standards.
MY 2019 AON	Access to Rheumatology was deficient in rural counties 89.80%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	The percentage of enrollees with access in urban counties fell below standard during the current measurement year (91.82%). Summit remained deficient in rural areas at 95.77%.
MY 2019 AON	Access to Substance Abuse Treatment Providers was deficient in urban counties at 73.50%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	The percentage of enrollees with access in urban and rural counties fell below standard during the current measurement year at 11.97% and 84.79%, respectively.
MY 2019 AON	Access to Urology was deficient in rural counties at 97.50%.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Access in rural areas remained deficient in the current measurement year at 99.79%.
MY 2019 AON	Access to Vascular Surgery was deficient in urban (99.80%) and rural counties (89.10%).
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.

Table 58. Geographic Network Adequacy Progress Update	
Results from Analysis	Access in urban and rural areas remained deficient in the current measurement year, although there was improvement in rural counties from 89.10% to 92.88%. The provider-to-enrollee ratio fell below standard in the current measurement year at 1:1,650.3 enrollees.
MY 2019 AON	Access to Outpatient Dialysis was highly deficient in urban (13.70%) and rural counties (34.30%) and did not meet the required provider-to-enrollee ratios.
PASSE Response	*Assisting with Outpatient Dialysis gaps, Summit; (1) identified that it had not listed outpatient dialysis services in various outpatient hospital settings throughout the State, (2) finalized additional hospital agreements with Mercy Health and others which also offer outpatient dialysis, and (3) initiated discussions with national Dialysis partner, DaVita and anticipate executed agreement in June 2021 which will cover the majority of all outpatient dialysis gaps.*
Results from Analysis	Access in urban and rural areas remained deficient in the current measurement year at 2.68% and 40.42%, respectively. The provider-to-enrollee ratio remained deficient at 1:8,251.5 enrollees.
MCNA	
MY 2019 AON	Qsource found that specialist access was 100% for urban counties, but two rural counties did not meet specialist access standards - Chicot County at 68.79% and Little River County at 76.2% for children and 67.46% and 75.49% for adults, respectively.
DMO Response	*MCNA submitted its Action Plan to continue to recruit for specialists within close proximity to these two counties. The MCNA Network Development team will continue to reach out to providers currently not contracted in the MCNA network for AR. Furthermore, there are currently no specialists in Chicot and Little River counties. General Dentists in these counties typically provide specialty services for members as these services fall within their scope of their license. We have not had any access to care complaints regarding these counties. In the event a member requires a specialist, MCNA will refer them to the closest participating specialist. If there is not a participating specialist, we will reach out to non-contracted specialists (if available) that are willing to enter a Letter of Agreement to provide specialty care on a case by case basis.*
Results from Analysis	While MCNA met the standard for overall specialty dental care, it failed to meet standard for Periodontists and Endodontists in both urban and rural counties. Periodontists were 51.33% in urban counties and 46.40% in rural counties, while Endodontists were 78.93% and 21.79%, respectively.

Conclusions

ARTC

ARTC met enrollee distance access standards for urban areas at 100% for 49 out of 56 reported provider types/provider specialties, resulting in a rating of high adequacy. ARTC achieved 90%-99.99% enrollee access for six additional provider types/specialties. The only provider type/specialty for which urban enrollee access was significantly below standard (<90%) was Plastic Surgery at 54.59%.

For rural counties, ARTC met enrollee distance access standard at 100% for 40 out of 56 reported provider types/provider specialties, resulting in a rating of moderate adequacy. However, ARTC achieved 90%-99.99% enrollee access for 14 additional provider types/specialties. Provider types/provider specialties for which rural enrollee access was significantly below standard (<90%) included Outpatient Dialysis (88.55%) and Plastic Surgery (86.48%).

All but one statewide provider-to-enrollee ratios met standards achieving a high adequacy rating.

Qsource reviewed ARTC's policy ARTC.NTWK.100 Network Adequacy Standards which detailed ARTC's strategy for meeting network adequacy standards. The attestation combined with ARTC's policy provided sufficient evidence for ARTC's ability to meet network adequacy standards.

ARTC's ISCAT was reviewed by Qsource for general information about ARTC, the PASSE's integrity of all systems capabilities including administrative data, enrollment data systems, provider data, data completeness, integration of data for performance measure calculation and ancillary data and integration processes.

Overall, ARTC achieved high to moderate adequacy for all categories which indicated it closely aligned with Goal 2 of DHS's Quality Strategy regarding access to care. It specifically aligned with Objective 2.1: Improve access to appropriate care through network adequacy.

Empower

Empower met enrollee distance access standards for urban areas at 100% for 47 out of 56 reported provider types/provider specialties, resulting in a rating of high adequacy. Empower achieved 90%-99.9% enrollee access for five additional provider types/specialties. The provider types/specialties for which urban enrollee access was significantly below standard (<90%) was Plastic Surgery (89.88%). Pharmacy, Board Certified Psychiatrist, and Substance Abuse Treatment Provider were not reported to Qsource for its analysis. However, Empower did report these to DHS which was validated in this report

For rural counties, Empower met enrollee distance access standard at 100% for 42 out of 56 reported provider types/provider specialties, resulting in a rating of high adequacy. Empower achieved 90%-99.9% enrollee access for 11 additional provider types/specialties. Provider types/provider specialties for which rural enrollee access was not reported included

Pharmacy, Board Certified Psychiatrist, and Substance Abuse Treatment Provider.

Empower met 53 of 56 statewide provider-to-enrollee ratio standards, achieving a high adequacy rating.

Qsource reviewed the GEO1 Network Adequacy for BH/IDD policy as well as the 6013-01p Determining Network Adequacy procedure which detailed Empower's strategy for meeting network adequacy standards. The attestation combined with Empower's policy provided sufficient evidence for Empower's ability to meet network adequacy standards.

Empower's ISCAT was reviewed by Qsource for general information about Empower, the PASSE's integrity of all systems capabilities including administrative data, enrollment data systems, provider data, data completeness, integration of data for performance measure calculation and ancillary data and integration processes.

Overall, Empower achieved high to moderate adequacy for all categories which indicated it closely aligned with Goal 2 of DHS's Quality Strategy regarding access to care. It specifically aligned with Objective 2.1: Improve access to appropriate care through network adequacy.

Summit

Summit met enrollee distance access standards for urban areas at 100% for 43 out of 56 reported provider types/provider specialties, resulting in a rating of high adequacy. Summit achieved 90%-99.9% enrollee access for eight additional provider types/specialties. The provider types/specialties for which urban enrollee access was significantly below standard (<90%) were Outpatient Dialysis (2.68%) and Substance Abuse Treatment Provider (11.97%).

For rural counties, Summit met enrollee distance access standard at 100% for 34 out of 56 reported provider types/provider specialties, resulting in a rating of moderate adequacy. However, Summit achieved 90%-99.9% enrollee access for 16 additional provider types/specialties. Provider types/provider specialties for which rural enrollee access was significantly below standard (<90%) included Outpatient Dialysis (40.42%), Plastic Surgery (83.69%), and Substance Abuse Treatment Provider (84.79%).

Summit met 51 of 56 statewide provider-to-enrollee ratio standards, achieving a high adequacy rating. Statewide provider-to-enrollee ratios that did not meet standards included Outpatient Dialysis and Vascular Surgery.

Provider types/specialties that were not reported to Qsource for analysis were Diagnostic Radiology, Outpatient Infusion/Chemotherapy, and Pharmacy. However, Summit reported this provider data to DHS and Qsource validated for this report.

Qsource reviewed the Access and Availability-network Capacity-AR and the Access to Care Standards-AR policies which detail Summit's strategy for meeting network adequacy standards. The attestation combined with Summit's policy

provided sufficient evidence for Summit's ability to meet network adequacy standards.

Summit's ISCAT was reviewed by Qsource for general information about Summit, the PASSE's integrity of all systems capabilities including administrative data, enrollment data systems, provider data, data completeness, integration of data for performance measure calculation and ancillary data and integration processes.

Overall, Summit achieved high to moderate adequacy for all categories which indicated it closely aligned with Goal 2 of DHS's Quality Strategy regarding access to care. It specifically aligned with Objective 2.1: Improve access to appropriate care through network adequacy.

Delta Dental

Delta Dental continued to exceed the benchmarks for urban and rural distance standards, resulting in a rating of high adequacy. In this year's reporting, Qsource further analyzed Specialty Care Dentist by type. While Delta Dental met the standard for overall specialty dental care, it failed to meet the standard for Periodontists and Endodontists in both urban and rural counties. Pediatric dental service access also exceeded standard in both rural and urban areas.

The overall ratings of high adequacy indicated that Delta Dental aligned with Goal 2 of DHS's Quality Strategy regarding access to care. It specifically aligned with Objective 2.1: Improve access to appropriate dental services through network adequacy.

MCNA

MCNA continued to exceed the benchmarks for the urban and rural distance standards, resulting in a rating of high adequacy. In this year's reporting, Qsource further analyzed Specialty Care Dentist by type. While the DMO met the standard for overall specialty dental care, it failed to meet standard for Periodontists and Endodontists in both urban and rural counties. Pediatric dental service access also exceeded standard in both rural and urban areas.

The overall ratings of high adequacy indicated that MCNA aligned with Goal 2 of DHS's Quality Strategy regarding access to care. It specifically aligned with Objective 2.1: Improve access to appropriate dental services through network adequacy.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

ARTC

ARTC should re-evaluate the potential to secure contracts to correct network access deficiencies and ensure access to care. ARTC should verify that it contracts with 100% of Plastic Surgery providers participating in the Arkansas Medicaid program as the findings remain significantly below standard. ARTC should ensure that the outreach to Outpatient Dialysis providers was done as reported as the findings remain below standard. ARTC should ascertain the barrier to meeting the

Inpatient Psychiatric Facility for Individuals Under the Age of 21 ratio standard and address it.

Empower

Empower should re-evaluate the potential to secure contracts to correct network access deficiencies to ensure access to care. Empower should ensure complete and accurate reporting of data for analysis – Pharmacy, Board Certified Psychiatrist, and Substance Abuse Treatment Provider were not reported to Qsource, although they were reported to DHS. Similar to the previous measurement year's findings, Empower failed to meet the standard for Endocrinology and Rheumatology provider types. Empower should continue to focus on these areas to ensure access to care. Empower should determine why it failed to meet the urban standard for Outpatient Dialysis and address the issue in order to ensure adequate access to care. Empower remained deficient in rural Cardiothoracic Surgery, Dermatology, Neurosurgery, and Podiatry. Empower should continue to focus on these areas and ensure outreach to applicable providers has been conducted. Empower should determine the cause of network deficiencies in Plastic Surgery for urban and rural distance standards and address it.

Summit

Summit should re-evaluate the potential to secure contracts to correct network access deficiencies to ensure access to care. Summit should ensure accurate and complete reporting for analysis. In urban and rural counties, Diagnostic Radiology, Outpatient Infusion/Chemotherapy, and Pharmacy were not reported to Qsource, although they were reported to DHS. Summit should continue to focus on improving access to Cardiothoracic Surgery, Infectious Disease, Neurosurgery, and Vascular Surgery providers in urban counties as they remained deficient.

Summit should continue to focus on improving access to Dermatology, ENT/Otolaryngology, Gastroenterology, Infectious Disease, Neurosurgery, Plastic Surgery, Rheumatology, Urology, and Vascular Surgery in rural counties as they remained deficient. Summit should determine why the access to Substance Abuse Treatment Providers fell in both urban and rural counties compared to the previous measurement period. Although Summit reported strides in meeting standards for Outpatient Dialysis, it continued to be deficient by a significant margin. Summit should determine the barriers to meeting this standard and address them in order to ensure adequate access to care. Summit should ascertain the barriers to meeting the Outpatient Dialysis, Vascular Surgery, and Inpatient Psychiatric Facility for Individuals Under the Age of 21 ratio standards and address them.

Delta Dental

Delta Dental should continue to work on the individual dental specialties (Periodontists and Endodontists) which contributed to the low adequacy rating to ensure access to care for its enrollees.

MCNA

MCNA should continue to work on the individual dental specialties (Periodontists and Endodontists) which contributed to the low adequacy rating to ensure access to care for its enrollees.

Provider Access to Care Survey

Objectives

The PASSE Agreement with DHS establishes minimum requirements for access and availability of services and indicate that each PASSE must demonstrate that it has the capacity to serve the expected enrollment in accordance with DHS's standards for access and timeliness of care found in the PASSE Medicaid Manual, Section 226.000.

Per the contract, the DMO must maintain a provider network to ensure that all medically necessary covered services are available to enrollees on a timely basis, consistent with appropriate dental guidelines and quality metrics, with generally accepted practice parameters, and with the contract's requirements.

Qsource conducted an independent survey of providers to determine compliance with accessibility requirements.

Technical methods of Data Collection

Qsource used the most recent claims data provided by Optum for sampling. Prior to selecting each sample, Qsource examined claim types and selected providers who had at least one claim submitted during the measurement period (January 2021 through July 2021).

PASSE claims were classified into four categories: professional, institutional, pharmacy, and dental. Providers who submitted professional claims were further classified into five service categories: behavioral health, developmental disabilities, primary care physicians, OB/GYN, and other specialties.

Providers who submitted dental claims were classified into two service categories: primary care dentists and pediatric primary care dentists.

Duplicate records (those with the same Medicaid ID) were eliminated from the sample. A valid sample size was determined for each category. A random sampling technique was employed to select the samples. Exclusions were applied if a provider's phone number was not listed or if the provider was located outside of Arkansas, Missouri, Tennessee, Oklahoma, Texas, or Louisiana. Qsource sampled 10% of providers from each of these categories:

- Behavioral Health (PASSE)
- Developmental Disabilities (PASSE)
- Primary Care Physicians (PASSE)
- OB/GYN (PASSE)
- Primary Care Dentists (DMO)
- Pediatric Primary Care Dentists (DMO)
- Other Specialties (See Table 50 for PASSE provider types and Table 51 for DMO provider types)

Qsource also sampled 10% of all other provider types combined. The claim types and provider specialty codes used for sampling

are located in the *2021 Annual Network Adequacy Review Reports*.

Qsource call center staff were required to complete a training program prior to contacting providers. Staff also received the DHS-approved Provider Access to Care Survey script used for call completion and data collection. Qsource attempted to contact each provider up to three times by telephone to verify data. If three calls proved unsuccessful, the provider was considered non-responsive and recorded as such in the database. Obtaining the necessary information to complete the survey required less than five minutes of a provider's time.

Findings

There was a total of 1,693 provider calls made by the call center staff to conduct the survey. SAS software was used to conduct the analysis. For each data element as shown in the table below, the results were calculated by further filtering survey responses to eliminate missing or invalid responses for each question. The results presented in Table 59 reflect the percentage of those responding 'Yes' of the total number of responses for each category.

For the Wait Time for New Patient Appointments results, the responses were a fixed value or a range of days. For analysis purposes, the midpoint of the range was considered to replace the existing range to calculate the average value of the element.

The previous measurement year PASSE findings included a review of new patient availability by hospitals and pharmacies. DHS along with Qsource determined that those two provider types would not be included in this year's reporting. For MY 2021, Qsource included OB/GYN and Other provider specialties in the analysis.

Tables 59-66 present the results from the survey. The full survey is located in the *2021 Annual Network Adequacy Analysis Review Reports*.

The previous measurement year's results (MY 2020) are included for comparison, where applicable. Notable improvements from the previous measurement year are indicated using a green arrow (↑ **or** ↓) and notable decreases in performance are indicated using a red arrow (↓ **or** ↑).

Table 59. Providers Accepting New Patients: PASSE

Provider Type	ARTC		Empower		Summit	
	MY 2021 % Responding Yes	MY 2020 % Responding Yes	MY 2021 % Responding Yes	MY 2020 % Responding Yes	MY 2021 % Responding Yes	MY 2020 % Responding Yes
Behavioral Health	100%↑	87.5%	83.3%↓	87.5%	83.3%↓	87.5%
Developmental Disabilities	100%	100%	100%	100%	100%	100%
Primary Care Physicians	91.8%↑	75.0%	91.9%↑	74.1%	91.9%↑	74.7%
OB/GYN	85.7%	*	84.6%	*	91.7%	*
Others	94.5%	*	95.0%	*	94.8%	*

**Not reported in the 2020 report*

Table 60. Providers Accepting New Patients: DMO

Provider Type	Delta Dental		MCNA	
	MY 2021 % Responding Yes	MY 2020 % Responding Yes	MY 2021 % Responding Yes	MY 2020 % Responding Yes
Pediatric Primary Care Dentists	89.2%↓	93.0%	86.2%↓	94.4%
Primary Care Dentists	91.4%↑	90.0%	87.5%↑	86.5%

Table 61. Earliest New Patient Appointment Availability: PASSE

Provider Type	ARTC		Empower		Summit	
	MY 2021 Avg # of Days	MY 2020 Avg # of Days	MY 2021 Avg # of Days	MY 2020 Avg # of Days	MY 2021 Avg # of Days	MY 2020 Avg # of Days
Behavioral Health	24↑	8	25↑	7	25↑	8
Developmental Disabilities	9↓	16	9↓	16	9↓	16
Primary Care Physicians	17↑	10	16↑	9	16↑	9

Table 61. Earliest New Patient Appointment Availability: PASSE						
Provider Type	ARTC		Empower		Summit	
	MY 2021 Avg # of Days	MY 2020 Avg # of Days	MY 2021 Avg # of Days	MY 2020 Avg # of Days	MY 2021 Avg # of Days	MY 2020 Avg # of Days
OB/GYN	16	*	14	*	14	*
Others	8	*	9	*	9	*

**Not reported in the 2020 report*

Table 62. Earliest New Patient Appointment Availability: DMO				
Provider Type	Delta Dental		MCNA	
	MY 2021 Avg # of Days	MY 2020 Avg # of Days	MY 2021 Avg # of Days	MY 2020 Avg # of Days
Pediatric Primary Care Dentists	18↑	17	16↓	18
Primary Care Dentists	8↓	14	7↓	15

Table 63. Access to Service/Wait Time for Existing Patient Appointments: PASSE								
Provider Type/ Service Type	Time Frame Standard	Time Frame Goal	ARTC		Empower		Summit	
			% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met
Behavioral Health/Substance Abuse								
Urgent Care	Within 24 hours	100%	100%	Met	100%	Met	100%	Met
Routine, Non-Urgent, Non-Emergency Care	Within 21 calendar days	≥ 90%	50.0%	Not Met	50.0%	Not Met	50.0%	Not Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	100%	Met	100%	Met	100%	Met
Mobile Crisis Service/Mobile Crisis Response	Access 24 hours a day, 7 days a week	100%	75.0%	Not Met	75.0%	Not Met	75.0%	Not Met

Table 63. Access to Service/Wait Time for Existing Patient Appointments: PASSE								
Provider Type/ Service Type	Time Frame Standard	Time Frame Goal	ARTC		Empower		Summit	
			% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	100%	Met	100%	Met	100%	Met
OB/GYN								
Prenatal Care	Within 14 calendar days	≥ 90%	75.0%	Not Met	72.7%	Not Met	70.0%	Not Met
Urgent Care	Within 24 hours	100%	60.0%	Not Met	55.5%	Not Met	50.0%	Not Met
Routine, Non-Urgent, Non-Emergency Care	Within 60 calendar days	≥ 90%	100%	Met	100%	Met	100%	Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	85.7%	Not Met	84.6%	Not Met	83.3%	Not Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	84.6%	Not Met	83.3%	Not Met	81.8%	Not Met
Primary Care								
Urgent Care	Within 24 hours	100%	87.1%	Not Met	87.1%	Not Met	87.5%	Not Met
Routine, Non-Urgent, Non-Emergency Care	Within 21 calendar days	≥ 90%	90.3%	Met	90.3%	Met	90.6%	Met
Preventive visit/well visits	Within 30 calendar days	≥ 90%	90.3%	Met	90.3%	Met	90.6%	Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	100%	Met	100%	Met	100%	Met

Table 63. Access to Service/Wait Time for Existing Patient Appointments: PASSE								
Provider Type/ Service Type	Time Frame Standard	Time Frame Goal	ARTC		Empower		Summit	
			% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	96.8%	Met	96.8%	Met	96.9%	Met
Developmental Disabilities								
Urgent Care	Within 24 hours	100%	100%	Met	100%	Met	100%	Met
Routine, Non-Urgent, Non-Emergency Care	Within 21 calendar days	≥ 90%	100%	Met	100%	Met	100%	Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	100%	Met	100%	Met	100%	Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	50.0%	Not Met	50.0%	Not Met	50.0%	Not Met
All Other Specialties								
Urgent Care	Within 24 hours	100%	93.7%	Not Met	95.0%	Not Met	93.5%	Not Met
Routine, Non-Urgent, Non-Emergency Care	Within 60 calendar days	≥ 90%	93.1%	Met	93.8%	Met	93.9%	Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	79.0%	Not Met	79.5%	Not Met	79.7%	Not Met

Table 63. Access to Service/Wait Time for Existing Patient Appointments: PASSE								
Provider Type/ Service Type	Time Frame Standard	Time Frame Goal	ARTC		Empower		Summit	
			% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	76.4%	Not Met	76.5%	Not Met	76.9%	Not Met

Table 64. Access to Service/Wait Time for Existing Patient Appointments: DMO						
Provider Type/ Service Type	Time Frame Standard	Time Frame Goal	Delta Dental		MCNA	
			% Within Standard	Met/ Not Met	% Within Standard	Met/ Not Met
All Other Specialties						
Urgent Care	Within 24 hours	100%	93.1%	Not Met	91.9%	Not Met
Routine, Non-Urgent, Non-Emergency Care	Within 60 calendar days	≥ 90%	72.5%	Not Met	71.2%	Not Met
Emergency Care	Access 24 hours a day, 7 days a week	100%	74.3%	Not Met	77.1%	Not Met
After-Hours Care	Office number answered 24 hours / 7 days a week by answering service or instructions on how to reach a physician	≥ 90%	72.2%	Not Met	76.2%	Not Met

Table 65. Provider Satisfaction: PASSE			
Question	ARTC	Empower	Summit
	% Satisfactory Responses	% Satisfactory Responses	% Satisfactory Responses
Behavioral Health/Substance Abuse			
Outside of the services you provide, how would you rate the PASSE's coordination of additional care for your patients?	50.0%	50.0%	50.0%
How would you rate the ease of use of the PASSE plans' website or provider portal?	100.0%	100.0%	100.0%
What is your overall satisfaction with the PASSE plan?	50.0%	50.0%	50.0%
OB/GYN			
Outside of the services you provide, how would you rate the PASSE's coordination of additional care for your patients?	77.8%	75.0%	71.4%
How would you rate the ease of use of the PASSE plans' website or provider portal?	57.1%	66.7%	66.7%
What is your overall satisfaction with the PASSE plan?	77.8%	75.0%	71.4%
Primary Care			
Outside of the services you provide, how would you rate the PASSE's coordination of additional care for your patients?	70.4%	65.4%	66.7%
How would you rate the ease of use of the PASSE plans' website or provider portal?	60.0%	57.7%	57.7%
What is your overall satisfaction with the PASSE plan?	65.5%	63.0%	64.3%
Developmental Disabilities			
Outside of the services you provide, how would you rate the PASSE's coordination of additional care for your patients?	50.0%	50.0%	50.0%
How would you rate the ease of use of the PASSE plans' website or provider portal?	50.0%	50.0%	50.0%
What is your overall satisfaction with the PASSE plan?	50.0%	50.0%	50.0%
All other Specialties			
Outside of the services you provide, how would you rate the PASSE's coordination of additional care for your patients?	56.1%	55.8%	55.3%

Table 65. Provider Satisfaction: PASSE			
Question	ARTC	Empower	Summit
	% Satisfactory Responses	% Satisfactory Responses	% Satisfactory Responses
How would you rate the ease of use of the PASSE plans' website or provider portal?	57.5%	57.4%	55.7%
What is your overall satisfaction with the PASSE plan?	59.5%	59.0%	57.6%

Table 66. Provider Satisfaction: DMO		
Question	Delta Dental	MCNA
	% Satisfactory Responses	% Satisfactory Responses
Dental Providers		
Outside of the services you provide, how would you rate the DMO's coordination of additional care for your patients?	71.4%	72.7%
How would you rate the ease of use of the DMO plans' website or provider portal?	83.7%	84.1%
What is your overall satisfaction with the DMO plan?	77.1%	79.5%

Conclusions

ARTC

The majority of all provider types responded that they were accepting new patients. Of the 14 OB/GYNs that responded, 85.7% were accepting new patients. All providers improved or maintained the percentage of accepting new patients from the previous measurement year.

Behavioral Health providers reported an average of 24 days for the earliest new patient appointment. Primary Care Physicians and OB/GYN providers reported just over two weeks at 17 and 16 days, respectively. Developmental Disabilities providers reported an average of nine days. The average number of days for a new patient appointment increased significantly for Behavioral Health providers and Primary Care Physicians compared to the previous measurement year, while it decreased for Developmental Disabilities providers.

Wait times ranged from four days to 13 days. Developmental Disabilities providers and Others both had the least median wait time (4 days) while OB/GYN providers' response was 13 days. The median number of days for a new patient appointment decreased compared to the previous measurement year for all provider types.

Behavioral Health providers met three of the time frame standards, falling short for non-emergency care and mobile crisis service. OB/GYN providers met one of the five time frame standards – non-emergency care. Primary Care providers met four time frame standards, falling short for urgent care. Developmental Disabilities providers met three of four time frame standards, with rates for after-hours care falling below. For Other Specialties, only the non-emergency care time frame standard was met.

Overall, 12 out of 23 elements were met for the Access to Service/Wait Time for Existing Patient Appointments standard resulting in a moderate adequacy rating.

Few Behavioral Health providers responded to the survey questions. Of those who responded, 50.0% reported overall satisfaction with ARTC. For OB/GYN providers, 77.8% reported overall satisfaction and 57.1% reported the website and provider portal were easy to use. Primary Care providers reported 65.5% overall satisfaction with ARTC and 70.4% reported satisfaction with the care coordination for their patients. Of the few Developmental Disabilities providers that responded, they reported 50% satisfaction overall as well as 50% satisfaction for both care coordination and ARTC's website/portal. For Other Specialties, 59.5% reported overall satisfaction with ARTC and 57.5% reported satisfaction with ARTC's website and provider portal.

Empower

For the provider types surveyed, the results ranged from 83.3% to 100%. Behavioral Health scored the lowest at 83.3% followed by OB/GYN providers at 84.6%. Compared to the previous

measurement year, Behavioral Health providers reported a decrease in the percentage of accepting new patients, while Primary Care Physicians reported a significant increase.

The earliest new patient average appointment availability ranged from nine to 25 days. Developmental Disabilities providers and Others responded with an average of nine days while Behavioral Health providers responded with an average of 25 days. Behavioral Health providers and Primary Care Physicians reported a significant increase in the average number of days for a new patient appointment compared to the previous measurement year, while Developmental Disabilities providers reported a decrease.

Wait times ranged from four days to 16 days. Developmental Disabilities providers and Others had the least wait time while Behavioral Health providers' response was 16 days. Primary Care Physicians and OB/GYN reported five and nine days, respectively. Behavioral Health providers reported an increase in the median number of days for new patient appointments, while Developmental Disabilities providers and Primary Care Physicians reported a significant decrease compared to the previous measurement year.

Behavioral Health providers met three of the time frame standards, falling short for non-emergency care and mobile crisis service. OB/GYN providers met one of the five time frame standards – non-emergency care. Primary Care providers met four time frame standards, falling short for urgent care. Developmental Disabilities providers met three of four time frame standards, with rates for after-hours care falling below. For Other Specialties, only the non-emergency care time frame standard was met.

Overall, 12 out of 23 elements were met for the Access to Service/Wait Time for Existing Patient Appointments standard resulting in a moderate adequacy rating.

Few Behavioral Health providers responded to the survey questions. Of those who responded, 50.0% reported overall satisfaction with Empower. For OB/GYN providers, 75.0% reported overall satisfaction and 66.7% reported the website and provider portal were easy to use. Primary Care providers reported 63.0% overall satisfaction with Empower and 65.4% reported satisfaction with the care coordination for their patients. Of the few Developmental Disabilities providers that responded, they reported 50% satisfaction overall as well as 50% satisfaction for both care coordination and Empower's website/portal. For Other Specialties, 59.0% reported overall satisfaction with Empower and 57.4% reported satisfaction with Empower's website and provider portal.

Summit

For the provider types surveyed, the results ranged from 83.3% to 100%. Behavioral Health providers scored the lowest at 83.3% followed by OB/GYN providers at 91.7%. Compared to the previous measurement year, Behavioral Health providers

reported a decrease in the percentage of accepting new patients, while Primary Care Physicians reported a significant increase.

The earliest new patient average appointment availability ranged from nine to 25 days. Developmental Disabilities providers and Others responded with an average of nine days while Behavioral Health providers responded with an average of 25 days. Behavioral Health providers and Primary Care Physicians reported a significant increase in the average number of days for a new patient appointment compared to the previous measurement year, while Developmental Disabilities providers reported a decrease.

Wait times ranged from four days to 16 days. Developmental Disabilities providers and Others had the least wait time while Behavioral Health providers' response was 16 days. Primary Care Physicians and OB/GYN reported five and nine days, respectively. Behavioral Health providers reported an increase in the median number of days for new patient appointments, while Developmental Disabilities providers and Primary Care Physicians reported a significant decrease compared to the previous measurement year.

Behavioral Health providers met three of the time frame standards, falling short for non-emergency care and mobile crisis service. OB/GYN providers met one of the five time frame standards – non-emergency care. Primary Care providers met four time frame standards, falling short for urgent care. Developmental Disabilities providers met three of four time frame standards, with rates for after-hours care falling below. For Other Specialties, only the non-emergency care time frame standard was met.

Overall, 12 out of 23 elements were met for the Access to Service/Wait Time for Existing Patient Appointments standard resulting in a moderate adequacy rating.

Few Behavioral Health providers responded to the survey questions. Of those who responded, 50.0% reported overall satisfaction with Summit. For OB/GYN providers, 71.4% reported overall satisfaction and 66.7% reported the website and provider portal were easy to use. Primary Care providers reported 64.3% overall satisfaction with Summit and 66.7% reported satisfaction with the care coordination for their patients. Of the few Developmental Disabilities providers that responded, they reported 50% satisfaction overall as well as 50% satisfaction for both care coordination and Summit's website/portal. For Other Specialties, 57.6% reported overall satisfaction with Summit and 55.7% reported satisfaction with Summit's website and provider portal.

Delta Dental

While Pediatric Primary Care Dentists responded with a higher rate of accepting new patients, this provider type had on average, a longer wait period for Earliest New Patient Appointment Availability than Primary Care Dentists. The rate of Pediatric Primary Care Dentists accepting new patients was lower than the

previous measurement year, while the rate for Primary Care Dentists was improved.

The average earliest new patient appointment availability for Pediatric Primary Care Dentists was 18 days and for Primary Care Dentists it was eight days. Primary Care Dentists reported significantly lower wait times for a new patient appointment than the previous measurement year.

The median number of days for a new patient appointment for Pediatric Primary Care Dentists was three days, while it was five days for Primary Care Dentists. Both provider types reported a significant reduction compared to the previous measurement year.

None of the elements were met for the Access to Service/Wait Time for Existing Patient Appointments standard resulting in a no adequacy rating. DHS's Quality Strategy identified these metrics, among others, as a method to achieve Goal 2: Improve access to needed services and safety for all enrollees. These standards specifically related to Objective 2.1: Improve access to appropriate dental series through network adequacy. Delta Dental did not report these measures in PMV, and the provider responses reflected a failed score for these measures. DHS should review tracking and monitoring processes with Delta Dental to ensure they can meet targets for emergency and urgent dental care.

Of the dental providers who responded to the survey, 71.4% reported satisfaction with the coordination of care for their patients. A majority of dental providers reported satisfaction with Delta Dental's website and provider portal (83.7%). Overall satisfaction with Delta Dental was reported at 77.1%.

MCNA

The percentage of Pediatric Primary Care Dentists accepting new patients was 86.2% and lower than Primary Care Dentists at 87.5%. Pediatric Primary Care Dentists reported a significant decrease in accepting new patients from the previous measurement year.

The Pediatric Primary Care Dentists responded that the average number of days to obtain the earliest new patient appointment was 16 days and higher than the average for Primary Care Dentists at seven days. Both provider types reported lower wait times for a new patient appointment than the previous measurement year.

The median number of days for a new patient appointment for Pediatric Primary Care Dentists was three days and for Primary Care Dentists it was five days. Both provider types reported a significant reduction compared to the previous measurement year.

None of the elements were met for the Access to Service/Wait Time for Existing Patient Appointments standard resulting in a no adequacy rating. DHS's Quality Strategy identified these metrics, among others, as a method to achieve Goal 2: Improve access to needed services and safety for all enrollees. These standards specifically related to Objective 2.1: Improve access

to appropriate dental series through network adequacy. MCNA did not report these measures in PMV, and the provider responses reflected a failed score for these measures. DHS should review tracking and monitoring processes with MCNA to ensure they can meet targets for emergency and urgent dental care.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

PASSE

Qsource had the same recommendations for each of the PASSEs. The PASSEs should encourage providers to participate in the EQRO's survey to increase data collected for improvement decisions. They should explore the causes of comparatively long wait times for new appointments with Behavioral Health providers to improve access to care. The PASSEs should communicate time frame goals to all providers to improve access to care. They should focus on overall provider satisfaction and ways to increase it.

DMO

Qsource had the same recommendations for each of the DMOs. The DMOs should continue to evaluate the access and availability of pediatric dentists with respect to appointment availability to improve access to care. The DMOs should determine why the percentage of adult and pediatric primary care dentists accepting new patients has decreased since MY 2020 to ensure access to care.

Enrollee and Provider Satisfaction Surveys and Complaints

Objectives

Per the PASSE Medicaid Manual, Section 248.210, and pursuant to Act 775 of the 2017 Arkansas General Session, the PASSE was responsible for reporting to DHS on a quarterly basis, the satisfaction scores from the PASSE administered enrollee satisfaction survey. The PASSE Agreement, Section 8.6.5, states DHS will collect the results of any enrollee satisfaction survey conducted by the PASSE to improve the performance of its managed care program.

The DMOs were responsible for reporting the satisfaction scores from the enrollee satisfaction survey to DHS. DHS collected the results of enrollee satisfaction surveys conducted by the DMOs to improve the performance of its managed care program.

DHS asked that Qsource review the patient satisfaction surveys and complaints, together with processes for handling complaints and issue resolution as part of the evaluation of network adequacy. DHS asked that Qsource use information collected from the enrollee and provider surveys to determine if services were provided in accordance with PCSPs and were provided timely. Qsource reviewed and summarized the enrollee and provider satisfaction survey results from the PASSEs and DMOs for 2020. Delta Dental did not conduct satisfaction surveys in 2020. Qsource will provide technical assistance to Delta Dental to implement both enrollee and provider satisfaction surveys in 2022.

Technical Methods of Data Collection

Qsource used the satisfaction survey data reported by the PASSEs and DMOs and summarized the results for this report. Both the enrollee and provider surveys looked at multiple aspects of care. Qsource reviewed the surveys for questions that related to complaints and issue resolution as well as timeliness, quality, and access to care. While there were no questions in the enrollee satisfaction surveys regarding complaints and issue resolution, there were questions in the Provider Satisfaction Surveys that speak to this aspect of care. Those findings were included in this report. There were no questions specifically regarding whether services were provided in accordance with Patient-Centered Service Plans (PCSPs) in either survey. However, Qsource analyzed and presented results for timelines, quality, and access to care from both enrollee and provider satisfaction surveys. The full surveys are located in the *2021 Annual Network Adequacy Review Reports*.

Findings

Each PASSE/DMO satisfaction survey varied. Qsource reviewed the surveys for questions that related to complaints and issue resolution as well as timeliness, quality, and access to care. The specific survey results are located in the *2021 Annual Network Adequacy Analysis Review Reports*.

ARTC

Tables 67-68 present selected annual survey results for enrollee satisfaction for ARTC. ARTC reported that 9,386 surveys were sent out and 838 surveys were completed. That resulted in an 8.93% response rate for ARTC's enrollee satisfaction surveys.

Table 67. Enrollee Satisfaction – Timeliness of Care: ARTC

Survey Question	Satisfactory	Unsatisfactory
If it was a scheduled call or meeting, did your Care Coordinator arrive for call on time?	88.46%	11.54%
If you had contact with your Care Coordinator in the last three months and follow-up was required did they follow up with you in a timely manner?	84.10%	15.90%

Table 68. Enrollee Satisfaction – Quality and Access to Care: ARTC

Survey Question	Satisfactory	Unsatisfactory
If you have tried to reach your Care Coordinator in the past three months, were you able to reach them?	85.08%	14.92%
If you had contact with your Care Coordinator in the last three months, were they prepared and able to assist you with your questions and needs?	93.73%	6.27%

Table 68. Enrollee Satisfaction – Quality and Access to Care: ARTC

Survey Question	Satisfactory	Unsatisfactory
If you had contact with your Care Coordinator in the last three months, were you able to understand the information they gave you?	95.35%	4.65%
If you had contact with your Care Coordinator in the last three months, were there any questions or concerns that they were not able to assist you with?	82.33%	17.67%
Are you satisfied with the services you have received from your Care Coordinator in the last three months?	94.97%	5.03%

Tables 69-73 present selected annual survey results for provider satisfaction for ARTC. ARTC reported that 2,000 surveys were sent out and 142 surveys were completed. That resulted in a 7.1% response rate for ARTC's provider satisfaction surveys.

Table 69. Overall Provider Satisfaction: ARTC

Question	Satisfactory	Unsatisfactory
How would you rate Arkansas Total Care compared to all other health plans you contract with?	85.40%	14.6%
Overall satisfaction with health plan's call center staff	92.65%	7.35%

Table 69. Overall Provider Satisfaction: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
Using any number from 1 to 5, where 1 is not very likely and 5 is very likely, how likely would you be to recommend Arkansas Total Care to other physicians' practices?	84.17%	15.83%
Please rate your overall satisfaction with each of the following health plans: Arkansas Total Care	89.63%	10.37%
What is your overall satisfaction with Arkansas Total Care (Medicaid)?	88.15%	11.85%

Table 70. Provider Satisfaction – Timeliness of Care: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
Timeliness of claims processing	90.70%	9.30%
Timeliness of obtaining pre-certification/referral/authorization information	86.18%	13.82%
The timeliness of feedback/reports from specialists in this health plan's provider network	90.60%	9.40%
The timeliness of feedback/reports from Behavioral Health Clinicians for patients in your care	90.27%	9.73%

Table 71. Provider Satisfaction – Access to Care: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
Access to knowledgeable UM staff	90.08%	9.92%
Procedures for obtaining pre-certification/referral/authorization information	86.40%	13.60%
Access to Case/Care Managers from this health plan	84.03%	15.97%
The number of specialists in this health plan's provider network	90.91%	9.09%
Variety of branded drugs on the formulary	90.57%	9.43%
Ease of prescribing your preferred medications within formulary guidelines	90.38%	9.62%
Availability of comparable drugs to substitute those not included in the formulary	89.42%	10.58%
Ease of reaching health plan call center staff over the phone	90.08%	9.92%

Table 72. Provider Satisfaction – Quality of Care: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
The health plan's facilitation/support of appropriate clinical care for patients	91.74%	8.26%
Degree to which the plan covers and encourages preventive care and wellness	94.12%	5.88%

Table 72. Provider Satisfaction – Quality of Care: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
The quality of specialists in this health plan's provider network	92.56%	7.44%
Extent to which formulary reflects current standards of care	90.35%	9.65%
Helpfulness of health plan call center staff in obtaining referrals for patients in your care	89.52%	10.48%
Quality of online tools supporting the delivery of patient-centered, quality care	94.31%	5.69%
Quality of online tools supporting core business functions such as claims, eligibility, and prior authorizations	96.75%	3.25%

Table 73 Provider Satisfaction – Denials and Issue Resolution: ARTC		
Question	**Satisfactory**	**Unsatisfactory**
Resolution of claims payment problems or disputes	80.49%	19.51%
Extent to which UM staff share review criteria and reasons for adverse determinations	91.45%	8.55%
Consistency of review decisions	94.12%	5.88%

Empower

Tables 74-77 present selected annual survey results for enrollee satisfaction for Empower. Empower reported the total number of surveys sent out for adults was 1,347 with 299 returned, resulting in a 22.2% response rate. The total number sent out for children was 1,648 with 229 surveys returned, resulting in a 13.9% response rate.

Table 74. Enrollee Satisfaction – Timeliness of Care: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?	96.77%	3.23%
In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	98.13%	1.87%

Table 75. Enrollee Satisfaction – Quality of Care: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	92.09%	7.91%

Table 75. Enrollee Satisfaction – Quality of Care: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?	88.51%	11.49%
We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	74.59%	25.51%
In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	97.44%	2.56%

Table 76. Enrollee Satisfaction – Access to Care: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	95.45%	4.55%
In the last 6 months, how often was it easy to get this therapy for your child?	84.75%	15.25%

Table 76. Enrollee Satisfaction – Access to Care: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	91.53%	8.47%

Table 77. Overall Enrollee Satisfaction: Empower		
Survey Question	**Satisfactory**	**Unsatisfactory**
Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	78.93%	21.07%
Using any number from 0 to 10, where 0 is not at all likely and 10 is extremely likely, based on your overall experience with Empower, how likely are you to recommend Empower to your family or friends?	69.66%	30.34%

Tables 78-82 present selected annual survey results for provider satisfaction for Empower. Empower reported a 15% response rate.

Table 78. Overall Provider Satisfaction: Empower		
Question	**Satisfactory**	**Unsatisfactory**
How would you rate Empower Healthcare Solutions compared to all other health plans you contract with?	21.70%	78.30%
Overall satisfaction with health plan's call center staff	25.30%	74.70%
On a scale of zero to ten, how likely are you to recommend Empower Healthcare Solutions to a friend or colleague?	29.90%	70.10%
What is your overall satisfaction with Empower Healthcare Solutions?	57.00%	43.00%

Table 79. Provider Satisfaction – Timeliness of Care: Empower		
Question	**Satisfactory**	**Unsatisfactory**
Timeliness of claims processing	23.20%	76.80%
Timeliness of obtaining pre-certification/referral/authorization information	20.00%	80.00%
The timeliness of feedback/reports from specialists in this health plan's provider network	17.10%	82.90%
The timeliness of feedback/reports from Behavioral Health Clinicians for patients in your care	12.50%	87.50%

Table 80. Provider Satisfaction – Access to Care: Empower		
Question	**Satisfactory**	**Unsatisfactory**
Access to knowledgeable UM staff	17.00%	83.00%
Procedures for obtaining pre-certification/referral/authorization information	19.10%	80.90%
Access to Case/Care Managers from this health plan	20.20%	79.80%
The number of specialists in this health plan's provider network	15.00%	85.00%
The number of behavioral health providers in this health plan's provider network	13.90%	86.10%
Variety of branded drugs on the formulary	8.70%	91.30%
Ease of prescribing your preferred medications within formulary guidelines	9.40%	90.60%
Availability of comparable drugs to substitute those not included in the formulary	8.00%	92.00%
Ease of reaching health plan call center staff over the phone	26.40%	73.60%

Table 81. Provider Satisfaction – Quality of Care: Empower		
Question	**Satisfactory**	**Unsatisfactory**
The health plan's facilitation/support of appropriate clinical care for patients	19.10%	80.90%

Table 81. Provider Satisfaction – Quality of Care: Empower		
Question	**Satisfactory**	**Unsatisfactory**
Degree to which the plan covers and encourages preventive care and wellness	19.80%	80.2%
The quality of specialists in this health plan's provider network	23.60%	76.40%
The quality of behavioral health providers in this health plan's provider network	17.70%	82.30%
Extent to which the formulary reflects current standards	8.90%	91.10%
Helpfulness of health plan call center staff in obtaining referrals for patients in your care	24.30%	75.70%

Table 82. Provider Satisfaction – Denials and Issue Resolution: Empower		
Question	**Satisfactory**	**Unsatisfactory**
Resolution of claims payment problems or disputes	19.00%	81.00%

Summit

Tables 83-86 present selected annual survey results for adult enrollee satisfaction for Summit. Summit reported the response rate for the adult survey was 30.80% and 16.29% for the child survey.

Table 83. Enrollee Satisfaction – Timeliness of Care: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	88.59%	11.41%
In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	86.21%	13.73%
In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?	82.27%	17.73%

Table 84. Enrollee Satisfaction – Quality of Care: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last 6 months?	56.82%	43.18%
In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	92.23%	7.77%
In the last 6 months, how often did your personal doctor listen carefully to you?	92.21%	7.79%

Table 84. Enrollee Satisfaction – Quality of Care: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often did your personal doctor show respect for what you had to say?	93.45%	6.55%
In the last 6 months, how often did your personal doctor spend enough time with you?	91.91%	8.09%
In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	82.49%	17.51%
Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	82.88%	17.12%
In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	95.81%	4.19%

Table 85. Enrollee Satisfaction – Access to Care: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	87.73%	12.27%

Table 85. Enrollee Satisfaction – Access to Care: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	89.25%	10.75%

Table 86. Overall Enrollee Satisfaction: Summit		
Survey Question	**Satisfactory**	**Unsatisfactory**
Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	70.41%	29.59%

Tables 87-91 present selected annual survey results for provider satisfaction for Summit. Summit reported an 8% response rate.

Table 87. Overall Provider Satisfaction: Summit		
Question	**Satisfactory**	**Unsatisfactory**
Please rate your satisfaction with efficiency of the Summit Community Care Utilization Management process overall.	62.65%	37.35%
Would you recommend the Summit Community Care DM program(s) to other providers?	62.22%	37.78%

Table 87. Overall Provider Satisfaction: Summit		
Question	**Satisfactory**	**Unsatisfactory**
How does the Summit Community Care continuity and coordination of care compare to other Medicaid/Medicare Advantage plans?	24.32%	75.68%
If you were able to recommend Summit Community Care to your patients, would you?	42.06%	57.94%
Would you recommend Summit Community Care to other providers?	42.45%	57.55%
Please rate your overall satisfaction with Summit Community Care.	56.07%	49.93%

Table 88. Provider Satisfaction – Timeliness of Care: Summit		
Question	**Satisfactory**	**Unsatisfactory**
Timeliness of claims processing	72.48%	27.52%
Timeliness of the medical director's response to your concerns	59.74%	40.26%
Timeliness of information exchange for the coordination of medical and behavioral health care	60.23%	39.77%

Table 89. Provider Satisfaction – Access to Care: Summit		
Question	**Satisfactory**	**Unsatisfactory**
Please rate your satisfaction with obtaining precertification and/or authorization for Summit Community Care members.	61.76%	38.24%
Please rate your experience in the sufficiency of information to coordinate care.	57.65%	42.35%

Table 90. Provider Satisfaction – Quality of Care: Summit		
Question	**Satisfactory**	**Unsatisfactory**
Please rate your experience with the usefulness of the DM program in the telephonic assistance provided by staff.	70.18%	29.82%
Please rate your experience with the usefulness of the DM program in the member interventions by staff.	72.34%	27.66%
Please rate your experience with the usefulness of the DM program in the communications provided by DM case managers.	71.43%	28.57%
Please rate your satisfaction with helpfulness of staff providing DM services.	73.08%	26.92%
Please rate your experience with the helpfulness of Clinical Practice Guidelines in managing your patients.	67.92%	32.08%

Table 90. Provider Satisfaction – Quality of Care: Summit		
Question	**Satisfactory**	**Unsatisfactory**
Please rate your experience in the accuracy of information exchange for the coordination of medical and behavioral health care.	59.09%	40.91%
Please rate your experience in the clarity of information exchange for the coordination of medical and behavioral health care.	61.36%	38.64%
Please rate your experience with the quality of case management services regarding continuity and coordination of care.	57.75%	42.25%

Table 91. Provider Satisfaction – Denials and Issue Resolution: Summit		
Question	**Satisfactory**	**Unsatisfactory**
How satisfied are you with the clarity of the remittance advice?	77.06%	22.94%
Please rate your overall satisfaction with the provider complaint systems.	40.19%	59.81%

Delta Dental

Enrollee and provider satisfaction surveys were not conducted in 2020. Qsource will provide technical assistance for Delta Dental to implement both enrollee and provider satisfaction surveys in 2022.

MCNA

Tables 92-93 present selected annual survey results for enrollee satisfaction for MCNA. MCNA reported a total of 178 enrollee survey responses.

Table 92. Enrollee Satisfaction – Timeliness of Care: MCNA		
Survey Question	**Satisfactory**	**Unsatisfactory**
Did you get the care that you needed in a timely manner?	98.65%	1.35%
Were you satisfied with the time you had to wait to see the dentist on your last visit?	98.32%	1.68%
If you had to see a specialist, were you able to get an appointment in a timely manner?	98.92%	1.08%
If you had a referral or authorization to a different dentist, was it processed in a timely manner?	97.66%	2.34%

Table 93. Enrollee Satisfaction – Quality and Access to Care: MCNA		
Survey Question	**Satisfactory**	**Unsatisfactory**
Did the dentist explain your dental condition and needed treatment?	98.90%	1.10%
Did the dentist explain your covered benefits before starting treatment?	95.32%	4.68%
Was the dentist office staff courteous and helpful?	99.50%	0.50%

Table 93. Enrollee Satisfaction – Quality and Access to Care: MCNA		
Survey Question	**Satisfactory**	**Unsatisfactory**
Did the dentist staff speak your language?	98.99%	1.01%
Is MCNA's member services representatives courteous and helpful?	99.88%	0.12%
How would you rate your overall level of satisfaction with your recent visit to a MCNA dentist?	98.68%	1.32%

Tables 94-97 present selected annual survey results for provider satisfaction. MCNA reported a total of 159 provider survey responses.

Table 94. Overall Provider Satisfaction: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Overall experience with MCNA?	96.31%	3.69%
I would recommend MCNA to other providers.	96.50%	3.50%

Table 95. Provider Satisfaction – Timeliness of Care: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Timeliness of claims payment	93.18%	6.82%
Responded to your inquiry promptly	97.40%	2.60%
Resolved inquiry in a timely manner	97.45%	2.55%

Table 95. Provider Satisfaction – Timeliness of Care: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Timeliness of Pre-Authorization Process	93.96%	6.04%

Table 96. Provider Satisfaction – Quality and Access to Care: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Accuracy of claims payment	95.90%	4.10%
Knowledge/accuracy of response to telephone inquiries	92.45%	7.55%
Ease of submitting electronic claims	97.91%	2.09%
Accuracy of remittance advice (EOB)	96.37%	3.63%
Provider representative was knowledgeable	98.08%	1.92%
Provider representative provided courteous service	99.75%	0.25%
MCNA provide accurate, complete information on the plan	97.71%	2.29%
Your staff received adequate orientation to MCNA procedures	99.62%	0.38%
Your staff receives ongoing training that is effective and useful	98.57%	1.43%
Accessibility of MCNA's dental director	92.11%	7.89%

Table 96. Provider Satisfaction – Quality and Access to Care: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Provides accurate eligibility information on the phone	93.66%	6.34%

Table 97. Provider Satisfaction – Denials and Issue Resolution: MCNA		
Question	**Satisfactory**	**Unsatisfactory**
Resolution of unpaid/rejected claims	94.74%	5.26%
Timeliness of appeal process	90.00%	10.00%

Strengths and Weaknesses

Tables 98-99 present the strengths and weaknesses identified by the analysis of both enrollee and provider satisfaction surveys.

Table 98. MY 2020 Satisfaction Surveys Strengths
ARTC

- Enrollees reported high rates of satisfaction regarding services received from Care Coordinators, understanding the information given by Care Coordinators, and the level of assistance provided by them.
- Providers reported high overall satisfaction with ARTC's call center staff.
- Providers appear to be mostly satisfied with timeliness factors related to working with ARTC.
- For access questions, providers reported moderately high rates of satisfaction regarding access to knowledgeable utilization management (UM) staff, the number of specialists in the provider network, the variety of branded drugs on the formulary, ease of prescribing preferred medications within formulary guidelines, and ease of reaching ARTC's call center staff over the phone.
- Providers also reported moderately high rates of satisfaction regarding all of the quality of care questions, especially the quality of online tools supporting core business functions such as claims, eligibility, and prior authorizations (96.75%).
- For denials and issue resolution, providers reported being mostly satisfied with the extent to which UM staff share review criteria and reasons for adverse determinations and the consistency of review decisions.

Table 98. MY 2020 Satisfaction Surveys Strengths
Empower

- Enrollees reported high rates of satisfaction regarding the timeliness of care provided to their children and the quality of care in regard to informative providers and helpful customer service staff. Enrollees also reported satisfaction with access to care, testing, and treatment for their children.

Table 98. MY 2020 Satisfaction Surveys Strengths
Summit

- Enrollees reported high rates of satisfaction regarding the timeliness of care provided.
- For quality of care questions, enrollees reported satisfaction with their care, except when rating their overall health care in the past six months (56.82%).
- Enrollees also reported satisfaction with helpful customer service and access to care, testing, and treatment.
- Providers appear to be moderately satisfied with timeliness factors related to working with Summit.
- Providers reported moderate rates of satisfaction regarding the quality of care questions.

Table 98. MY 2020 Satisfaction Surveys Strengths
MCNA
♦ Enrollees reported high rates of satisfaction regarding receiving care in a timeline manner, access to specialist care in a timely manner, and dental staff being helpful and courteous.
♦ Enrollees reported a high overall satisfaction with MCNA.
♦ Overall provider satisfaction scores ranged from 90.00% to 99.75%.
♦ Providers reported high overall satisfaction with MCNA's staff, providing knowledgeable and courteous service.
♦ Providers appeared to be mostly satisfied with timeliness factors related to working MCNA.
♦ Providers reported high satisfaction with orientation and training provided by MCNA.
♦ Providers reported being mostly satisfied with quality and access factors related to working with MCNA. For denials and issue resolution, providers reported being mostly satisfied.

Table 99. MY 2020 Satisfaction Surveys Weaknesses
ARTC
♦ ARTC reported that 9,386 enrollee surveys were sent out and 838 surveys were completed, resulting in an 8.93% response rate.
♦ Enrollees reported lower rates of satisfaction regarding Care Coordinators arriving on time and following up in a timely manner after a meeting.
♦ ARTC reported that 2,000 provider surveys were sent out and 142 surveys were completed, resulting in a 7.1% response rate.
♦ Providers reported lower rates of overall satisfaction with ARTC including the likelihood of recommending ARTC to other providers.

Table 99. MY 2020 Satisfaction Surveys Weaknesses
♦ The lowest rate of provider satisfaction regarding timeliness was obtaining pre-certification/ referral/authorization information from ARTC in a timely manner (86.18%).
♦ The lowest rate of provider satisfaction regarding access was with case/care managers working for ARTC (84.03%).
♦ The highest rate of provider dissatisfaction was in regard to the resolution of claims payment problems or disputes with ARTC (80.49%).
Empower
♦ Empower reported the total number of surveys sent out for adults was 1,347, resulting in a 22.2% response rate.
♦ Empower reported the total number of surveys sent out for children was 1,648, resulting in a 13.9% response rate.
♦ Enrollees reported low rates of satisfaction regarding care provided by specialists and access to therapy for their children.
♦ Empower reported a 15% response rate for provider surveys.
♦ Providers appeared to be mostly dissatisfied with timeliness factors related to working with Empower.
♦ For access questions, providers reported low rates of satisfaction regarding medications on the formulary.
♦ Overall provider satisfaction scores ranged from 8.00% to 57.00%. Providers reported lower rates of overall satisfaction with Empower, especially in regard to recommending Empower to other providers.
♦ The lowest rate of satisfaction for timeliness was regarding the timeliness of feedback/reports from Behavioral Health Clinicians (17.10%).
♦ The lowest rate of satisfaction for access to care was regarding availability of comparable drugs to substitute those not included in the formulary (8.00%).
♦ The lowest rate of satisfaction for quality of care was regarding the Extent to which the formulary reflects current standards (8.90%).

Table 99. MY 2020 Satisfaction Surveys Weaknesses
♦ Providers appeared to be relatively dissatisfied regarding the resolution of claims payment problems or disputes with Empower (19.00%).
Summit
♦ Summit reported the response rate for the adult survey was 30.80% and 16.29% for the child survey.
♦ Enrollees reported low rates of satisfaction regarding quality of health care.
♦ Summit reported an 8% response rate for provider surveys.
♦ Overall provider satisfaction scores ranged from 24.32% to 77.06%, with the majority of scores being in the 50% to 70% range.
♦ The lowest rate of provider satisfaction regarding timeliness was responsiveness of the medical director to concerns (59.74%).
♦ The lowest rate of provider satisfaction regarding access was receiving sufficient information for care coordination (57.65%).
♦ The lowest rate of provider satisfaction regarding quality was case management services for continuity and coordination of care (57.75%).
♦ Providers reported being dissatisfied with the provider complaint systems in place for Summit (40.19%).
MCNA
♦ MCNA reported a total of 178 enrollee survey responses.
♦ MCNA reported a total of 159 provider survey responses.
♦ Providers reported lower satisfaction rates regarding the timeliness of claims payment and pre-authorization process.
♦ Providers reported lower satisfaction rates regarding the timeliness of the appeal process.
♦ The lowest rate of satisfaction for timeliness was regarding the timeliness of claims payment (93.18%).

Table 99. MY 2020 Satisfaction Surveys Weaknesses
♦ The lowest rate of satisfaction for quality and access to care was regarding the accessibility of MCNA's dental director (92.11%).
♦ The highest rate of dissatisfaction for denials and issue resolution was in regard to the timeliness of the appeals process (90.00%).

Complaints and Issue Resolution

DHS requested that Qsource review the processes for handling complaints and issue resolution in regard to the enrollee satisfaction surveys. While no questions in the enrollee satisfaction surveys addressed complaints directly, this was evaluated in the *2021 Compliance Assessment Report*. See *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* for more details.

The EQR surveyors began assessment of grievances and appeals by reviewing documentation from the PASSEs and DMOs that details its complaints, grievances, and appeals processes. Each PASSE and DMO must have specific and meaningful procedures in place for timely resolution of complaints and grievances between enrollees and the PASSE/DMO. Documentation was critical to prove that the PASSE/DMO resolves complaints and grievances with thoughtful consideration of the issues in a timely manner. Policy and procedures, quality committee meetings, and analytic reports were all documentation that assisted the surveyor in the review. In addition, live demonstrations in the review along with staff interviews gave surveyors an understanding of how the

processes and systems interface to ensure coordination throughout the life of the complaint or grievance. It was important the PASSEs and DMOs captured dates and times with a clear audit trail in order for surveyors to understand the entire workflow process.

Within the scope of the Compliance Assessment, each PASSE and DMO was subjected to a review of the Grievance and Appeals standard. Each PASSE and DMO was asked to present documented evidence of its complaints, grievances, and appeals processes and were expected to answer questions and give additional insight during the review.

ARTC scored 98.39% on the Grievance and Appeals standard and scored 100% on both the Grievances and Appeals file reviews. Empower scored 100% on the Grievance and Appeals standard and scored 100% on both the Grievances and Appeals file reviews. Summit scored 100% on the Grievance and Appeals standard and scored 100% on both the Grievances and Appeals file reviews. Delta Dental scored 100% on the Grievance and Appeals standard and scored 100% on both the Grievances and Appeals file reviews. MCNA scored 100% on the Grievance and Appeals standard and scored 100% on both the Grievances and Appeals file reviews.

Each PASSE and DMO produced, as evidence, current policy and procedure which gave specific requirements, timetables, and responsibilities for staff in the processing and resolution of complaints, grievances, and appeals. Complaints were considered the initial step of the process with the majority of complaints coming through enrollee relations and care coordinator staff. If unresolved, the complaint transitioned into a grievance and was the responsibility of the Grievance and Appeal team.

Conclusions

ARTC

Enrollees reported high rates of satisfaction regarding services received from Care Coordinators. Providers reported high overall satisfaction with ARTC's call center staff. Providers appeared to be mostly satisfied with timeliness factors related to working with ARTC. For access and quality of care questions, providers reported moderately high rates of satisfaction. For denials and issue resolution, providers reported being mostly satisfied.

ARTC's response rate was an area of opportunity as well as Care Coordinators arriving on time and following up in a timely manner after a meeting. However, overall, ARTC's enrollees and providers reported being mostly satisfied with the PASSE.

Empower

Enrollees reported high rates of satisfaction with timeliness and access to care. There were some areas of opportunity regarding the overall satisfaction of enrollees. Empower's response rate was an area of opportunity as well as timeliness when it comes to providers. Providers appeared to be relatively dissatisfied with the PASSE overall.

Summit

While enrollees reported high rates of satisfaction regarding the timeliness and quality of care provided, providers were reportedly moderately satisfied. There were some areas of opportunity regarding overall satisfaction of both the enrollees and providers. Overall, Summit's enrollees and providers reported being somewhat satisfied with the PASSE.

Delta Dental

Delta Dental did not conduct enrollee or provider satisfaction surveys in 2020. Qsource will provide technical assistance for Delta Dental to implement both enrollee and provider satisfaction surveys in 2022.

MCNA

Enrollees reported high rates of satisfaction regarding receiving care in a timely manner. Enrollees reported high overall satisfaction. Providers were mostly satisfied with the DMO.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

ARTC

ARTC to should work to improve response rates. ARTC should encourage Care Coordinators to arrive on time for meetings and calls and follow up with enrollees in a timely manner to improve the timeliness of care. They should ensure pre-certification/referral/authorization information is given to providers in a timely manner to improve the timeliness of care. ARTC should work to ensure providers have access to case/care managers to improve access to care. ARTC should work to increase provider satisfaction regarding the resolution of claims payment problems or disputes to improve the quality of care as well as overall provider satisfaction.

Empower

Empower should work to improve response rates. Empower should investigate low levels of enrollee satisfaction reported in regards to specialists to improve the quality of care. Empower should work to increase access to therapists for children. Empower should focus on timelines and access to care for its providers. Empower should ensure timely feedback and reports from Behavioral Health Clinicians. Empower should work with DHS to ensure the formulary is allowing providers to prescribe enrollees' necessary medication. Empower should review processes and workflows to resolve claims payment problems and disputes timely. Empower should work to increase overall provider satisfaction through continuous improvement cycles based on the survey feedback.

Summit

Summit should work to improve response rates for its provider surveys. Summit should investigate the low levels of enrollee satisfaction reported in regard to their overall health care to improve the quality of care. It should work to improve the timeliness of care in regard to specialists. Summit should ensure the provider complaint systems in place are efficient to improve the timeliness of care. It should explore solutions to increase the

responsiveness of the medical director to improve the timeliness of care. Summit should work to increase provider satisfaction regarding the exchange of information for the coordination of medical and behavioral health as well as case management services to improve the quality of care.

MCNA

MCNA should focus on improving the number of responses to obtain as much information as possible. MCNA should review workflows and processes to ensure timeliness of claims payment pre-authorization processes. MCNA should review its appeal process for efficiency and timeliness. MCNA should explore solutions to increase accessibility of its dental director.

Person-Centered Service Plans (PCSPs) Assessment

Objectives

PASSEs were required to employ Care Coordinators who were responsible for providing care coordination to all clients receiving State plan HCBS, including the development of PCSPs. Qsource reviewed a sample of each PASSE's PCSP written plans, behavior support plans, PCSP timelines, and PASSE Agreement. Qsource, in conjunction with DHS, developed a tool to assess each required area of the PCSP requirements within the scope of the ANA review. PCSP standards are outlined in 42 CFR § 441.540, the Arkansas PASSE Medicaid Policy Manual, the PASSE Agreement, and CMS waiver sections 1915(b), 1915(c), and 1915(i) State Plan Amendment.

Technical Methods of Data Collection

DHS and Qsource established that a quarterly review of PCSPs would allow Qsource to assess PCSPs in a more impactful way by providing real-time feedback to each PASSE. Therefore, rather than a retrospective annual review similar to the previous measurement period, Qsource conducted a quarterly review of each PASSE's PCSPs. This report includes results from Quarter 2 and Quarter 3 (April-September) of 2021.

Qsource determined a statistically valid sample size of the PASSE's PCSPs using the sampling strategy outlined in *Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs*, produced for CMS. This methodology yields a 95% confidence limit with a 5% margin of error. DHS provided Qsource with a sample of enrollee records. DHS excluded any records already reviewed and records for those enrolled less than three consecutive months at the time of the sampling (to allow for sufficient time for PCSP development).

Based on the sample selected, Qsource submitted a request to the PASSE that included a spreadsheet of every enrollee in the sample and a checklist of documents requested.

Qsource convened a team of reviewers from diverse healthcare backgrounds.

Qsource imported the PCSP review sheet into a database to allow for project monitoring. Documents were analyzed for each case to determine compliance with federal and PASSE Agreement requirements. Findings were documented in the PCSP Assessment Tool. An example of the tool is located in the *2021 Annual Network Adequacy Review Report*s.

Qsource assessed PCSPs that were current at the time of submission. If a PCSP was due for its annual review prior to the submission but the review had not been done, the enrollee was determined to have no current PCSP. The PASSE was reminded that if the PCSP submitted was not current (new or updated within the required 12-month period), that PCSP would not be reviewed and would be classified as having no current PCSP. Other documents were handled in the same manner.

Targeted reviews of data were utilized during the assessment. In some cases, where a reviewer identified concerns in the progress notes that enrollees were having issues with access to services or if there was a significant change in condition for the enrollee clinically, the enrollee records were escalated to a senior reviewer. Data were reviewed to look for gaps in services. Any discrepancies were recorded in the review notes.

In addition to assessing whether services in the PCSP were provided, DHS asked Qsource to further investigate if the Care Coordinator was actively attempting to engage the enrollee in accessing the services listed in their PCSP. DHS acknowledged that there could be instances when an enrollee may have refused a service or there may have been other extenuating circumstances which prevent the enrollee from engaging in a service. DHS asked Qsource to determine if a Care Coordinator was making every attempt to engage an enrollee in the services listed in the PCSP. Qsource reviewers read the Care Coordinator notes associated with the enrollees PCSP in order to determine if active outreach was conducted.

Per the 1915(i) Waiver, enrollees must receive services listed in the PCSP by providers specified in the PCSP. In order to assess whether the PASSE met this requirement, Qsource compared the providers listed in the enrollee's PCSP to encounter data provided by DHS. If the encounters were associated with the providers listed in the PCSP, it was indicated in the score.

As part of the quarterly assessment, DHS asked that Qsource follow up with any enrollee from the selected sample who filed complaints or grievances in the review period. DHS provided a list of enrollees who filed complaints or grievances in the measurement period. Qsource then compared that list to the review sample. If an enrollee in the sample filed a grievance or complaint within the measurement period, DHS provided standardized follow up questions for Qsource's reviewers to utilize. There were no applicable enrollees for follow up in the samples assessed in 2021.

Findings

Table 100 presents a summary of files in the sample including records without a PCSP.

Table 100. MY 2021 Enrollee Records by PASSE							
Record Type	ARTC		Empower		Summit		Total
	PCSP	No Current PCSP	PCSP	No Current PCSP	PCSP	No Current PCSP	
Behavioral Health Count	87	28	35	86	80	30	**346**
Developmental Disabilities Count	32	12	5	36	44	7	**136**
Dually Diagnosed Count	3	0	1	5	6	0	**15**
Waiver Waitlist Count	16	4	0	18	13	6	**57**
Total (%)	**138 (75.8%)**	**44 (24.2%)**	**41 (22.0%)**	**145 (78.0%)**	**143 (76.9%)**	**43 (23.1%)**	**554 Total Records**

Table 101 presents a comparison between the PCSP scores in measurement year (MY) 2021 and measurement year 2019. These are the standards that received a "yes" from Qsource's reviewers. The sample tool used for the assessment is available upon request. It should be noted that the baseline data includes the results of a retrospective review for all of MY 2019, while the current measurement period includes two quarters (Q2 and Q3) of MY 2021. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases are indicated using a downward arrow (↓).

Detailed results are located in Appendix D.

Table 101. MY 2021 PCSP Assessment Findings by PASSE						
PCSP Section	ARTC		Empower		Summit	
	MY 2021	MY 2019	MY 2021	MY 2019	MY 2021	MY 2019
Section I: Review of the PCSP Process	68.1%↓	82.3%	90.7%	91.9%	76.0%	77.9%
Section II: PCSP Written Plan	69.6%↓	81.7%	73.2%↓	86.7%	76.1%	76.9%

Table 101. MY 2021 PCSP Assessment Findings by PASSE						
PCSP Section	ARTC		Empower		Summit	
	MY 2021	MY 2019	MY 2021	MY 2019	MY 2021	MY 2019
Section III: Behavior Support Plan	3.3%↑	1.4%	1.8%↑	1.0%	4.5%↑	2.9%
Section IV: PCSP Timelines	42.5%↑	31.0%	24.4%↓	35.0%	17.5%↓	29.6%
Section V: PASSE Agreement Requirements	79.0%↑	71.5%	83.5%↓	89.7%	85.1%↑	79.8%
Total (%)	**61.2%↓**	**65.0%**	**67.4%↓**	**73.2%**	**63.7%**	**64.1%**

Table 102 presents the findings for Requirement 1 of the 1915(i) Waiver assessing if the PCSPs adequately and appropriately addressed enrollees' needs. The numerator was the number of services listed in the PCSP that were provided to the enrollee and the denominator was the total number of PCSPs reviewed.

Table 102. MY 2021 Enrollee Services Performance Measure Results			
Requirement	ARTC	Empower	Summit
The percentage of PCSPs developed by PASSE Care Coordinators that meet the requirements of 42 CFR 441.725	64.5%	70.7%	71.3%

Table 103 presents the results for the additional performance measure on enrollee engagement. The numerator was the number of Care Coordinators and providers who attempted to engage enrollees in services and the denominator was the total number of PCSPs reviewed.

Table 103. MY 2021 Additional DHS Performance Standard Results			
Standard Component	ARTC	Empower	Summit
Enrollee Engagement	91.3%	82.9%	95.8%

Table 104 presents findings for Requirement 6 of the 1915(i) Waiver assessing whether or not the enrollees received the services listed in their PCSPs. The numerator was the number of providers reviewed who delivered the services specified in the PCSPs and the denominator was the total number of providers listed in the PCSPs.

Table 104. MY 2021 Service Providers Performance Measure Results

Requirement	ARTC	Empower	Summit
Number and percentage of services delivered and paid for with the Per Member Per Month (PMPM) as specified by the enrollee's PCSP*	64.3%	58.5%	63.7%

**PCSP is not an authorization of services*

Strengths and Weaknesses

ARTC

DHS's quality strategy includes a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those 90% of enrollees will have a PCSP that includes all needed HCBS services. Of the 182 enrollee records reviewed, 75.8% included a current PCSP. Approximately a quarter (24.2%) of the enrollee records in the sample reviewed did not include a current PCSP. These 44 records were considered to have failed the metrics. Ninety percent of those reviewable PCSPs included all needed HCBS services. The performance target determined by DHS was less than a 10% failure rate for the 41 metrics required for the PCSP. ARTC achieved the target for 15 of the 41 metrics, while the remaining 26 metrics failed by more than 10%. ARTC had a net success rate of 36.6%, determined through Qsource's review of only those enrollee records that included a current PCSP. ARTC's average success rate was 56.3%, which included those records in the sample that did not have a current PCSP.

Qsource found that 64.5% of the PCSPs reviewed adequately and appropriately met the needs of ARTC's enrollees. ARTC achieved a score of 91.3% for the enrollee engagement performance measure. Qsource also determined that 64.3% of the providers specified in the reviewed PCSPs delivered services to the enrollees.

Qsource noted strengths in ARTC's PCSPs, including the person-centered nature of PCSP development. The PCSPs were assessed to be written in plain, easily understood language, and they included enrollee strengths and preferences. The majority of the PCSPs prevented the provision of unnecessary or inappropriate services. The PCSPs included treatment goals as well as individually identified goals of the enrollee. Most records reviewed also identified an individual with legal authority and noted advance directives and/or living wills. The majority of the PCSPs included crisis plans.

ARTC increased the number of enrollee records with current PCSPs from 64.5% to 75.8%, but the net success rate for ARTC decreased from 46.2% to 36.6% when compared to the previous measurement period.

ARTC increased the overall score for Section III: Behavior Support Plans from 1.4% to 3.3% but scored 0.0% on the ISP standard (down from 2.5%).

ARTC demonstrated improvement for the timeliness standard from 14.6% to 34.1%.

DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact, but ARTC experienced a decrease in correctly finalized PCSPs from 6.3% to 1.4%.

ARTC increased the rate of PCSPs that included relevant diagnoses from 85.0% to 94.9% and increased the rate of PCSPs that included relevant history from 83.8% to 91.3%.

ARTC increased the rate of PCSPs with a crisis plan from 67.9% to 92.0%.

The rate of PCSPs that included the amount and duration of services for enrollees decreased from 43.8% to 30.4%.

Empower

DHS's quality strategy includes a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those 90% of enrollees will have a PCSP that includes all needed HCBS services. Of the 186 enrollee records reviewed, 22.0% included a current PCSP. A majority (78.0%) of the enrollee records in the sample reviewed did not include a current PCSP. These 145 records were considered to have failed the metrics. Of those reviewable PCSPs, 97.6% included all needed HCBS services. There was a significant decrease in the number of enrollee records with current PCSPs from 74.5% to 22.0% when compared to the previous measurement period.

Qsource noted the low number of enrollee records with a current PCSP may be due to Empower failing to update the PCSPs with the 12-month required timeframe. Empower decreased the percentage of enrollee records that met the timeliness standard from 36.4% to 24.4% when compared to the previous measurement period.

The performance target determined by DHS was less than a 10% failure rate for the 41 metrics required for the PCSP. Empower achieved the target for 25 of the 41 metrics, while the remaining 16 metrics failed by more than 10%. There was a significant decrease in the net success rate (Qsource's review of only those enrollee records that included a current PCSP) for Empower from 79.5% to 61.0% when compared to the previous measurement year. Empower's average success rate was 26.4%, which included those records in the sample that did not have a current PCSP.

Qsource found that 70.7% of the PCSPs reviewed adequately and appropriately met the needs of Empower's enrollees. Empower achieved a score of 82.9% for the enrollee engagement performance measure. Qsource found that 58.5% of the providers specified in the reviewed PCSPs delivered services to the enrollees.

Qsource noted strengths in Empower's PCSPs, including the person-centered nature of PCSP development, including informed choices for services and options for home and community-based settings (HCBS) services. The PCSPs were assessed to be written in plain, easily understood language, and they included enrollee strengths and preferences. The majority of the PCSPs prevented the provision of unnecessary or inappropriate services. The PCSPs included a process for requesting updates and noted who was responsible for monitoring them. The majority of the PCSPs included relevant medical and mental health diagnoses. The PCSPs included a crisis plan the majority of the time at 95.1%.

DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact. Empower experienced a decrease in correctly finalized PCSPs from 11.1% to 9.8%.

The rate of PCSPs that included the amount and duration of services for enrollees decreased from 61.8% to 34.1%.

Empower had a significant decrease in the rate of PCSPs that were distributed to the enrollee and others involved in the plan from 87.9% to 12.2%.

Empower increased the percentage of PCSPs that attempted to minimize risk factors from 76.1% to 90.2%.

Empower increased the score for Behavior Support Plans from 1.0% to 1.8% but scored 0.0% on the ISP standard (down from 0.4%).

Summit

DHS's quality strategy includes a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those 90% of enrollees will have a PCSP that includes all needed HCBS services. Of the 186 enrollee records reviewed, 76.9% included a current PCSP. Less than a quarter (23.1%) of the enrollee records in the sample reviewed did not include a current PCSP. These 43 records were considered to have failed the metrics. Of those reviewable PCSPs, 98.6% included all needed HCBS services. The performance target determined by DHS was less than a 10% failure rate for the 41 metrics required for the PCSP. Summit achieved the target for 17 of the 41 metrics, while the remaining 24 metrics failed by more than 10%. Summit had a net success rate of 41.5%, determined through Qsource's review of only those enrollee records that included a current PCSP. Summit's average success rate was 58.0%, which included those records in the sample that did not have a current PCSP.

Qsource found that 71.3% of the PCSPs reviewed adequately and appropriately met the needs of Summit's enrollees. Summit achieved a score of 95.8% for the enrollee engagement performance measure. Qsource also determined that 63.7% of the providers specified in the reviewed PCSPs delivered services to the enrollees.

Qsource noted strengths in Summit's PCSPs, including the person-centered nature of PCSP development, allowing for informed choices and decision making. The PCSPs included the enrollees' strengths and preferences and individually identified goals and outcomes. The PCSPs were assessed to be written in plain, easily understood language. The majority of the PCSPs prevented the provision of unnecessary or inappropriate services and had a clearly identified individual who was responsible for monitoring them. Most records reviewed also identified an individual with legal authority to make decisions and noted advance directives and/or living wills. Most of the PCSPs reviewed included a crisis plan, as well.

Summit's percentage of enrollee records with current PCSPs decreased from 78.2% to 76.9%, but the net success rate for

Summit increased from 35.9% to 41.5% when compared to the previous measurement period.

Summit increased the score for Behavior Support Plans from 2.9% to 4.5% but scored 0.7% on the ISP standard (down from 3.1%).

The rate for timely development of the PCSPs decreased from 16.3% to 10.5%.

Summit demonstrated improvement for the strengths and preferences standard from 89.8% to 93.0%. Summit increased the percentage of PCSPs that identified the enrollees' goals and desired outcomes from 85.7% to 93.0%. For this year's assessment, DHS added question 12 in Section I: Review of the PCSP Process. The requirement states "The treatment goals are documented in the PCSP." The PASSE scored 100% on the new standard.

DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact and Summit experienced an increase in correctly finalized PCSPs from 3.1% to 4.9%.

Summit increased the rate of PCSPs that were distributed to the enrollee and others involved in the plan from 48.3% to 50.3%.

Summit increased the rate of PCSPs that included relevant diagnoses from 56.8% to 82.5% and increased the rate of PCSPs that included relevant history from 71.4% to 89.5%.

Summit increased the rate of PCSPs with a crisis plan from 86.1% to 95.8%.

The rate of PCSPs that included the amount and duration of services for enrollees decreased from 54.4% to 46.2%.

Summit increased the percentage of PCSPs that attempted to minimize risk factors from 58.2% to 84.6%.

Summit decreased the percentage of PCSPs that included the provider for each service listed from 87.8% to 80.4%.

Improvements

DHS requested follow up from the PASSEs on areas of deficiency noted in the previous measurement period (MY 2019). **Table 105** includes MY 2019 findings and plan responses as well as a comparison of the performance from the previous measurement period to the current measurement period. Direct quotes from the PASSEs are in italics.

Table 105. PCSP Assessment Progress Update

ARTC	
MY 2019 AON	Qsource concluded that ARTC's 2019 PCSPs addressed the majority of CFR and DHS PASSE Agreement requirements for those enrollees for whom a Care Coordinator developed a PCSP. However, more than a third (35.5%) of the enrollee records in the sample reviewed did not include a PCSP. These 132 records were considered to have failed the metrics. The performance target determined by DHS was to not have more than a 10% failure rate for the 39 metrics required for the PCSP. ARTC achieved targets for 18 of the 39 metrics, while the remaining 21 metrics failed by more than 10%. ARTC had a net success rate of 46.2%, determined through Qsource's review of only those enrollee records that included a PCSP. The average overall success rate including records without a PCSP was 44.3%. The DHS review noted that the template was not capturing key metrics. Also noted in the DHS review was untimeliness.
PASSE Response	*Prior to March 2019, the three PASSEs collaborated to create a uniform PCSP document. Unfortunately, the first year of the PASSE program revealed deficiencies with the document. ARTC's effort to improve PCSP content began in October 2020, with a revised PCSP process, template, and document. Our new PCSP is completed digitally within our Care Coordination system. The revised PCSP includes many of the elements of the CFR and PASSE Agreement that were missing in the 2019 PCSP document. The change to our process also created an avenue for more accurate reporting. ARTC identified additional areas to improve soon after the implementation of the digital PCSP. A revision to our digital PCSP development template has been submitted to be updated in our Care Coordination system. Implementation is planned for Q3 2021.*
Results from Assessment	ARTC increased the number of enrollee records with current PCSPs from 64.5% to 75.8%, but the net success rate decreased from 46.2% to 36.6%.
MY 2019 AON	Qsource determined the PCSP should be improved to specifically address each of the required metrics.
PASSE Response	*The ARTC PCSP process, document, and template revision implemented in October 2020 remediated many of the missing elements. The second version planned for implementation in Q3 2021 will remediate the remaining elements.*
Results from Assessment	The net success rate decreased from 46.2% to 36.6%.

Table 105. PCSP Assessment Progress Update	
MY 2019 AON	As all questions in the PCSP were tied to required metrics, ARTC should avoid leaving questions blank on the PCSP.
PASSE Response	*ARTC Care Coordinators participated in a PCSP retraining conducted in September 2020. Another training refresher will be provided in June 2021, which will include instruction to avoid leaving questions blank.*
Results from Assessment	The net success rate decreased from 46.2% to 36.6%.
MY 2019 AON	ARTC should avoid using "not applicable" for questions regarding enrollee choices. In cases where "not applicable" is needed, an explanation should be included. Qsource recommends none of the questions be left blank.
PASSE Response	*ARTC CCs participated in a PCSP retraining conducted in September 2020. Another training refresher will be provided in June 2021, which will include instruction to avoid using "not applicable" for questions regarding enrollee choices and to include explanations when "not applicable" is necessary.*
Results from Assessment	The net success rate decreased from 46.2% to 36.6%.
MY 2019 AON	Qsource recommends ARTC have a separate Behavior Support Plan and Interim Support Plan as required where applicable.
PASSE Response	*ARTC believes providers hold the primary responsibility for positive behavior support plans and is in collaboration with providers to ensure these plans are included in the PCSPs.*
Results from Assessment	ARTC increased the score for Behavior Support Plans from 1.4% to 3.3% but scored 0.0% on the ISP standard (down from 2.5%).
MY 2019 AON	The PCSP should be developed within 60 calendar days of enrollment into the PASSE to ensure meeting timeliness metrics.
PASSE Response	*The switch to a digital PCSP template permitted preemptive PCSP reporting to assist Care Coordinators in timely scheduling PCSP development meetings and to ensure PCSP completion complies with the 60-day requirement.*
Results from Assessment	ARTC demonstrated improvement for the timeliness standard from 14.6% to 34.1%.
MY 2019 AON	ARTC should ensure the PCSP is signed by all individuals, including the providers responsible for its implementation.

Table 105. PCSP Assessment Progress Update	
PASSE Response	*ARTC implemented a digital signature option within our Care Coordination system. Unfortunately, this option can only be used when face-to-face with members. The suspension of face-to-face meetings due to the PHE caused disruption to our PCSP signature retrievals throughout 2020. However, ARTC began face-to-face meetings again in April 2021 and will ensure PCSPs are signed by all individuals, including providers responsible for implementation.*
Results from Assessment	DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact. The PASSE experienced a decrease in correctly finalized PCSPs from 6.3% to 1.4%.
MY 2019 AON	The PCSP should include relevant medical and mental health diagnoses and relevant medical and social history.
PASSE Response	*The second version of our digital PCSP template scheduled for implementation in Q3 2021 will ensure PCSPs include relevant medical and mental health diagnoses and relevant medical and social history.*
Results from Assessment	ARTC increased the rate of PCSPs that included relevant diagnoses from 85.0% to 94.9%. ARTC increased the rate of PCSPs that included relevant history from 83.8% to 91.3%.
MY 2019 AON	A crisis plan should be included for each enrollee.
PASSE Response	*ARTC is collaborating with providers and DHS to further define and develop the crisis plans created by providers to be included in ARTC PCSPs.*
Results from Assessment	ARTC increased the rate of PCSPs with a crisis plan from 67.9% to 92.0%.
MY 2019 AON	The PCSP should include the amount and duration of services for the enrollee.
PASSE Response	*The second version of our digital PCSP template scheduled for implementation in Q3 2021 will ensure amount and duration of services.*
Results from Assessment	The rate of PCSPs that included the amount and duration of services for enrollees decreased from 43.8% to 30.4%.

Table 105. PCSP Assessment Progress Update	
Empower	
MY 2019 AON	Qsource found that Empower's PCSPs did not address each of the metrics. The PCSP should be improved to specifically address each of the required metrics. Empower should avoid using "not applicable" for questions regarding enrollee advance directives or living wills. In cases where "not applicable" is needed, an explanation should be provided.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	There was a significant decrease in the number of enrollee records with current PCSPs from 74.5% to 22.0% and the net success rate for Empower decreased from 79.5% to 61.0%.
MY 2019 AON	The PCSP should be developed within 60 calendar days of enrollment into the PASSE to ensure meeting timeliness metrics.
PASSE Response	*A PCSP Audit team was created.*
Results from Assessment	There was a decrease in the percentage of enrollee records that met the timeliness standard from 36.4% to 24.4%.
MY 2019 AON	Empower should ensure the PCSP is signed by all individuals, including the providers responsible for its implementation.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact. Empower experienced a decrease in correctly finalized PCSPs from 11.1% to 9.8%.
MY 2019 AON	The PCSP should include the amount and duration of services for the enrollee.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	The rate of PCSPs that included the amount and duration of services for enrollees decreased from 61.8% to 34.1%.

Table 105. PCSP Assessment Progress Update	
MY 2019 AON	Qsource recommended that Empower should provide a copy of the PCSP for all participants involved with the creating and carrying out of the PCSP.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	Empower had a significant decrease in the rate of PCSPs that were distributed to the enrollee and others involved in the plan from 87.9% to 12.2%.
MY 2019 AON	Qsource recommended that the PCSP should include services, risks, and providers from other assessments and treatment plans.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	Empower increased the percentage of PCSPs that attempted to minimize risk factors from 76.1% to 90.2%.
MY 2019 AON	Qsource recommends Empower have a separate Behavior Support Plan and Interim Support Plan as required where applicable.
PASSE Response	*A PCSP training series was implemented.*
Results from Assessment	Empower increased the score for Behavior Support Plans from 1.0% to 1.8% but scored 0.0% on the ISP standard (down from 0.4%).
Summit	
MY 2019 AON	The PCSP should be improved to specifically address each of the required metrics. More than a fifth (21.8%) of the enrollee records in the sample reviewed did not include a PCSP. These 82 records missing a PCSP were considered to have failed the metrics. The performance target determined by DHS was to not have more than a 10% failure rate for the 39 metrics required for the PCSP. Summit achieved targets for 14 of the 39 metrics, with the remaining 25 metrics failing by more than 10%. Summit had a net success rate of 35.9% determined through Qsource's review of only those enrollee records that included a PCSP. The average overall success rate including records without a PCSP was 53.4%. The DHS review noted that the template was not capturing key metrics and also noted untimeliness.

Table 105. PCSP Assessment Progress Update	
PASSE Response	*1) Implemented COVID Task Force 3/2020 - ongoing until the end of the public health emergency* ♦ *Daily meetings until 08/2020, moved to weekly and currently held on an ad hoc basis* ♦ *Variety of discussions held around the PHE/COVID-19, including contact in lieu of face to face* *2) Increased education and training to reinforce metric requirements 9/2020 – ongoing* ♦ *In-person quadrant trainings for care coordinators held 09/2020* ♦ *Tuesday Talk newsletter; 01/19/2021* ♦ *Recurring virtual training and education; 04/2021* *3) Healthy Innovations Platform (HIP) implementation. New electronic health record that allows for more accurate PCSP tracking. 12/2019 – 12/2020* ♦ *Weekly workgroup meetings* ♦ *Go-live 12/2020* ♦ *HIP includes annual PCSP task reminders and due dates* *4) Increased staffing (added business analyst and two quality assurance positions) 11/2020 – 01/2021* ♦ *Business analyst added to improve visibility of data and increased monitoring of metrics* ♦ *QA staff assist with PCSP quality and completion oversight* *5) Reallocation of resources to complete PCSPs. 01/2021 – ongoing* ♦ *The reallocation of resources is ongoing until PCSP metrics are met* *6) Increased direct reminders to staff for new attributions and past due PCSPs. 03/2021 – ongoing* ♦ *Reminders to staff included applicable member information as well as due dates and status information* *7) Implemented weekly reports to monitor progress. 03/2021 – ongoing* ♦ *Weekly reports monitor due dates, completion status and assigned CC staff and their lead*
Results from Assessment	Summit's percentage of enrollee records with current PCSPs decreased from 78.2% to 76.9%, but the net success rate increased from 35.9% to 41.5%.
MY 2019 AON	Qsource recommended that Summit should have a separate Behavior Support Plan and Interim Support Plan as required when applicable.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	The PASSE increased the score for Behavior Support Plans from 2.9% to 4.5% but scored 0.7% on the ISP standard (down from 3.1%).
MY 2019 AON	Qsource recommended that the PCSP should be developed within 60 calendar days of enrollment into the PASSE to ensure meeting timeliness metrics.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.

Table 105. PCSP Assessment Progress Update	
Results from Assessment	The rate for timely development of the PCSP decreased from 16.3% to 10.5%.
MY 2019 AON	Qsource recommended that Summit avoid leaving sections regarding enrollees' goals and preferences blank and that the PCSP include individually identified goals and desired outcomes.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit demonstrated improvement for the strengths and preferences standard from 89.8% to 93.0%. Summit increased the percentage of PCSPs that identified the enrollees' goals and desired outcomes from 85.7% to 93.0%. For this year's assessment, DHS added question 12 in Section I: Review of the PCSP Process. The requirement states "The treatment goals are documented in the PCSP." The PASSE scored 100% on the new standard.
MY 2019 AON	Qsource recommended that Summit should ensure the PCSP is signed by all individuals, including the providers responsible for its implementation.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	DHS allowed electronic signatures in 2021 due to COVID-19 restrictions on in-person contact. Summit experienced an increase in correctly finalized PCSPs from 3.1% to 4.9%.
MY 2019 AON	Qsource recommended that Summit should provide a copy of the PCSP for all participants involved with the creating and carrying out of the PCSP.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit increased the rate of PCSPs that were distributed to the enrollee and others involved in the plan from 48.3% to 50.3%.
MY 2019 AON	Qsource recommended that the PCSP should include relevant medical and mental health diagnoses and relevant medical and social history.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit increased the rate of PCSPs that included relevant diagnoses from 56.8% to 82.5%. Summit increased the rate of PCSPs that included relevant history from 71.4% to 89.5%.
MY 2019 AON	A crisis plan should be included for each enrollee.

Table 105. PCSP Assessment Progress Update	
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit increased the rate of PCSPs with a crisis plan from 86.1% to 95.8%.
MY 2019 AON	The PCSP should include the amount and duration of services for the enrollee.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	The rate of PCSPs that included the amount and duration of services for enrollees decreased from 54.4% to 46.2%.
MY 2019 AON	Qsource recommended that the PCSP should include services, risks, and providers from other assessments and treatment plans.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit increased the percentage of PCSPs that attempted to minimize risk factors from 58.2% to 84.6%.
MY 2019 AON	Qsource recommended that the PCSP should include the provider who will provide each service**.**
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Assessment	Summit decreased the percentage of PCSPs that included the provider for each service listed from 87.8% to 80.4%. In this year's reporting, Qsource compared the providers listed in the PCSP to the providers listed in the encounters provided by DHS. Qsource found that 63.7% matched.

Conclusions

ARTC

ARTC's net success rate was 36.6%. Its average success rate was 56.3%, including those records in the sample that did not have a current PCSP. ARTC failed to meet the Quality Strategy performance metric requiring ≥90% of enrollees have a PCSP or Interim Plan of Care, but the PASSE met the metric requiring ≥80% of the 90% of enrollees have a PCSP that included all needed HCBS services. Qsource found that PCSPs were an area of opportunity for ARTC in order to more closely align with the goals and objectives in DHS's Quality Strategy related to care coordination.

Empower

Empower's net success rate was 61.0%. Its average success rate was 26.4% including those records in the sample that did not have a current PCSP. Empower failed to meet the Quality Strategy performance metric requiring ≥90% of enrollees have a PCSP or Interim Plan of Care, but the PASSE met the metric requiring ≥80% of the 90% of enrollees have a PCSP that included all needed HCBS services. Qsource found that PCSPs were an area of opportunity for Empower in order to more closely align with the goals and objectives in DHS's Quality Strategy related to care coordination.

Summit

Summit's net success rate was 41.5%. Its average success rate was 58.0% including those records in the sample that did not have a current PCSP. Summit failed to meet the Quality Strategy performance metric requiring ≥90% of enrollees have a PCSP or Interim Plan of Care, but the PASSE met the metric requiring ≥80% of the 90% of enrollees have a PCSP that included all needed HCBS services. Qsource found that PCSPs were an area of opportunity for Summit in order to more closely align with the goals and objectives in DHS's Quality Strategy related to care coordination.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

ARTC

ARTC should have a separate Behavior Support Plan and Interim Support Plan as required when applicable. The PCSPs should be updated annually to ensure all enrollees are receiving quality care and that ARTC is meeting federal and state requirements. The PCSP planning process should include people, location, and a time chosen by the enrollee that is documented in the PCSPs. The PCSPs should be developed within 60 calendar days of enrollment into ARTC to ensure it is meeting timeliness metrics. The PCSPs should include a method for enrollees to request updates to their plan as needed. ARTC should ensure the PCSPs are signed by all individuals, including the providers responsible for their implementation. ARTC should ensure the PCSPs are distributed to the enrollees and others involved in the plan. The PCSPs should include all services necessary for the enrollees, including amount and

duration of services. The PCSP should include services, risks, and providers from other assessments and treatment plans.

Empower

The PCSPs should be updated annually to ensure all enrollees are receiving quality care and that Empower is meeting federal and state requirements. Empower should update the PCSP tracking process to improve the timeliness and accuracy of PCSPs. Empower should educate Care Coordinators on the requirements for the PCSPs. It should ensure the Medicaid and Waiver Renewal dates are documented in each PCSP. Empower should have a separate Behavior Support Plan and Interim Support Plan as required when applicable and ensure the PCSPs are signed by all individuals, including the providers responsible for their implementation. Empower should ensure the PCSPs are distributed to the enrollees and others involved in the plan. The PCSPs should include all services necessary for the enrollees, including amount and duration of services.

Summit

Summit should have a separate Behavior Support Plan and Interim Support Plan as required when applicable. The PCSP planning process should include people, location, and a time chosen by the enrollee that is documented in the PCSPs. The PCSPs should be developed within 60 calendar days of enrollment into Summit to ensure it is meeting timeliness metrics. The PCSPs should be updated annually to ensure all enrollees are receiving quality care and Summit is meeting federal and state requirements. The Medicaid and Waiver renewal dates should be included in the PCSPs. Summit should ensure the PCSPs are signed by all individuals, including the providers responsible for their implementation. The PCSPs should include all services necessary for the enrollees, including amount and duration of services.

Validation of DHS Person-Centered Service Plan (PCSP) Retrospective Review

Objectives and Methodology

DHS conducted a review of a sample of PCSPs from each PASSE. Following the review, Qsource performed a validation analysis of the results. The objective of this activity was to validate the accuracy of DHS calculations of PCSP review scores. To validate the State's calculations, Qsource reviewed all items contained in the PCSP data file received from DHS for Section 1 through Section 5. Qsource then compared the DHS-calculated results to the Qsource-calculated results from the same data file. The PCSP results included were from the three PASSEs.

Qsource analysts aggregated data for all items within each section to calculate a numerator and a denominator, subsequently resulting in a calculated rate presented as a percentage. Qsource compared its independently calculated results to the rates calculated by DHS.

PASSE-specific results are located in Appendix D.

Findings

Overall, the absolute difference between DHS calculations and Qsource calculations was less than 1% for all sections and items. There were no notable differences calculated, and in fact, many sections and questions resulted in a calculated result of zero.

For all sections, Qsource and DHS sample counts were the same. There was a notable improvement in the calculations from the prior year. The largest difference continued to be where there were differences identified in the count of records that did not have a PCSP submitted for each section. Qsource analysts used the value of zero or blank to tabulate these figures. Differences ranged between 25-28 records.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations. Where there were differences, DHS should continue to consider if the results were due to errors in manual or automated system tabulation and analyses. Processes should be implemented to ensure accuracy of both data and calculation. This would further ensure accurate scoring of PCSPs and program evaluation. Results could be tied to PCSP outcomes and identify the successes of the program or where improvements may be necessary.

Protocol 5: Encounter Data Validation (EDV)

Objectives

DHS contracted with Qsource to perform an optional activity—Validation of Encounter Data (EDV) submitted by the PASSEs and DMOs. Qsource conducted EDV based on the Centers for Medicare & Medicaid Services' (CMS's) *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan* (2019).

CMS's EDV activity protocol defines encounter data as "the information related to the receipt of any item or service by an enrollee in a managed care plan (MCP). Encounter data reflects that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider." Encounter data include most of the same information that appears on claim forms; however, encounter data may be less complete or accurate than claim data due to provider payments via capitation or episodes of care versus a claim for individual services provided. EDV determines the accuracy and completeness of encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, determine capitation payment rates, conduct risk adjustments, and incorporate alternative payment methods.

This report addressed encounter data with service dates between January 1, 2020 and December 31, 2020 (MY 2020).

EQR Protocol 5 includes five activities. Activity 1 (review of DHS requirements) involved submission of encounter data in standard Electronic Data Interchange (EDI) 837 format. Activity 2 (reviewing the capacity to produce accurate and complete encounter data) was completed by review of information provided in the Information Systems Capabilities Assessment Tools (ISCATs). Activity 3 included analyses of various aspects (reflecting volume, consistency, accuracy, and completeness) of encounter data. Activity 4, a review of medical records for a random statistically significant sample of statewide encounter data. The *2020 Service Dates EDV Reports* for each PASSE and DMO met the requirements of Activity 5 (submission of EQRO findings).

Technical Methods for Data Collection and Validation for PASSEs

Encounter data were analyzed at the institutional, professional, and pharmacy levels. Institutional data include any records submitted by a healthcare institution via a CMS-1450 form (UB-04 [Uniform Bill]), a standard billing claim form for institutional medical claims. Professional data include any records submitted by a provider via a CMS-1500 form (Health Insurance Claim Form), a standard claim form for non-institutional medical provider claims. Pharmacy data include any records submitted by pharmacies following the National Council for Prescription Drug Programs (NCPDP) standard D.0. format and field definitions.

This report includes the PASSE's encounter data for service dates from January 1, 2020 through December 31, 2020 and an analysis of the volume, consistency, completeness, and validity of the data of distinct institutional, professional, and pharmacy encounters submitted by the PASSEs to DHS. This report also includes improvements and trends from the baseline measurement year where applicable.

Collection and Submission of Encounters

Per the PASSE Provider Agreement section 8.3.7(a)(b)(c)(d), all PASSE encounters must be submitted to DHS in the Standard HIPAA (Health Insurance Portability and Accountability) transaction formats: ANSI X12N 837 transaction formats (P – Professional; I – Institutional;). Further, the PASSE must follow the instructions in the User Guide and Report Guide. The PASSE's encounters follow the standards in DHS's 5010 Companion Guides, the Arkansas D.0 Payer Specification - Encounters. The PASSE follows the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the NCPDP standard D.0 format and field definitions. The PASSE converts all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats. The full data layouts and standards are available on request. The companion guides 837P Professional, 837I Institutional, and NCPDP Payer Sheet, can be found on the Arkansas Medicaid System Documents webpage.

The PASSE Agreement section 8.3.7(a) states that Pharmacy encounters must be submitted in the NCPDP standard D.0. format and field definitions.

Section 8.3.1 of the PASSE Agreement states that DHS requires the PASSEs to collect encounter data for all services provided to enrollees, including in lieu of services and expanded benefits. The encounter data must include characteristics of the enrollee and the provider as specified by the State and meet established DHS data quality standards.

Types of Encounters to be Validated

The PASSE was required to collect encounter data for all services provided to enrollees, including in lieu of services and expanded benefits. For this report, **distinct encounters** represent the encounter as a whole, while the **distinct encounter lines** display the different procedures associated with an encounter, date of service start and end dates, the related diagnoses, the charges, and total amount, adjustment amount, claim status, accounting date, etc.

Technical Methods for Data Collection and Validation for DMOs

Dental data include any records submitted by a provider via an ADA Dental Claims form.

This report includes the DMO's encounter data for service dates from January 1, 2020 through December 31, 2020 and an analysis of the volume, consistency, completeness, and validity of distinct dental encounters submitted by the DMOs to DHS.

This report includes improvements and trends from the baseline measurement year where applicable.

Collection and Submission of Encounters

Per the Agreement, all DMO encounters must be submitted to DHS for all services provided to enrollees, including value-added services as required by the Managed Care regulations in 42 CFR 438.818. The encounter must include characteristics of the enrollees and the provider and must meet data quality standards, as established by CMS and DHS to ensure complete and accurate data for program administrations.

Weekly encounter data submissions must include information on denied claims. The submission of denied claims will begin upon both (a) mutual agreement of all parties and (b) a written statement from DHS's vendors that all systems were ready to exchange denied claims.

Encounter Data must follow the format and include the data elements described in the most current version of HIPAA-compliant 837D Companion Guides and Encounters Submission Guidelines. For reporting Claims processed by the DMO and submitted on Encounter 837D format, the DMO must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by DHS.

Types of Encounters to be Validated

DMO encounters must be submitted to DHS for all services provided to enrollees, including value-added services as required by the Managed Care regulations in 42 CFR 438.818.

For this report, **distinct encounters** represent the encounter as a whole, while the **distinct encounter lines** display the different procedures associated with an encounter, date of service start and end dates, the related diagnoses, the charges, and total amount, adjustment amount, claim status, accounting date, etc.

Description of Data Obtained for PASSEs

Qsource conducted EDV activities for encounter data files submitted by the PASSEs to DHS.

Operational Definition of Encounter

DHS defines an encounter as a standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to an enrollee of the PASSE. There were two types of service encounters, paid claim encounters and non-paid encounters (i.e., encounters that were performed but were not reimbursable).

CMS defines encounter data as the information related to the receipt of any item or service by an enrollee in an MCP. It is often considered the managed care equivalent of fee-for-service (FFS) claims. Encounter data reflects that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider.

Types of Encounters the PASSE Must Report

According to the PASSE Provider and Medicaid Manuals, the PASSE was required to report all Medicaid services provided under contract with the Arkansas Division of Medical Services

(DMS) in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports. Per section 8.3.9 in the PASSE Manual, the PASSE must submit complete, accurate, and timely encounter data to DHS for all services rendered to its enrollees (excluding services paid directly by DHS on a fee-for-service basis).

Format for Reporting Encounters

All PASSE encounters must be submitted to DHS in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional), and, for pharmacy services, in the NCPDP format.

Objective Standards to Which Encounters Are Compared

Section 8.3.1(a)-(d) of the PASSE Agreement states that encounter data must meet established DHS data quality standards. These standards were defined by DHS to ensure receipt of complete and accurate data for program administration and were closely monitored and enforced. DHS defines these standards as follows:

1. The PASSE must submit data on the basis of which the State certifies the actuarial soundness of capitation rates to a PASSE, including base data that was generated by the PASSE.
2. The PASSE must submit data on the basis of which the State determines the compliance of the PASSE with the Medical Loss Ratio (MLR) requirement.
3. The PASSE must submit data on the basis of which the State determines that the PASSE has made adequate provision against the risk of insolvency.
4. The PASSE must submit documentation on which the State bases its certification that the PASSE has complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.

State Standards

Per the 2020 PASSE Agreement sections 8.3.9, 8.3.10, and 8.3.11, the PASSE must submit complete, accurate, and timely encounter data to DHS. For this report, Qsource reviewed two levels of completeness and accuracy — the completeness and accuracy of overall encounter submission in its entirety of the measurement year as well as the completeness and accuracy of each encounter.

At least 95% of all encounter data must be accurate. The PASSE must submit encounters for 95% of the covered services provided by participating and non-participating providers. The PASSE must submit pharmacy encounters for all the covered services provided by participating and non-participating providers.

No less than 95% of the PASSE's encounter lines submission must pass Medicaid management information system (MMIS) edits as specified by DHS. For each pharmacy encounter data submission, 95% of the PASSE's encounter lines submissions must pass NCPDP edits and the pharmacy benefits system edits

as specified by DHS. The NCPDP edits were described in the National Council for Prescription Drug Programs Telecommunications Standard.

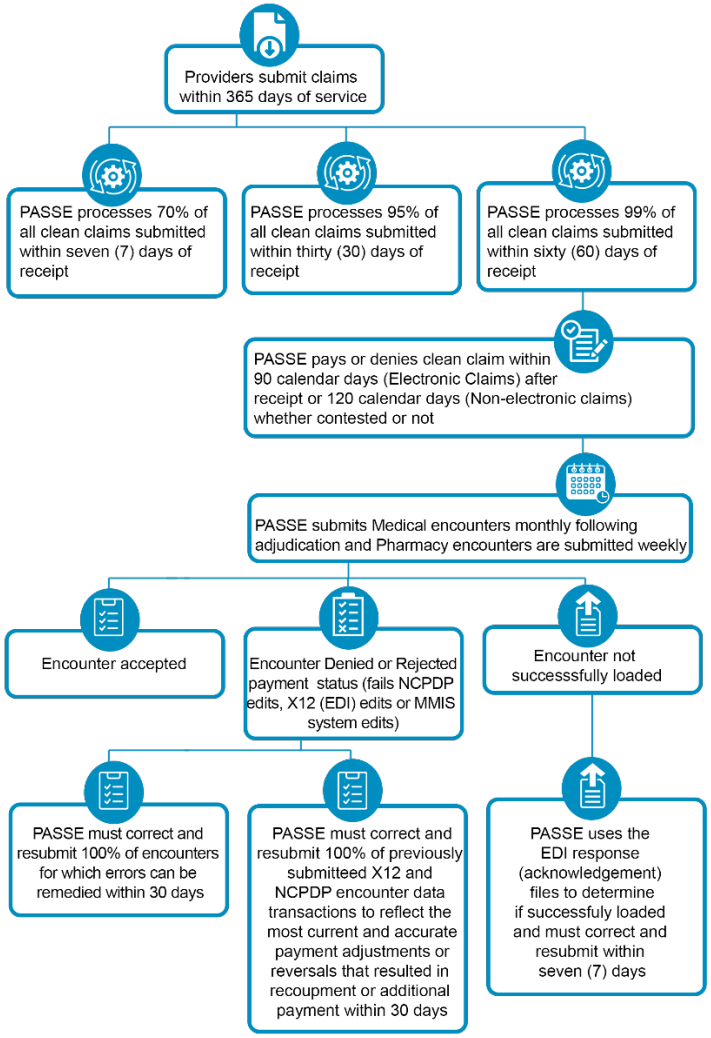
Data Dictionary

Qsource collaborated with the PASSE to understand data file formats, including the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional), and, for pharmacy services, in the NCPDP format. The PASSE's encounters follow the standards in DHS's 5010 Companion Guides, the Arkansas D.0 Payer Specification - Encounters. The PASSE follows the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the NCPDP standard D.0 format and field definitions. The PASSE converts all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats. The companion guides 837P Professional, 837I Institutional, and NCPDP Payer Sheet, can be found on the Arkansas Medicaid System Documents webpage.

Information Flow

Providers submitted claims to the PASSE. Adjudication of these services was performed with front-end edits at the clearing house and in the PASSE transaction systems. The PASSE submitted its data to DHS. **Figure 1** illustrates the information flow for claims and encounters per the PASSE Agreement.

Figure 1. PASSE Claims Process



Data Edits and Checks

Per the PASSE Agreement section 8.3.13, within 30 days after encounters fail, X12 (EDI) edits, MMIS edits, or NCPDP edits the PASSE must correct and resubmit all encounters for which errors can be remedied. The PASSE must correct and resubmit 100% of previously submitted X12 and NCPDP encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within 30 days of the respective action. For encounter data acceptance purposes, the PASSE must ensure the provider information it supplied to DHS was sufficient to ensure providers were recognized in MMIS as actively enrolled Medicaid providers. The PASSE was responsible for ensuring information was sufficient for accurate identification of participating network providers and non-participating providers who render services to PASSE enrollees. The PASSE must implement and maintain review procedures to validate the successful loading of encounter files by DHS fiscal agent's EDI clearinghouse. The PASSE must use the EDI 997 response (functional acknowledgement) files to determine if files were successfully loaded. Within seven days of the original submission attempt, the PASSE must correct and resubmit files and/or records that fail to load.

Timeliness Requirements

For all services rendered to its enrollees (excluding services paid directly by DHS on a fee-for-service basis), the PASSE must submit encounter claims monthly following the date on which the PASSE adjudicated the claims. The PASSE must submit pharmacy encounters for all the covered services provided by participating and non-participating providers on a weekly basis. Within 30 days after notice by DHS or its fiscal agent of encounters getting a denied or rejected payment status (failing fiscal agent edits), the PASSE must accurately resubmit 100% of all encounters for which errors can be remedied. The PASSE must use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven days of the original submission attempt, the PASSE must correct and resubmit files that fail to load.

Previous Reports

This report includes improvements and trends from the baseline measurement year (2019) where applicable.

Other Relevant Information

In the future, Qsource, DHS, and the PASSEs may determine further information is relevant to encounter data validation. No other documentation was utilized in this EDV.

Description of Data Obtained for DMOs

Qsource conducted EDV activities for encounter data files submitted by the DMOs to DHS.

Operational Definition of Encounter

DHS defines an encounter as a standardized record of a health care-related service, procedure, treatment, or therapy rendered by a licensed provider or providers to an enrollee of the DMO. There were two types of service encounters, paid claim

encounters and non-paid encounters (i.e., encounters that were performed but were not reimbursable).

CMS defines encounter data as the information related to the receipt of any item or service by an enrollee in an MCP. It is often thought of as the managed care equivalent of fee-for-service (FFS) claims. Encounter data reflects that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider.

Types of Encounters the DMO Must Report

Per the DMO Appendix 8.5, all DMO encounters must be submitted to DHS for all services provided to enrollees, including value-added services as required by the Managed Care regulations in 42 CFR 438.818. The encounter must include characteristics of the enrollee and the provider and must meet data quality standards, as established by CMS and DHS to ensure complete and accurate data for program administrations.

Weekly Encounter Data submissions must include information on denied claims. The submission of denied claims will begin upon both (a) mutual agreement of all parties and (b) a written statement from DHS' vendors that all systems were ready to exchange denied claims.

The DMO must provide complete and accurate encounter data for all Medically Necessary Covered Dental Services including Value-Added Services.

Format for Reporting Encounters

All DMO encounters must be submitted to DHS in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (D — Dental).

Objective Standards to Which Encounters Are Compared

Encounter data must meet established DHS data quality standards. These standards were defined by DHS to ensure receipt of complete and accurate data for program administration and were closely monitored and enforced. Per the DMO Appendix 8.5.3, DHS defines these standards as follows:

1. The DMO must submit data on the basis of which the State certifies the actuarial soundness of capitation rates to a DMO, including base data that was generated by the DMO.
2. The DMO must submit data on that basis of which the State determines the compliance of the DMO with the Medical Loss Ratio (MLR) requirement.
3. The DMO must submit data on the basis of which the State determines that the DMO has made adequate provision against the risk of insolvency.
4. The DMO must submit data on the basis of which the State determines that the DMO has complied with the state's requirements of availability and accessibility of services, including network adequacy.
5. The DMO must submit documentation on which the State bases its certification that the DMO has complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.

State Standards

The DMO must provide complete and accurate Encounter Data for all Medically Necessary Covered Services including Value-Added Services. For this report, Qsource reviewed two levels of completeness and accuracy — the completeness and accuracy of overall encounter submission in its entirety of the measurement year as well as the completeness and accuracy of each encounter.

Per the DMO contract 3.11(D)(1) The DMO must provide complete Encounter Data for all Medically Necessary Covered Services including Value-Added Services. For purposes of this report, Qsource has identified >95% as the threshold for completeness for each encounter.

The accuracy of the encounter data must be closely monitored and enforced. Per the DMO contract 3.11(D)(10), the DMO must ensure that at least 99% of data was accurate.

Data Dictionary

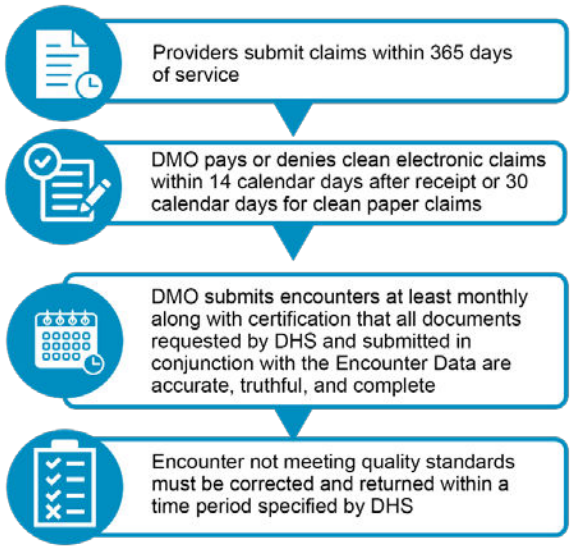
For reporting claims processed by the Contractor and submitted on Encounter 837D format, the DMO must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by DHS. Any exceptions will be considered on a code-by-code basis after DHS receives written notice from the Contractor requesting an exception.

Qsource collaborated with the DMO to understand data file formats, including the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (D — Dental). The DMO's encounters follow the standards in DHS's 5010 Companion Guides. The DMO converts all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats. The companion guides can be found on the Arkansas Medicaid System Documents webpage.

Information Flow

Providers submit dental claims to the DMO. Adjudication of these services was performed with front-end edits at the clearing house and at the DMO transaction systems. The DMO submits its data to DHS. **Figure 2** illustrates the information flow for claims and encounters per the Agreement.

Figure 2. DMO Claims Process



Data Edits and Checks

Per the DMO Appendix 8.5.4, the DMO must certify all encounter data, to the extent required by 42 CFR 438.606. Such certification must be submitted to DHS with the certified data. It must be based on the knowledge, information, and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by DHS were accurate, truthful, and complete. The DMO must provide the certification at the same time it submits the certified data in the format and within the timeframe required by DHS. According to the DMO Contract 3.11(D)(7) encounter data that did not meet quality standards must be corrected and returned within a time period specified by DHS.

Timeliness Requirements

All encounter data must be submitted in accordance with the timeframes established in the Contract. The DMO must submit encounter data transmissions at least monthly and include all encounter data and adjustments processed by the DMO.

Weekly encounter data submissions must include information on denied claims. The submission of denied claims will begin upon both (a) mutual agreement of all parties and (b) a written statement from DHS's vendors that all systems were ready to exchange denied claims.

Data that did not meet quality standards must be corrected and returned within the time period specified by DHS.

Previous Reports

This report includes improvements and trends from the baseline measurement year (2019) where applicable.

Other Relevant Information

In the future, Qsource, DHS, and the DMOs may determine further information was relevant to encounter data validation. No other documentation was utilized in the 2020 validation.

Findings

Table 106 presents the EDV validation rating criteria.

Table 106. EDV Validation Rating Criteria

Rating	Criteria
High Confidence	Met or exceeded DHS target
Moderate Confidence	Within 10 percentage points of DHS target
Low Confidence	Within 20 percentage points of DHS target
No Confidence	Below 20 percentage points of DHS target

Table 107 presents the results from EDV and the confidence rating for each standard component by PASSE.

Table 107. MY 2020 EDV Results and Validation Rating: PASSEs

Standard Component	DHS Target	ARTC		Empower		Summit	
		Results	Validation Rating	Results	Validation Rating	Results	Validation Rating
Encounters submitted for 100% of the covered services by participating and non-participating providers	100%	98.3%	Moderate Confidence	99.9%	Moderate Confidence	98.4%	Moderate Confidence
No less than 95% of encounter lines submission pass MMIS system edits	≥95%	96.6%	High Confidence	89.2%	Moderate Confidence	73.1%	No Confidence
Submit encounter claims monthly	100%	94.5%	Moderate Confidence	94.2%	Moderate Confidence	92.4%	Moderate Confidence
Accurately resubmit 100% of all encounters for which errors can be remedied	100%	17.5%	No Confidence	77.6%	No Confidence	10.2%	No Confidence
Resubmit remedied encounters within 30 days of notice by DHS	100%	10.0%	No Confidence	75.6%	No Confidence	12.3%	No Confidence
At least 95% of all encounters must be complete*	≥95%	97.2%	High Confidence	96.2%	High Confidence	96.0%	High Confidence
At least 95% of all encounters must be valid*	≥95%	100%	High Confidence	100%	High Confidence	100%	High Confidence

**These components include pharmacy data.*

Table 108 presents the results from EDV and the confidence rating for each standard component by DMO.

Table 108. MY 2020 EDV Results and Validation Rating: DMOs

Standard Component	DHS Target	Delta Dental		MCNA	
		Results	Validation Rating	Results	Validation Rating
At least 99% of all encounter encounters must be accurate (Pass MMIS edits)	99%	90.1%	Moderate Confidence	88.3%	Low Confidence
All encounter data submitted in accordance within the timeframes established in the contract	100%	100%	High Confidence	83.4%	Low Confidence
Submit encounter claims monthly	100%	60.9%	No Confidence	53.0%	Moderate Confidence
Accurately resubmit 100% of all encounters for which errors can be remedied	100%	28.3%	No Confidence	78.3%	No Confidence
Resubmit remedied encounters within 30 days of notice by DHS	100%	1.3%	No Confidence	0%	No Confidence
At least 95% of all encounters must be complete	≥95%	99.0%	High Confidence	100%*	High Confidence
At least 99% of all encounter data (by field) must be valid	≥99%	100%	High Confidence	100%	High Confidence

**Rounded up to 100%*

ISCAT Review

Qsource conducted an assessment of the capacity to produce accurate and complete encounter data during a series of Virtual Systems Reviews held in July – August 2021. Prior to the virtual review, each ISCAT was reviewed by Qsource for general information, the integrity of all systems capabilities including administrative data (dental claims), enrollment data systems, provider data, data completeness, integration of data for performance measure calculation and ancillary data, and integration processes. The PASSEs and DMOs prepared well-documented ISCATs which greatly facilitated the Virtual Systems Review process. The review of the ISCATs, the systems demonstrations, along with interviews with PASSE and DMO personnel helped Qsource to identify weaknesses in the information systems, if any. This step in the Protocol helped determine where and how information systems may be vulnerable to incomplete or inaccurate data capture or processing, integration, storage, or reporting.

Qsource conducted interviews with key staff involved in the production of performance measures using questions tailored to the processes based on findings from the ISCAT. Primary Source Verification was done on data tracking logs that were used to monitor data transfer and incorporation across all facets of data: claims, enrollment, provider, and ancillary vendors. Qsource observed a live demonstration of the data systems and key processes required for performance measure calculation. Qsource assessed the ability to link data from multiple sources and the extent to which they have created processes to ensure the accuracy of the calculated performance measures. Data file reviews were conducted as well as a review of all systems.

All PASSEs and DMOs fully met the criteria defined in the IS Capabilities Assessment. See Table 36.

The findings from the ISCA reviews and the previous measurement year's results can be found in the *2020 Service Dates EDV Reports* for each PASSE and DMO.

Validation Results

Completeness and Accuracy of Encounter Data Submission

Table 109 presents the general magnitude of missing encounter data, type of encounters that may be missing, and overall data quality (completeness and accuracy) for the PASSEs. For this year's reporting, Qsource analyzed results further by encounter type.

Table 109. MY 2020 Completeness and Accuracy of Encounter Data Submission: PASSE						
	ARTC		Empower		Summit	
(i) Encounters submitted for 100% of the covered services by participating and non-participating providers						
Encounter Types	Submitted	Not Submitted	Submitted	Not Submitted	Submitted	Not Submitted
Institutional	98.7%	1.3%	99.4%	0.6%	97.4%	2.6%
Professional	97.5%	2.5%	100%*	0%†	98.2%	1.8%
Pharmacy	100%	0%	100%*	0%†	99.8%	0.2%
Total	**98.3%**	**1.7%**	**99.9%**	**0.1%**	**98.4%**	**1.6%**
(ii) No less than 95% of encounter lines submission pass MMIS system edits						
	Pass MMIS System Edits	Rejected by MMIS System Edits	Pass MMIS System Edits	Rejected by MMIS System Edits	Pass MMIS System Edits	Rejected by MMIS System Edits
Institutional	82.0%	18.0%	86.3%	13.7%	60.6%	39.4%
Professional	96.3%	3.7%	86.5%	13.5%	67.0%	33.0%
Pharmacy	100%	0%	100%*	0%†	97.2%	2.8%
Total	**96.6%**	**3.4%**	**89.2%**	**10.8%**	**73.1%**	**26.9%**

**This rate was rounded up to 100%*

† Too small to yield percentage

Note: Data Source - 2020 Performance Measure Validation Report

Table 110 shows the general magnitude of missing encounter data and data quality (accuracy and timeliness) for the DMOs. This analysis pertains to the entirety of the encounter data submitted to DHS by the DMOs.

Table 110. MY 2020 Accuracy and Timeliness of Encounter Data Submission: DMO				
	Delta Dental		MCNA	
(i) At least 99% of all encounter data must be accurate				
	Pass MMIS System Edits	Rejected by MMIS	Pass MMIS System Edits	Rejected by MMIS
Percentage	90.1%*	9.9%	88.3%	11.7%

Table 110. MY 2020 Accuracy and Timeliness of Encounter Data Submission: DMO				
	Delta Dental		MCNA	
(ii) All encounter data submitted in accordance within the timeframes established in the contract				
	Submitted within Timeframes		Not Submitted within Timeframes	
Percentage	100%	0%	83.4%	17%

**2020 Accepted was defined as encounters that resulted in a paid M5 Category of Service status on the received response files. The Category of Service was not provided to Delta Dental in the supplemental files, until May 8, 2020, resulting in a lower than normal Q1 result.*
Note: Data Source – Plan-reported data for the 2020 Performance Measure Validation Report

Timeliness

Tables 111-116 present the timeliness analysis results for the current measurement year. Qsource did not receive pharmacy adjudication dates, therefore it is not included in this analysis.

For **Tables 111-112**, Qsource used the following methodology. The first original (MMIS Claim Trans Type = O) MMIS ICN for a MCO ICN (Patient Account Number - PAN) was considered the first submission. If the first submission was in PAID status in MMIS, the first submission will remain the submission of record for timeliness calculations regardless of future adjustments. For original submissions, the number of days between the Adjudication Date and the MMIS Submission Date was calculated. Timeliness of original submissions was calculated by comparing MMIS Submission date to the End of the Next Month (EONM) following the Adjudication Date.

Table 111. MY 2020 Timeliness of PASSE Encounter Data Submission - Original Submissions												
Submission Days	ARTC				Empower				Summit			
	Institutional		Professional		Institutional		Professional		Institutional		Professional	
	#	%	#	%	#	%	#	%	#	%	#	%
0 - 30 days	20,427	70.5%	559,625	95.7%	7,775	89.2%	118,635	94.5%	30,527	81.6%	840,122	92.9%
31 days – EONM*	418	1.4%	527	0.1%	51	0.6%	619	0.5%	277	0.7%	1,284	0.1%
> EONM	1,845	6.4%	2,710	0.5%	304	3.5%	3,287	2.6%	1,756	4.7%	13,354	1.5%
Missing PASSE Adjudication Date	6,282	21.7%	22,213	3.8%	585	6.7%	3,001	2.4%	4,869	13.0%	49,623	5.5%
Total	**28,972**	**100%**	**585,075**	**100%**	**8,715**	**100%**	**125,542**	**100%**	**37,429**	**100%**	**904,383**	**100%**

**EONM: End of Next Month*

Table 112. MY 2020 Timeliness of DMO Encounter Data Submission - Original Submissions				
Submission Days	Delta Dental		MCNA	
	#	%	#	%
0 - 30 days	142,830	60.9%	100,326	53.0%
31 days - EONM*	4,245	1.8%	142	0.1%
> EONM	7,409	3.2%	3,066	1.6%
Missing PASSE Adjudication Date	80,005	34.1%	85,627	45.3%
Total	**234,489**	**100%**	**189,161**	**100%**

**EONM: End of Next Month*

For **Tables 113-114**, Qsource used the following methodology. If the first original MMIS ICN was in DENIED status in MMIS for a MCO ICN, the first PAID status MMIS ICN received under the same MCO ICN was considered the remediated submission. For remediated submissions, the number of days between the MMIS Adjudication date of the first (denied status) MMIS ICN and the submission date of the first paid status MMIS ICN for the same MCO ICN was calculated. The timeliness of remediated submissions was calculated using a threshold of less than or equal to 30 days.

Table 113. MY 2020 Timeliness of PASSE Encounter Data Submission - Remediated Submissions												
Submission Days	ARTC				Empower				Summit			
	Institutional		Professional		Institutional		Professional		Institutional		Professional	
	#	%	#	%	#	%	#	%	#	%	#	%
0 - 30 days	72	6.3%	3,727	10.1%	876	62.7%	21,348	76.2%	122	9.4%	7,124	12.4%
> 30 days	1,072	93.7%	33,288	89.9%	521	37.3%	6,663	23.8%	1,172	90.6%	50,519	87.6%
Total	**1,144**	**100%**	**37,015**	**100.0%**	**1,397**	**100%**	**28,011**	**100.0%**	**1,294**	**100%**	**57,643**	**100%**

**Too small to produce a percentage*
*** Rounded to 100%*

Table114. MY 2020 Timeliness of DMO Encounter Data Submission - Remediated Submissions				
Submission Days	Delta Dental		MCNA	
	#	%	#	%
0 - 30 days	263	1.3%	2	0%*
> 30 days	20,475	98.7%	7,059	100%**
Total	**20,738**	**100%**	**7,061**	**100%**

For **Tables 115-116**, Qsource used the following methodology. If the first original MMIS ICN was in DENIED status in MMIS for a MCO ICN, the submission was considered to need remediation. If the MCO ICN had been remediated (see Remediated Submissions above) then it will appear as P (Paid) on the timeliness report. If the MCO ICN had not been remediated (no PAID status MMIS ICN exists for the MCO ICN) then it was considered as "not remediated" on the timeliness report.

Table 115. MY 2020 Timeliness of PASSE Encounter Data Submission - Submissions to Remediate												
Submissions to Remediate	ARTC				Empower				Summit			
	Institutional		Professional		Institutional		Professional		Institutional		Professional	
	#	%	#	%	#	%	#	%	#	%	#	%
Not Remediated	5,336	82.3%	174,128	82.5%	545	28.1%	7,955	22.1%	20,613	94.1%	496,333	89.6%
Remediated	1,144	17.7%	37,015	17.5%	1,397	71.9%	28,011	77.9%	1,294	5.9%	57,643	10.4%
Total	**6,480**	**100%**	**211,143**	**100%**	**1,942**	**100%**	**35,966**	**100%**	**21,907**	**100%**	**553,976**	**100%**

Table 116. MY 2020 Timeliness of DMO Encounter Data Submission - Submissions to Remediate				
Submissions to Remediate	Delta Dental		MCNA	
	#	%	#	%
Not Remediated	52,553	71.7%	25,442	78.3%
Remediated	20,738	28.3%	7,061	21.7%
Total	**73,291**	**100%**	**32,503**	**100%**

Volume and Consistency

As required in Step 2 of Activity 3 of the protocols, Qsource's EDV included an analysis of the volume and consistency of encounter data. Qsource used the flat file format of claims data submitted directly by the PASSEs and DMOs to compare to the volume of encounters in the data DHS provided to Qsource. These comparisons are shown in **Tables 117-118**.

Table 117. MY 2020 Volume Comparison Between PASSE Distinct Original Claims and DHS Distinct Original Encounters

Data	ARTC	DHS for ARTC	Empower	DHS for Empower	Summit	DHS for Summit
Claim/Encounter*						
Institutional	47,125	62,654	83,668	80,376	69,107	63,415
Professional	66,759	922,338	1,455,496	1,583,663	1,589,246	1,640,107
Pharmacy**	370,474	264,938	448,998	397,854	250,779	299,068
Total	**484,358**	**1,249,930**	**1,988,162**	**2,061,893**	**1,909,132**	**2,002,590**
Claim/Encounter Lines						
Institutional	205,466	147,948	333,427	195,946	219,688	201,835
Professional	128,539	1,146,433	1,909,209	1,994,798	2,198,418	2,253,119
Pharmacy**	370,474	264,938	449,514	397,854	250,779	299,068
Total	**704,479**	**1,559,319**	**2,692,150**	**2,588,598**	**2,668,885**	**2,754,022**

**CLAIM_TRANS_TYPE = Original Claims*
***Pharmacy Claim_Type=P only.*

Table 118. MY 2020 Volume Comparison Between DMO Original Claims and DHS Distinct Original Encounters

Data	Delta Dental	DHS	MCNA	DHS
Total Claims/Encounters*	331,823	338,469	269,329	220,313
Total Claim/Encounter Lines	1,196,289	1,154,647	1,134,790	900,552

**CLAIM_TRANS_TYPE = Original Claims*

Tables 119-120 include the number and percentage of processed and voided encounters. The term processed refers to both paid and denied encounters and encounter lines. The term voided refers to claims that were recouped in full. The table presents both, **distinct encounters** which represent the encounter as a whole as well as **distinct encounter lines** which display the different procedures associated with an encounter, date of service start and end dates, the related diagnoses, the charges, and total amount, adjustment amount, claim status, accounting date, etc. Changes in the percentages from the previous measurement year are indicated using an arrow (↑ **or** ↓).

Table 119. Total Encounters Submitted by PASSEs to DHS

Encounters	ARTC				Empower				Summit			
	Processed MY 2020	Processed MY 2019	Voided MY 2020	Voided MY 2020	Processed MY 2020	Processed MY 2019	Voided MY 2020	Voided MY 2020	Processed MY 2020	Processed MY 2019	Voided MY 2020	Voided MY 2020
Total Encounters (Headers)	1,354,964 (88.4%) ↑	1,252,258 (70.0%)	178,562 (11.6%) ↓	535,300 (30.0%)	2,237,889 (89.0%) ↑	2,318,900 (72.0%)	276,260 (11.0%) ↓	900,269 (28.0%)	2,123,919 (92.4%) ↑	1,923,116 (70.8%)	173,691 (7.6%) ↓	794,070 (29.2%)
Total Encounter Lines (Details)	1,710,756 (87.3%) ↑	1,539,854 (69.4%)	248,285 (12.7%) ↓	679,509 (30.6%)	2,834,231 (88.4%) ↑	2,919,070 (71.2%)	370,785 (11.6%) ↓	1,180,492 (28.8%)	2,953,121 (90.9%) ↑	2,566,021 (69.4%)	295,539 (9.1%) ↓	1,130,901 (30.6%)

Table 120. Total Encounters Submitted by DMOs to DHS

Encounters	Delta Dental				MCNA			
	Processed MY 2020	Processed MY 2019	Voided MY 2020	Voided MY 2019	Processed MY 2020	Processed MY 2019	Voided MY 2020	Voided MY 2019
Total Encounters (Headers)	457,956 (83.1%) ↓	444,670 (95.0%)	92,983 (16.9%) ↑	23,401 (5.0%)	349,740 (77.9%) ↑	415,112 (62.4%)	99,512 (22.2%) ↓	249,673 (37.6%)
Total Encounter Lines (Details)	1,825,673 (76.3%) ↓	1,698,702 (94.9%)	566,629 (23.7%) ↑	91,404 (5.1%)	1,684,590 (72.6%) ↑	1,821,701 (62.1%)	636,875 (27.4%) ↓	1,112,813 (37.9%)

The percentage of the PASSE enrollees with at least one encounter is presented in **Table 121**.

Table 121. Percentage of PASSE Enrollees with at Least One Distinct Encounter

Encounter Type	ARTC		Empower		Summit	
	MY 2020	MY 2019	MY 2020	MY 2019	MY 2020	MY 2019
Institutional	7,505 (47.8%) ↑	6,950 (45.8%)	11,769 (52.0%) ↑	11,250 (45.6%)	9,370 (49.9%) ↑	8,980 (46.6%)
Professional	13,240 (84.3%) ↓	13,810 (91.0%)	20,476 (90.5%) ↑	21,661 (87.8%)	17,506 (93.3%) ↑	17,743 (92.0%)
Pharmacy	10,590 (67.4%) ↓	11,301 (74.5%)	16,314 (72.1%) ↓	17,808 (72.2%)	12,026 (64.1%) ↓	13,240 (68.6%)

The percentage of the DMO enrollees with at least one encounter is presented in **Table 122**.

Table 122. Percentage of DMO Enrollees with at Least One Distinct Encounter

	Delta Dental		MCNA	
	MY 2020	MY 2019	MY 2020	MY 2019
Percentage of Enrollees with at Least One Encounter	141,009 (37.4%) ↓	160,034 (41.8%)	121,831 (34.2%) ↓	140,340 (38.8%)

Completeness and Validity

Qsource analyzed the completeness and validity of critical institutional, professional, and pharmacy data fields. Completeness rates for each encounter were calculated as the number of data fields with data present, and validity rates were calculated as the number of valid data points as a percentage of those with data present. These completeness and validity rates for encounter lines are detailed in Appendix E. **Tables 123-124** present summaries of the completeness and validity rates for the PASSEs and DMOs. Completeness and validity rates less than 95.0% appear in **red**.

Table 123. MY 2020 Summary of Completeness and Validity Rates for Selected Fields: PASSEs

	ARTC		Empower		Summit	
	Completeness Rate	Validity Rate	Completeness Rate	Validity Rate	Completeness Rate	Validity Rate
Distinct Encounter Lines						
Institutional	100%	100%	100%†	100%	100%	100%
Professional	100%†	100%†	100%†	100%	100%†	100%
Pharmacy	100%	100%	100%	100%	100%	100%
Distinct Encounters						
Institutional	99.9%	100%†	99.6%	100%	100%†	100%
Professional	96.2%	92.7%	95.1%	100%	95.2%	100%
Pharmacy	100%	100%	100%	100%	100%	100%

†*Rounded up to 100%*

Table 124. MY 2020 Summary of Completeness and Validity Rates for Selected Fields: DMOs

	Delta Dental		MCNA	
	Completeness Rate	Validity Rate	Completeness Rate	Validity Rate
Distinct Encounter Lines	100%†	100%	100%	100%
Distinct Encounters	99.0%	100%	100%†	100%

†*Rounded to 100%*

Medical Record Review

Activity 4 of the CMS EDV protocol—medical record review (MRR) of selected encounter records to confirm EDV findings—was conducted for encounters with dates of service between January 1, 2020 and December 31, 2020 (MY 2020). The majority of encounters involved physician providers, therefore Qsource determined that MRR would be focused on professional encounters. Within the analysis of professional encounters, Qsource noted errors in data completeness for certain fields, namely Provider NPI. DHS approved this approach. MRR was limited to encounters coded in the electronic record as professional physician encounters from the PASSEs. In order to align the DMO review with the PASSEs, DMO MRR was limited to encounters coded in the electronic record as dentist encounters.

Qsource selected a statistically valid stratified random sample of statewide professional physician and dentist encounters. An oversample was applied accordingly to each PASSE and DMO. A sample of 384 encounter records was selected with a 10% oversample of 39 records, for a total of 423 distinct encounters. This sample was stratified across the PASSEs and DMOs based on distinct encounters. Qsource requested that the PASSEs and DMOs secure medical and dental records associated with these encounters from participating providers. The records were reviewed to confirm that key electronic encounter data were supported by the appropriate medical record.

Qsource first identified if the appropriate record was available, then validated the following data in each record as compared to the electronic encounter data:

1. Performing provider name match to National Provider Identifier (NPI) number
2. Date of service
3. Current Procedural Terminology (CPT) codes and Current Dental Technology (CDT) codes
4. International Classification of Diseases (ICD-10) diagnosis codes for each encounter

Table 125 summarizes the medical and dental records requested and received.

Table 125. MY 2020 Requested Records for MRR

PASSE/DMO	Records Requested	Records Received	Records Unavailable
PASSE			
ARTC	43	27	16
Empower	66	45	21
Summit	46	38	8
PASSE Total	155	110	45
DMO			
Delta	153	142	11
MCNA	115	103	12
DMO Total	268	245	23
Grand Total	423	355	68

The PASSEs and DMOs reported difficulty in obtaining 100% of the records for the following reasons:

- *Provider offices' internal policies that required medical records to be mailed and time constraints would not allow that process*
- *Provider offices turn-around times for records*
- *Provider offices have permanently closed*
- *Death of the provider*
- *Uncooperative provider's office*
- *Record was not available as it was for a non-covered service and the claim was not paid*
- *Provider was no longer in the network*
- *Provider's office was unable to locate the record for the requested date of service*

Table 126 summarizes the records reviewed by provider specialty.

Table 126. MY 2020 Record Type for MRR

Record Type	PASSE			DMO		Total
	ARTC	Empower	Summit	Delta Dental	MCNA	
Emergency	5	2	3			10
Hospital	4	1	0			5
Lab	1	2	1			4
Neuro or Pain	5	3	3			11
PCP	2	17	12			31

Table 126. MY 2020 Record Type for MRR

Record Type	PASSE			DMO		Total
	ARTC	Empower	Summit	Delta Dental	MCNA	
Pediatrics	2	6	3			11
Psych	3	5	0			8
Pulmonology	0	3	1			4
Radiology	1	3	9			13
Other*	4	3	6			13
Dental				142	103	245
Total	**27**	**45**	**38**	**142**	**103**	**355**

**Other includes allergy, dermatology, ophthalmology, physical therapy, surgery, and others, etc.*

Table 127 summarizes results of the validation of the Performing Provider NPI data field on the electronic encounter record versus the associated medical record. Table 128 summarizes results of the validation of the Date of Service data field.

Table 127. MY 2020 MRR Results – Performing Provider NPI Validation

PASSE/DMO	Present and Accurate	Total Record Received	Validity Rate
PASSE			
ARTC	26	27	96.3%
Empower	37	45	82.2%
Summit	35	38	92.1%
PASSE Total	98	110	89.1%

Table 127. MY 2020 MRR Results – Performing Provider NPI Validation			
PASSE/DMO	**Present and Accurate**	**Total Record Received**	**Validity Rate**
DMO			
Delta Dental	103	142	72.5%
MCNA	79	103	76.7%
DMO Total	182	245	74.3%
Grand Total	**280**	**355**	**78.9%**

Table 128. MY 2020 MRR Results – Date of Service Validation			
PASSE/DMO	**Present and Accurate**	**Total Record Received**	**Validity Rate**
PASSE			
ARTC	26	27	96.3%
Empower	44	45	97.8%
Summit	38	38	100%
PASSE Total	108	110	98.2%
DMO			
Delta Dental	133	142	93.7%
MCNA	101	103	98.1%
DMO Total	234	245	95.5%
Grand Total	**342**	**355**	**96.3%**

Table 129 and **Table 130** display the results of the validation of CPT and CDT procedure codes and ICD-10 diagnosis codes on each encounter record.

Table 129. MY 2020 MRR Results – CPT/CDT Procedure Codes Validation						
PASSE/DMO	**Correctly Coded**		**Undocumented Codes**		**Missing Codes**	
PASSE – CPT Codes						
ARTC	25	92.6%	1	3.7%	1	4%
Empower	45	100%	0	0%	0	0%
Summit	32	84.2%	4	10.5%	2	5.3%
PASSE Total	102	92.7%	5	4.5%	3	2.7%
DMO – CDT Codes						
Delta	128	90.1%	13	9.2%	1	0.7%
MCNA	93	90.3%	10	9.7%	0	0%
DMO Total	221	90.2%	23	9.4%	1	0.4%
Grand Total	**323**	**91.0%**	**28**	**7.9%**	**4**	**1.1%**

Table 130. MY 2020 MRR Results – ICD-10 Diagnosis Codes Validation						
PASSE	**Correctly Coded**		**Undocumented Codes**		**Missing Codes**	
ARTC	22	81.5%	5	18.5%	0	0%
Empower	41	91%	1	2%	3	7%
Summit	34	89.5%	3	7.9%	1	2.6%
Total	**97**	**88.2%**	**9**	**8.2%**	**4**	**3.6%**

Dental records did not include diagnosis codes. Therefore, this analysis was only applicable to the PASSEs.

Medical Record Review Findings Summary

Qsource received a total of 355 distinct records out of the 423 records requested. Although EDV results indicated possible data completeness issues for provider NPI, Qsource's focused medical record review found that overall, the records demonstrated that electronic data for performing provider NPI were mostly consistent with the medical record, with an overall percentage of 78.9%. The PASSEs were most consistent with an 89.1% validity rate. ARTC had the highest validity rating for the PASSEs at 96.3%, while Empower had the lowest validity rate at 82.2%. The majority of inconsistencies for the PASSEs resulted from a Performing provider NPI mismatch between the electronic encounter record and the medical record.

The DMOs had a validity rating of 74.3%, with MCNA receiving a score of 76.7% and Delta Dental at 72.5%. For the DMOs, the most common error was the provider's name missing from the dental record.

Dates of service on electronic records were highly accurate for all the PASSEs and DMOs, at 96.3% overall.

Overall procedure coding accuracy was 91%. Procedure coding accuracy on electronic records varied among the PASSEs at 92.6% for ARTC, 100% for Empower, and 84.2% for Summit for an overall accuracy rate of 92.7%. Only five electronic records (4.5%) included procedure codes that were not documented in the medical record. The electronic records were missing procedure codes in three (2.7%) cases.

The DMO's procedure coding accuracy was similar with 90.1% for Delta Dental and 90.3% for MCNA. The DMOs had an overall accuracy rate of 90.2%. Twenty-three electronic records (9.4%) included procedure codes that were not documented in the medical record. The electronic records were missing procedure codes in one (0.4%) case.

Diagnosis coding was varied with results of 81.5% for ARTC, 91% for Empower, and 89.5% for Summit. The PASSEs had an overall diagnosis code accuracy rate of 88.2%. Codes in the electronic record were not documented in the medical record in 8.2% of encounters. Codes were missing from the electronic record in 3.6% of encounters.

Strengths and Weaknesses

ARTC

ARTC prepared a well-documented ISCAT. Qsource observed a live demonstration of the data systems and key processes. Qsource assessed ARTC's ability to link data from multiple sources and the processes to ensure data accuracy. A data file review was conducted as well as a review of all systems. The review of ARTC's ISCAT, the systems demonstrations, along with interviews with personnel identified no weaknesses in ARTC's information systems.

According to the PASSE-reported data regarding overall encounter submission, ARTC did not meet target of 100% submitted for the covered services by participating and non-participating providers (98.3%). However, when analyzed by encounter type, pharmacy encounters did meet target. Overall, ARTC met the goal of no less than 95% of encounter lines submission pass MMIS system edits (96.6%). However, when analyzed by encounter type, Institutional encounters did not meet the standard at 82.0%.

ARTC had 28,972 original institutional encounter submissions and 585,075 original professional encounter submissions. The majority of institutional and professional encounters were submitted within 30 days at 70.5% and 95.7%, respectively. ARTC submitted 1,144 remediated institutional encounter submissions, with 93.7% submitted after 30 days. For remediated professional encounter submissions, 37,015 were submitted with 89.9% submitted after 30 days. ARTC remediated 17.7% of original denied institutional encounter submissions and 17.5% of original denied professional encounter submissions.

ARTC reported a different number of distinct original encounters than DHS. ARTC submitted encounter data by paid date rather than by service date as requested by Qsource. These results were not consistent with the PASSE-reported results.

Distribution of processed versus voided encounters submitted to DHS by ARTC was consistent between the headers (distinct encounters) and the detail lines for the encounters. Data for 2020 service dates demonstrated that professional encounters accounted for the majority of encounter submissions at 70.5%. Institutional and pharmacy encounters accounted for 5.8% and 23.7%, respectively. Most distinct encounter lines were professional with 70.2%.

ARTC enrollees who had at least one distinct professional encounter for service dates in 2020 accounted for 84.3%. ARTC accounted for 25.9% of aggregate enrollment across the PASSEs, which was consistent with distinct encounter percentages ranging from 21.9% to 32.9%.

Other medical service types accounted for 59.3% of medical service encounter lines. Most of the remaining encounter lines were for Medicine (24.8%), with Evaluation and Management and Pathology and Laboratory accounting for 6.6% and 6.5%, respectively

Rehabilitation Center/Services, CES Waiver Supportive Living/Respite/Support, and Clinics accounted for approximately 67.4% of total distinct medical encounters.

The average number of days from the last date of service to paid date were 80.3 and 138.8, respectively, for both professional and institutional encounters. The average number of days from billing date to paid date for professional encounters was 15.4 days, while the average for institutional encounters was 39.6 days. The ARTC data indicated a long time period from service date to paid date. On average, the time from the service date to billing date was the greater contributor to the overall wait time.

ARTC enrollees' age, gender, and race were derived from the encounter header record and was consistent with the enrollees' enrollment records. There were 31 Institutional, 83 Professional, and 36 Pharmacy encounters without demographic information (negligible percentage of total). Children under age 21 accounted for 77.0% of enrollment with a range from 69.8% to 79.7% for encounters. Females accounted for 46.5% of enrollment with a range from 46.7% to 50.2% for encounters. Whites accounted for the highest percentage of enrollment at 56.8%, while the lowest percentage was Asian with 0.4%

ARTC was consistent with reporting enrollees although there was a slight increase over the review period. Reporting was consistent with a downward trend in reported encounters. Institutional encounters were reported consistently over the review period. ARTC had a decrease in institutional encounters during the measurement year, but overall had a higher number of institutional encounters compared to 2019. Professional encounters were reported consistently with no gaps with a slight increase during the measurement year. Pharmacy encounters were reported consistently with no gaps. ARTC experienced a decrease in pharmacy encounters during the measurement year, and overall had a lower number of pharmacy encounters compared to 2019. However, these trends had no impact on the consistency of reported encounters, which was evaluated.

ARTC's accuracy of enrollee IDs was high ranging from 99.4% to 99.7%. Accuracy rates for Date of Birth ranged from 99.3% to 99.6%.

For institutional encounters, completeness rates for all distinct encounter line fields were 100%. Completeness rates for distinct encounters were 99.9%-100%. ARTC achieved an overall completeness rate of 100% for distinct encounter lines and 99.9% for distinct encounters. ARTC had 100% validity rate for both distinct encounter lines and distinct encounters. For professional encounters, completeness rates for all distinct encounter line fields were all 100%. Completeness rates for distinct encounters were above the 95.0% threshold, except for Performing provider NPI (77.7%) and Billing provider NPI (80.8%). ARTC achieved an overall completeness rate of 100% for distinct encounter lines and 96.2% for distinct encounters. ARTC had 100% validity rate for both distinct encounter lines and distinct encounters.

Empower

Empower prepared a well-documented ISCAT. Qsource observed a live demonstration of the data systems and key processes. Qsource assessed Empower's ability to link data from multiple sources and the processes to ensure data accuracy. A data file review was conducted as well as a review of all systems. The review of Empower's ISCAT, the systems demonstrations, along with interviews with personnel identified no weaknesses in Empower's information systems.

According to the PASSE-reported data regarding overall encounter submission, Empower nearly met the target of 100% of encounters of covered services submitted by participating and non-participating providers at 99.9%. When analyzed by encounter type, institutional encounters did not meet the target with 99.4%. Overall, Empower did not meet the standard of no less than 95% of encounter lines submission pass MMIS system edits at 89.2%. When analyzed by encounter type neither Institutional nor Professional encounter types met the standard with 86.3% and 86.5% passing MMIS edits, respectively.

Empower had 8,715 original institutional encounter submissions and 125,542 original professional encounter submissions. The majority of institutional and professional encounters were submitted within 30 days at 89.2% and 94.5%, respectively. Empower submitted 1,397 remediated institutional encounter submissions, with 62.7% submitted within 30 days. For remediated professional encounter submissions, 28,011 were submitted with 76.2% submitted within 30 days. Empower remediated 71.9% of original denied institutional encounter submissions and 77.9% of original denied professional encounter submissions. In this analysis, Qsource found that a high percentage (39.3%) of Patient Account Numbers (PANs) were associated with multiple Recipient IDs.

Empower reported a similar number of distinct original encounters as DHS. The difference was negligible and did not indicate any issues with data submission. The volume comparison analysis results were consistent with the PASSE-reported results.

Distribution of processed versus voided encounters submitted to DHS by Empower was consistent between the headers (distinct encounters) and the detail lines for the encounters. Data for 2020 service dates demonstrated that professional encounters accounted for the majority of encounter submissions at 74.8%. Institutional and pharmacy encounters accounted for 4.0% and 21.1%, respectively. Most distinct encounter lines were professional with 75.2%.

Empower enrollees who had at least one distinct professional encounter for service dates in 2020 accounted for 90.5%. Empower accounted for 40.8% of aggregate enrollment across the PASSEs, which was consistent with distinct encounter percentages ranging from 37.6% to 42.4%.

Other medical service types accounted for 60.8% of medical service encounter lines. Most of the remaining encounter lines were for Medicine (24.1%), with Evaluation and Management

and Pathology and Laboratory accounting for 6.8% and 5.6%, respectively

Rehabilitation Center/Services, CES Waiver Supportive Living/Respite/Support, and Other accounted for approximately 70.8% of total distinct medical encounters.

The average number of days from the last date of service to paid date was 79.5 and 126.9, respectively, for both professional and institutional encounters. The average number of days from billing date to paid date for professional encounters was 12.4 days, while the average for institutional encounters was 16.7 days. The Empower data indicated a long time period from service date to paid date. On average, the time from the service date to billing date was the greater contributor to the overall wait time.

Empower enrollees' age, gender, and race were derived from the encounter header record and was consistent with the enrollees' enrollment records. There were 244 Institutional, 452 Professional, and 59 Pharmacy encounters without demographic information (negligible percentage of total). Children under age 21 accounted for 77.5% of enrollment with a range from 70.2% to 80.8% for encounters. Females accounted for 46.4% of enrollment with a range from 46.5% to 50.9% for encounters. Whites accounted for the highest percentage of enrollment at 56.3%, while the lowest percentage was Asian with 0.4%

Empower was consistent with reporting enrollees although there was a slight increase in enrollees for 2020. Reporting was consistent with a slight decrease in encounters throughout the measurement year, and overall had a lower number of encounters compared to 2019. Institutional encounters were reported consistently over the review period. Empower had a decrease in institutional encounters during the measurement year. Professional encounters were reported consistently with no gaps with a slight decrease during the measurement year. Pharmacy encounters were reported consistently with no gaps. Empower experienced a slight decrease in pharmacy encounters during the measurement year, and overall had a lower number of pharmacy encounters compared to 2019. However, these trends had no impact on the consistency of reported encounters, which was evaluated.

Empower's accuracy of enrollee IDs was high ranging from 97.8% to 99.6%. Accuracy rates for Date of Birth ranged from 97.7% to 99.5%.

For institutional encounters, completeness rates for all distinct encounter line fields were 100%, except for recipient ID which was 99.8%. Completeness rates for distinct encounters were 96.6%-100%. Empower achieved an overall completeness rate of 100% for distinct encounter lines and 99.6% for distinct encounters. Empower had 100% validity rate for both distinct encounter lines and distinct encounters. For professional encounters, completeness rates for all distinct encounter line fields were all 100% except recipient ID which was 99.9%. Completeness rates for distinct encounters were above the 95.0% threshold, except for Performing provider NPI (74.6%),

Performing provider ID (93.6%), Performing provider specialty (93.6%), and Billing provider NPI (81.9%). Empower achieved an overall completeness rate of 100% for distinct encounter lines and 95.1% for distinct encounters. Empower had 100% validity rate for both distinct encounter lines and distinct encounters.

Summit

Summit prepared a well-documented ISCAT. Qsource observed a live demonstration of the data systems and key processes. Qsource assessed the PASSE's ability to link data from multiple sources and the processes to ensure data accuracy. A data file review was conducted as well as a review of all systems. The review of Summit's ISCAT, the systems demonstrations, along with interviews with personnel identified no weaknesses in Summit's information systems.

According to the PASSE-reported data regarding overall encounter submission, Summit did not meet the target for 100% of the submitted covered services by participating and non-participating providers at 98.4%. When analyzed by encounter type, none of the encounter types met the target. Summit did not meet the target of no less than 95% of encounter lines submission passing MMIS system edits (73.1%). When analyzed by encounter type, none of the encounter types met the target.

Summit had 37,429 original institutional encounter submissions and 904,383 original professional encounter submissions. The majority of institutional and professional encounters were submitted within 30 days at 81.6% and 92.9%, respectively. Summit submitted 1,294 remediated institutional encounter submissions, with 90.6% submitted after 30 days. For remediated professional encounter submissions, 57,643 were submitted with 87.6% submitted after 30 days. Summit remediated 5.9% of original denied institutional encounter submissions and 10.4% of original denied professional encounter submissions.

Summit reported a similar number of distinct original encounters as DHS. The difference was negligible and did not indicate any issues with data submission. The volume comparison analysis results were consistent with the PASSE-reported results.

Distribution of processed versus voided encounters submitted to DHS by Summit was consistent between the headers (distinct encounters) and the detail lines for the encounters. Data for 2020 service dates demonstrated that professional encounters accounted for most encounter submissions at 81.6%. Institutional and pharmacy encounters accounted for 3.3% and 15.1%, respectively. Most distinct encounter lines were professional with 81.4%.

Summit enrollees who had at least one distinct professional encounter for service dates in 2020 accounted for 93.3%. Summit accounted for 33.9% of aggregate enrollment across the PASSEs, which was consistent with distinct encounter percentages ranging from 28.7% to 39.7%.

Other medical service types accounted for 72.1% of medical service encounter lines. The majority of the remaining encounter lines were for Medicine (16.8%), with Evaluation and Management and Pathology and Laboratory accounting for 4.6% and 4.2%, respectively

Rehabilitation Center/Services, CES Waiver Supportive Living/Respite/Support, and Clinics accounted for approximately 70.3% of total distinct medical encounters.

The average number of days from the last date of service to paid date were 87.8 and 88.2, respectively, for both professional and institutional encounters. The average number of days from billing date to distinct encounter paid date for professional encounters was 13.9 days, while the average for institutional encounters was 18.5 days. The Summit data indicated a long time period from service date to paid date. On average, the time from the service date to billing date was the greater contributor to the overall wait time.

Encounter rates for adults and children were slightly disproportionate to the enrollment rates for all three service types. Encounter rates for gender and race were proportionate to the enrollment rates for all three service types.

There were 132 Institutional, 554 Professional, and 54 Pharmacy encounters without demographic information (negligible percentage of total). Children under age 21 accounted for 68.0% of enrollment with a range from 60.0% to 75.6% for encounters. Females accounted for 44.1% of enrollment with a range from 44.2% to 48.4% for encounters. Whites accounted for the highest percentage of enrollment at 55.5%, while the lowest percentage was Asian with 0.5%

Summit was consistent with reporting enrollees although there was a slight increase in enrollees for 2020. Institutional encounters were reported consistently over the review period. Summit had a slight increase in institutional encounters during the measurement year. Professional encounters were reported consistently with no gaps with a slight increase during the measurement year. Pharmacy encounters were reported consistently with no gaps. Summit overall had a lower number of pharmacy encounters compared to 2019. However, these trends had no impact on the consistency of reported encounters, which was evaluated.

Summit's accuracy of enrollee IDs was high ranging from 96.8% to 99.6%. Accuracy rates for Date of Birth ranged from 96.8% to 99.5%.

For institutional encounters, completeness rates for all distinct encounter line fields were 100%. Completeness rates for distinct encounters were 99.8%-100%. Summit achieved an overall completeness rate of 100% for distinct encounter lines and 100% for distinct encounters. Summit had 100% validity rate for both distinct encounter lines and distinct encounters. For professional encounters, completeness rates for all distinct encounter line fields were all 100%. Completeness rates for distinct encounters

were above the 95.0% threshold, except for Performing provider NPI (72.7%) and Billing provider NPI (77.3%). Summit achieved an overall completeness rate of 100% for distinct encounter lines and 95.2% for distinct encounters. Summit had 100% validity rate for both distinct encounter lines and distinct encounters.

Delta Dental

Delta Dental prepared a well-documented ISCAT. Qsource observed a live demonstration of the data systems and key processes. Qsource assessed Delta Dental's ability to link data from multiple sources and the processes to ensure data accuracy. A data file review was conducted as well as a review of all systems. The review of Delta Dental's ISCAT, the systems demonstrations, along with interviews with personnel identified no weaknesses in Delta Dental's information systems.

According to the DMO-reported data regarding overall encounter submission, Delta Dental did not meet the target of at least 99% overall encounter data accuracy at 90.1%. Delta Dental achieved 100% encounter data submitted within established timeframes. However, of the encounters submitted, Qsource found that selected fields did meet DHS's target of greater than 95% completeness and 99% accuracy.

Delta Dental had 234,489 original encounter submissions. The majority of encounters were submitted within 30 days (60.9%). Delta Dental had 20,738 remediated encounter submissions. The majority of them were submitted in more than 30 days (98.7%). Delta Dental remediated 28.3% of original denied encounter submissions.

Delta Dental reported a lower number of distinct original encounters than DHS, but the difference was small and did not indicate any issues with data submission.

Distribution of processed versus voided encounters submitted to DHS by Delta Dental was somewhat consistent between the header (distinct encounters) and the detail lines for the encounters.

Delta Dental submitted 369,557 distinct encounters in 2020. Delta Dental submitted 1,307,780 distinct encounter lines in 2020.

Delta Dental enrollees who had at least one encounter for 2020 service dates accounted for 37.4%. Compared to aggregate enrollment (51.8%), the percentage of encounters was slightly higher at 59.4%.

Dental Preventative Services, Dental Radiographs/Diagnostic Imaging (X-Rays), and Dental Clinical Oral Evaluations accounted for the majority of dental service types in 2020 with 28.6%, 22.6%, and 15.7%, respectively.

There were 319 encounters without demographic information (negligible percentage of total). Children under age 21 accounted for 71.5% of enrollment and 86.3% of encounters. Females accounted for 54.6% of enrollment and 53.9% of

encounters. Whites accounted for the highest percentage of enrollment at 48.3%, while the lowest percentage was Asian with 1.1%.

Encounter rates for adults and children were not proportionate to the enrollment rates. Encounter rates for gender and race were proportionate to enrollment rates.

Enrollment and encounters were reported consistently with no gaps. Delta Dental experienced a slight increase in enrollees and encounters throughout 2020. There was a reduction in encounters in April 2020 which was likely due to COVID-19 restrictions on non-emergency dental care during that timeframe.

Delta Dental's accuracy rate for Enrollee IDs was 99.8%. The accuracy rate for Date of Birth was 99.6%.

Completeness rates for all distinct encounter lines and distinct encounters were above the 95.0% threshold. Validity rates for all fields were 100%.

MCNA

MCNA prepared a well-documented ISCAT. Qsource observed a live demonstration of the data systems and key processes. Qsource assessed MCNA's ability to link data from multiple sources and the processes to ensure data accuracy. A data file review was conducted as well as a review of all systems. The review of MCNA's ISCAT, the systems demonstrations, along with interviews with personnel identified no weaknesses in MCNA's information systems.

According to the DMO-reported data regarding overall encounter submission, MCNA did not meet the target of at least 99% overall encounter data accuracy at 88.3%. MCNA did not meet the target for encounter data submitted within established timeframes. However, of the encounters submitted, Qsource found that selected fields did meet DHS's target of >95% completeness and 99% accuracy.

MCNA had 189,161 original encounter submissions. Approximately half of the encounters were submitted within 30 days (53.0%). MCNA had 7,061 remediated encounter submissions. They were all submitted in more than 30 days (100%). MCNA remediated 21.7% of original denied encounter submissions.

MCNA reported a higher number of distinct original encounters and encounter lines than DHS. The bulk of the difference between DMO-reported encounters and DHS data was likely due to encounters not passing MMIS edits. These results were not consistent with the DMO-reported results. The DMO-reported data showed 11.7% of overall encounters failed to pass MMIS system edits, while Qsource's comparison of distinct original claims submitted by the DMOs to distinct original encounters provided by DHS found a difference of approximately 18%-20%.

Distribution of processed versus voided encounters submitted to DHS by MCNA was somewhat consistent between the header (distinct encounters) and the detail lines for the encounters.

MCNA submitted 252,302 distinct encounters in 2020. MCNA submitted 1,072,567 distinct encounter lines in 2020.

MCNA enrollees who had at least one encounter for 2020 service dates was 34.2%. Compared to enrollment (48.6%), the percentage of encounters was slightly lower at 40.6%.

Dental Preventative Services, Dental Radiographs/Diagnostic Imaging (X-Rays), and Dental Clinical Oral Evaluations accounted for the majority of dental service types in 2020 with 27.2%, 26.3%, and 15.5%, respectively.

Encounter rates for adults and children were somewhat disproportionate to the enrollment rates. Encounter rates for females and males were proportionate to the enrollment rates. Encounter rates for all race categories were proportionate to the enrollment rates. There were 249 encounters without demographic information (negligible percentage of total). Children under age 21 accounted for 71.0% of enrollment and 86.5% of encounters. Females accounted for 54.6% of enrollment and 53.9% of encounters. Whites accounted for the highest percentage of enrollment at 47.7%, while the lowest percentage was Asian with 1.0%.

Enrollment was reported consistently with no gaps. MCNA experienced a slight increase in enrollees for 2020. Encounters were reported consistently with no gaps. MCNA experienced an increase in encounters throughout the measurement year. The reduction in encounters in April 2020 was likely due to COVID-19 restrictions on non-emergency dental care.

MCNA's accuracy rate for Enrollee IDs was 99.8%. The accuracy rate for Date of Birth was 99.6%.

Improvements

DHS requested Qsource compare key results from the previous measurement year to monitor progress. **Table 131** presents a comparison from the previous measurement year's key results. Notable improvements from the previous measurement year are indicated using a green arrow (↑ **or** ↓) and notable decreases in performance are indicated using a red arrow (↓ **or** ↑).

Table 131. Progress Update for EDV Key Results

Key Results	MY 2020 Results	MY 2019 Results
ARTC		
Completeness and Accuracy of Overall Encounter Data Submission		
Percentage of encounters submitted for covered services by participating and non-participating providers	98.3%↓	99.0%
Percentage of encounter lines passing MMIS edits	96.6%↑	90.0%
Average and Median Days and Range from Last Service Date to Paid Date		
Average number of days for Professional encounters	80.3 days↓	106.5 days
Median number of days for Professional encounters	34 days↓	63 days
Average number of days for Institutional encounters	138.8 days↓	159.9 days
Median number of days for Institutional encounters	108 days↑	105 days
Percentage of Enrollee IDs Accurately Incorporated into System		
Accuracy rate for Professional encounters	99.4%↑	98.4%
Accuracy rate for Institutional encounters	99.6%↑	98.4%
Accuracy rate for Pharmacy encounters	99.7%↑	98.8%
Summary of Completeness and Validity Rates for Selected Fields		
Completeness rate for Professional encounters	96.2%↑	92.7%
Empower		
Completeness and Accuracy of Overall Encounter Data Submission		
Percentage of encounters submitted for covered services by participating and non-participating providers	99.9%↓	100%

Table 131. Progress Update for EDV Key Results		
Key Results	**MY 2020 Results**	**MY 2019 Results**
Percentage of encounter lines passing MMIS edits	89.2%↑	88.7%
Average and Median Days and Range from Last Service Date to Paid Date		
Average number of days for Professional encounters	79.5 days↓	137.2 days
Median number of days for Professional encounters	35 days↓	87 days
Average number of days for Institutional encounters	126.9 days↓	209.4 days
Median number of days for Institutional encounters	71 days↓	177 days
Average and Median Days and Range from Billing Date to Paid Date		
Average number of days for Professional encounters	12.4 days↓	32.1 days
Median number of days for Professional encounters	8 days↓	9 days
Average number of days for Institutional encounters	16.7 days↓	75.6 days
Median number of days for Institutional encounters	9 days↓	10 days
Percentage of Enrollee IDs Accurately Incorporated into System		
Accuracy rate for Professional encounters	97.8%↓	98.7%
Accuracy rate for Institutional encounters	97.9%↓	98.7%
Accuracy rate for Pharmacy encounters	99.6%↑	99.2%
Summary of Completeness and Validity Rates for Selected Fields		
Completeness rate for Professional distinct encounters	95.1%↑	93.6%
Summit		
Completeness and Accuracy of Overall Encounter Data Submission		
Percentage of encounters submitted for covered services by participating and non-participating providers	98.4%↓	99.5%
Percentage of encounter lines passing MMIS edits	73.1%↓	90.2%
Average and Median Days and Range from Last Service Date to Paid Date		
Average number of days for Professional encounters	87.8 days↓	135.6 days

Table 131. Progress Update for EDV Key Results		
Key Results	**MY 2020 Results**	**MY 2019 Results**
Median number of days for Professional encounters	36 days↓	80 days
Average number of days for Institutional encounters	88.2 days↓	202.5 days
Median number of days for Institutional encounters	37 days↓	186 days
Average and Median Days and Range from Billing Date to Paid Date		
Average number of days for Professional encounters	13.9 days↓	41.1 days
Median number of days for Professional encounters	7 days↓	10 days
Average number of days for Institutional encounters	18.5 days↓	54.3 days
Median number of days for Institutional encounters	7 days↓	9 days
Summary of Completeness and Validity Rates for Selected Fields		
Completeness rate for Professional distinct encounters	96.2%↑	94.9%
Delta Dental		
Completeness and Accuracy of Overall Encounter Data Submission		
Percentage of Dental encounters submitted accurately	90.1%↑	82.7%
Percentage of Dental encounter data submitted within established timeframes	100%↑	79.5%
Average and Median Days and Range from Last Service Date to Paid Date		
Average number of days for Dental encounters	118.3 days↑	116.6 days
Average and Median Days and Range from Billing Date to Paid Date		
Average number of days for Dental encounters	50.8 days↑	12.9 days
Percentage of Enrollee IDs Accurately Incorporated into System		
Accuracy rate for Dental encounters	99.8%↑	99.2%
Summary of Completeness and Validity Rates for Selected Fields		
Completeness rate for Dental distinct encounters	99.0%↑	97.2%

Table 131. Progress Update for EDV Key Results		
Key Results	**MY 2020 Results**	**MY 2019 Results**
MCNA		
Completeness and Accuracy of Overall Encounter Data Submission		
Percentage of Dental encounters submitted accurately	88.3%↓	83.5%
Percentage of Dental encounter data submitted within established timeframes	83.4%↓	83.5%
Average and Median Days and Range from Last Service Date to Paid Date		
Average number of days for Dental encounters	90 days↓	170.3 days
Median number of days for Dental encounters	21 days↓	190 days
Average and Median Days and Range from Billing Date to Paid Date		
Average number of days for Dental encounters	66 days↓	68.9 days
Percentage of Enrollee IDs Accurately Incorporated into System		
Accuracy rate for Dental encounters	99.8%↑	99.1%
Summary of Completeness and Validity Rates for Selected Fields		
Completeness rate for Dental distinct encounters	100%↑	99.98%

Conclusions

Overall, the completeness rates for selected encounter fields were above DHS's threshold of 95% for distinct encounter lines and distinct encounters for all PASSEs and DMOs. Validity rates remained at 100% for all fields for ARTC, Empower, Summit, and MCNA. Delta Dental's validity rates were above DHS's threshold of 99%. All three PASSEs improved the completeness rate for professional distinct encounters from the baseline measurement year.

ARTC achieved a validation rating of moderate to high confidence on five of the seven encounter data standards required by DHS. The two remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters.

Empower achieved a validation rating of moderate to high confidence on five of the seven encounter data standards required by DHS. The two remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters.

Summit achieved a validation rating of moderate to high confidence on four of the seven encounter data standards required by DHS. The three remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters as well as encounters passing MMIS system edits.

Delta Dental achieved a validation rating of moderate to high confidence on four of the seven encounter data standards required by DHS. The three remaining standards indicated an opportunity for improvement in timely and accurate submission and resubmission of encounters.

MCNA achieved a validation rating of moderate to high confidence on three of the seven encounter data standards required by DHS. The four remaining standards indicated an opportunity for improvement in timely and accurate submission and resubmission of encounters.

Overall, Qsource found the ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was high for ARTC, Empower, Summit, and Delta Dental. Qsource found MCNA's ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was moderate.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

ARTC

ARTC should investigate root causes for encounters submitted for less than 100% of the covered services by participating and non-participating providers. It should continue to strive to reduce the time from last service date to paid date and from

billing date to paid date. ARTC should ensure all claims/encounters are submitted to DHS to improve accuracy and completeness of data submission. It should work to improve the percentage of both institutional encounters and encounters submitted within 30 days to meet timeliness standards. ARTC should work to improve the percentage of remediated encounters submitted within 30 days to meet timeliness standards. ARTC should identify ways to reduce the number of encounter data submissions with missing plan adjudication dates to improve timeliness of payment. It should work with providers to ensure the provider NPI in the electronic encounter record matches the provider in the medical record. ARTC should work with providers to ensure that the billed diagnoses are in the medical record.

Empower

Empower should investigate root causes for institutional encounters submitted for less than 100% of the covered services by participating and non-participating providers. It should investigate root causes for overall encounters submitted not meeting the standard of no less than 95% of encounters passing MMIS edits. Qsource found that a high percentage (39.3%) of Patient Account Numbers (PANs) were associated with multiple Recipient IDs. Empower should investigate possible encounter data errors responsible for this. Empower should continue to strive to reduce the time from last service date to paid date and from billing date to paid date to ensure timeliness of payment. It should work to improve the accuracy of enrollee data, including Enrollee ID and Birth Date. Empower should work to improve completeness rates for professional encounter data fields falling below 95%. It should strive to improve the percentage of both institutional encounters and encounters submitted within 30 days to meet timeliness standards. Empower should work to improve the percentage of remediated encounters submitted within 30 days to meet timeliness standards. Empower should work with providers to ensure the provider NPI in the electronic encounter record matches the provider in the medical record. It should work with providers to ensure that the billed diagnoses are in the medical record.

Summit

Summit should investigate root causes for less than 100% of encounters submitted for the covered services by participating and non-participating providers. It should investigate root causes for overall encounters submitted not meeting the standard of no less than 95% of encounters passing MMIS edits. Summit should continue to strive to reduce the time from last service date to paid date and from billing date to paid date to ensure timeliness of payment. Summit should identify ways to reduce the number of encounter data submissions with missing plan adjudication dates to allow for evaluation of timeliness of submissions and therefore improve timeliness of payment. It should work to improve the percentage of both institutional encounters and encounters submitted within 30 days to meet timeliness standards. Summit should work to improve the percentage of remediated encounters submitted within 30 days

to meet timeliness standards. Summit should work with providers to ensure the provider NPI in the electronic encounter record matches the provider in the medical record. It should work with providers to ensure that the billed diagnoses are in the medical record.

Delta Dental

Delta Dental should work to improve overall encounter submission accuracy and completeness (passing MMIS edits). Encounters were disproportionate to enrollment for children. Delta Dental should conduct outreach to adult enrollees to ensure access to care. Delta Dental should compare payment of claims processes to determine why the average number of days from billing date to paid date increased significantly from the previous measurement year to improve timeliness of payment. It should identify ways to increase the amount of denied encounter submissions that were remediated. Delta Dental should identify ways to reduce the number of encounter data submissions with missing plan adjudication dates to improve timeliness of payment. Delta Dental should work with providers to ensure the provider is noted on the dental record. It should work with providers to ensure that the billed procedures are in the dental record.

MCNA

MCNA should ensure encounters are submitted within the timeframes established in the contract. It should work to improve overall encounter submission accuracy and completeness (passing MMIS edits). Encounters were disproportionate to enrollment for children. MCNA should conduct outreach to adult enrollees to ensure access to care. MCNA should compare payment of claims processes to determine why the average number of days from billing date to paid date increased significantly from the previous measurement year. It should identify ways to increase the amount of denied encounter submissions that are remediated. MCNA should identify ways to reduce the number of encounter data submissions with missing plan adjudication dates to improve timeliness of payment. MCNA should work with providers to ensure the provider is noted on the dental record. It should work with providers to ensure that the billed procedures are in the dental record.

Protocol 8: Additional Performance Improvement Projects

Objectives

For this activity, Qsource followed the October 2019 CMS *Protocol 8: Implementation of Additional Performance Improvement Projects*. Federal regulations at 42 C.F.R. § 438.330(b)(1) and 457.1240(b) required that Medicaid and CHIP managed care plans (MCPs) conduct performance improvement projects (PIPs) that focused on both clinical and nonclinical areas as part of a comprehensive quality assessment and performance improvement (QAPI) program. Validation of the PIPs conducted by MCPs as a part of their QAPI programs was a mandatory EQR activity, as described in *Protocol 1: Validation of Performance Improvement Projects*.

In addition, federal regulations in 42 C.F.R. § 438.358(c)(4) and 457.1250(a) specify that the EQRO may conduct PIPs in addition to those performed by the PASSEs and DMOs as a part of the QAPI programs. These additional PIPs were an optional EQR-related activity. DHS determined that Qsource should work with the PASSEs and DMOs to implement one PIP for the PASSEs and one for the DMOs. The PIPs were written by Qsource, with feedback from the PASSEs, DMOs, and DHS, and distributed to the PASSEs and DMOs to be implemented in 2022. DHS determined the topics of the PIPs to be the following:

- PASSE PIP: Improving Timeliness and Completeness of Person-Centered Service Plans (PCSPs)
- DMO PIP: Sealant Receipt on Permanent First Molars (SFM-CH)

These PIPs served as a submission of EQRO findings for the following activities, as described in *Protocol 8: Implementation of Additional Performance Improvement Projects* (October 2019).

1. Select the PIP Topic
2. Define the PIP Aim Statement
3. Identify the PIP Population
4. Use Sound Sampling Methods
5. Select the PIP Variables
6. Collect Valid and Reliable Data
7. Analyze Data and Interpret Results
8. Review Improvement Strategies
9. Assess Whether Significant and Sustained Improvement Occurred

Steps one through six were detailed in the submitted PIPs. Each PASSE and DMO will implement the PIPs in 2022, with a goal to improve the quality of care, timeliness of care, and access to care for enrollees. The PASSEs and DMOs will determine their improvement strategies for the selected PIP topic and provide results and progress updates to Qsource.

Table 132 provides the details of each PIP.

Table 132. PIP Details	
PASSE	
Name and Type	Improving Timeliness and Completeness of Person-Centered Service Plans (PCSPs) – Nonclinical
Topic	Timely and Comprehensive PCSP Development
Aim Statement	Will targeted PASSE interventions (e.g., increased tracking, improved documentation processes, and adoption of an improved PCSP template) result in achieving a 90% net success rate on the timeliness metrics, improved completeness of the PCSP as evidenced by each metric of the PCSP achieving not less than a 10% failure rate, and 90% of enrollees having a current PCSP for review over a 12-month review period?
Population and Sampling Method	DHS will report the current PASSE population inclusive of all enrollees with no age, diagnoses, or procedure restrictions. Qsource will select a statistically valid sample size of the PASSE's enrollees using the sampling strategy outlined in Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs, produced for the Centers for Medicare & Medicaid Services (CMS). This methodology yields a 95% confidence limit with a 5% margin of error. The population in the sample will be enrollees who have been enrolled in the PASSE at least 60 calendar days. Qsource will notify DHS of the sample size required. DHS will identify the sample of enrollees and instruct the PASSEs to pull the PCSPs for those enrollees in the sample. The PASSEs will pull the relevant documentation and post to Xchange for Qsource review.
Performance Measures	Person-Centered Service Plan: Comprehensive: Performance measure description and source: The comprehensiveness of each PCSP was defined by DHS as the successful completion of 40 component metrics in the PCSP. Attachment A provides the review tool with each of the 40 metrics.
	Person-Centered Service Plan: Timely: Per the 2021 PASSE Agreement, for any Enrolled Member without an existing PCSP or Master Treatment Plan (MTP), the PASSE will have sixty (60) days from date of enrollment to conduct the health questionnaire and to develop the PCSP and then the PCSP must be reviewed and revised upon reassessment of functional need as required by 42 CFR § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
	Person-Centered Service Plan: Complete: Per the 2021 PASSE Agreement, the PASSE is responsible for the creation, monitoring, and updating of the PCSP for all Enrolled Members of the PASSE. Exhibit I Performance Standards lays out the PCSP benchmarks.
DMO	
Name and Type	Sealant Receipt on Permanent First Molars (SFM-CH) - Clinical
Topic	Sealant Receipt on Permanent First Molars

Table 132. PIP Details	
Aim Statement	Will targeted provider interventions and educating members' parents/guardians increase the rate of sealant application 5 percentage points over baseline for all children continuously enrolled for the 12 months prior to the child's 10th birthday and who turn age 10 in the measurement year over a 12-month period?
Performance Measures	Sealant Receipt on Permanent First Molars: Percentage of enrolled children who have ever received sealants on permanent first molar teeth; at least one sealant by the 10th birthdate – SFM-CH
	Sealant Receipt on Permanent First Molars: Percentage of enrolled children who have ever received sealants on permanent first molar teeth; all four molars sealed by the 10th birthdate

Technical Methods for Data Collection and Study

PASSE

Qsource determined a statistically valid sample size of the PASSE's PCSPs using the sampling strategy outlined in *Sampling: A Practical Guide for Quality Management in Home and Community-Based Waiver Programs*, produced for CMS. This methodology yields a 95% confidence limit with a 5% margin of error. DHS provided Qsource with a sample of enrollee records. DHS excluded any records already reviewed and records for those enrolled less than three consecutive months at the time of the sampling (to allow for sufficient time for PCSP development).

DMO

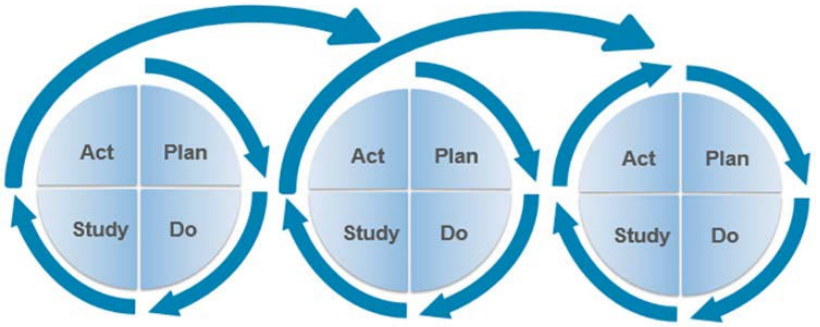
Data was collected administratively from DHS's encounter system. Encounters from the DMOs were submitted weekly to DHS and edits were in place to ensure complete, reliable, and valid data to accurately reflect dental services rendered. These processes were validated through the virtual systems review for each DMO including claims, enrollment, and provider systems. For each system, a visual inspection was conducted including the process by which data were integrated and housed within the respective data warehouse. Further, data transfer to the measure production software was visually demonstrated. Finally, when encounter data was not accepted by DHS, both DMOs had processes and procedures in place to ensure that any rejected encounters were resubmitted timely. This process was used to ensure complete, valid, and reliable data collection.

Next Steps

Qsource will begin Plan-Do-Study-Act (PDSA) meetings with the PASSEs and DMOs in the first quarter of 2022 after the PIPs have been implemented.

Figure 3 displays the PDSA cycle.

Figure 3. PDSA Cycle



In the "Plan" stage, the PASSEs and DMOs learn more about improvements needed and how these would be measured. In the "Do" stage, the PASSEs and DMOs strategic plan is carried out, including the measures that are selected. In the "Study" phase, each PASSE/DMO summarizes what has been learned. In the "Act" phase, the PASSEs, DMOs, and Qsource determine the next steps. Changes can be modified, adopted, or abandoned depending on successful integration.

Critical Incident Analysis

Objectives

Qsource conducted a critical incident analysis per 42 CFR § 441.474(a), which states, "The State must provide a quality assurance and improvement plan that describes the State's system of how it will perform activities of discovery, remediation and quality improvement in order to learn of critical incidents or events that affect participants, correct shortcomings, and pursue opportunities for system improvement."

Section 1915(c) of the *Social Security Act* also requires states to annually report the following to CMS:

- Information on the impact of the waiver granted
- Types and amounts of medical assistance provided
- Information on the health and welfare of participants

Per the 1915(i) waiver regarding DHS's Quality Strategy, the State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints. Goal 2 of the State's Quality Strategy was to improve access to needed services and safety for all enrollees. Specifically, Objective 2.3 was to ensure safety by monitoring compliance with incident and accident reporting requirements. For this report, a critical incident is an actual or alleged event that creates the risk of serious harm to the health or welfare of an enrollee receiving HCBS Waiver services. A critical incident may endanger or negatively impact the mental and/or physical well-being of an enrollee. When a critical incident occurs involving an HCBS Waiver participant, the provider must report the critical incident within the required time frames defined by DHS.

The HCBS Waiver Program, as required under 42 CFR § 441.474, must be evaluated to ensure compliance with performance measures for incident reporting for the HCBS providers. The measurement year for this review was January 1, 2020 through December 31, 2020 (MY 2020).

Technical Methods for Data Collection and Analysis

The Discovery Evidence Performance Measures analyzed by Qsource were identified by DHS and are listed in Table 133. The Arkansas Division of Medical Services (DMS) and the Arkansas Division of Developmental Disability Services (DDS) review all the critical incident reports received. Discovery Evidence Performance Measure technical specifications were based on service definitions from the 1915(i) State Plan HCBS guidelines.

Table 133. Critical Incident Performance Measures

Measure	Description
Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect, including unexplained death, training for staff	♦ Numerator: Number of provider agencies investigated who complied with required abuse and neglect training, including unexplained death set out in the Waiver and the PASSE provider agreement ♦ Denominator: Total number of provider agencies reviewed or investigated
Number and percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DMS or DDS within required time frames*	♦ Numerator: Number of critical incidents reported within required time frames ♦ Denominator: Number of critical incidents
Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions	♦ Numerator: Number of incident reports reviewed where provider adhered to PASSE policies for the use of restrictive interventions ♦ Denominator: Number of individuals for whom the provider utilized restrictive interventions
Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member	♦ Numerator: Number of PASSE Care Coordinators and HCBS Providers who took required protective actions regarding critical incidents ♦ Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents

**Time frames are defined in Description of Data Obtained*

Description of Data Obtained

PASSE HCBS providers and PASSE Care Coordinators were required to submit incident reports to the DHS PASSE Quality Assurance Unit and the designated PASSE, using the standard reporting form via secure email upon the occurrence of any one of the following events:

- Death of an enrollee
- The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on an enrollee
- Suspected maltreatment or abuse of an enrollee
- Any injury to an enrollee that:
  - requires the attention of an emergency medical technician, a paramedic, or physician;
  - may cause death;
  - may result in a substantial permanent impairment; or
  - requires hospitalization
- Threatened or attempted suicide by an enrollee
- The arrest of an enrollee, or commission of any crime by an enrollee
- Any situation in which the whereabouts of an enrollee is unknown for more than two hours (i.e., elopement and/or wandering), or where services are interrupted for more than two hours
- Any event where a staff member threatens an enrollee

- Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to an enrollee
- Medication errors made by staff that cause or have the potential to cause serious injury or illness to an enrollee, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, a wrong dose, a dose being administered at the wrong time by the wrong route, and the administration of the wrong medication
- Any violation of an enrollee's rights that jeopardizes the health, safety, or quality of life of the enrollee
- Any incident involving property destruction by an enrollee
- Vehicular accidents involving an enrollee
- Biohazard incidents involving an enrollee
- An arrest or conviction of a staff member providing direct care services
- Any use or possession of a non-prescribed medication or an illicit substance by an enrollee
- Any other event that might have resulted in harm to an enrollee or could have reasonably endangered the health, safety, or welfare of the enrollee

Incident reports involving unexpected occurrences involving actual or risk of death or serious physical or psychological injury to an enrollee were considered sentinel events and were investigated by DHS. In addition to sentinel events, DHS investigates if the network provider and/or network provider staff was suspected to be at fault. All other incidents were to be investigated by the PASSE.

Reporting Timeframes

The standard reporting time frames for the PASSEs were in three categories: immediate reporting, incidents involving potential publicity, and all other incident reports. For immediate reporting, providers must report the following incidents to the DHS PASSE Quality Assurance Unit emergency number within one hour of occurrence, regardless of hour, as well as the on-call emergency number for the PASSE:

- A death not related to the natural course of the patient's illness
- Serious physical or psychological injury to an enrollee

Critical incidents which a PASSE HCBS provider should reasonably know might be of interest to the public and/or media must be immediately reported to the DHS PASSE Quality Assurance unit and the PASSE, regardless of category. For all other incidents, except as otherwise provided above, all reportable incidents must be reported to the DHS PASSE Quality Assurance Unit and the PASSE using the automated PASSE HCBS Incident Report Form via secure email no later than two days following the incident. Any incident that occurs on a Friday was still considered timely if reported by the Monday immediately following.

Incident Report Requirements

Each of the incident reports must contain the following information:

1. Date of the incident
2. Detailed description of the accident/injury
3. Time of the incident
4. Location of the incident
5. Persons involved in the incident
6. Other agencies contacted regarding the incident, and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by the provider or provider staff, both at the time of the incident and subsequent to the incident
10. Any expected follow-up
11. Name of the person that prepared the report

Information not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports.

Abuse and Neglect Training Requirements

DHS provided a list of active HCBS providers for 2020. DDS provided the attendance log for Abuse and Neglect Training from April 18, 2019. Per DDS, this was the most recent abuse and neglect training session for HCBS providers. As requested by DHS, Qsource compared the training attendee log to the list of HCBS providers that were active in 2020 to determine the number and percentage of providers who received the required training.

Data Analysis

Qsource analyzed data submissions to determine the degree of volume, accuracy, and completeness of data. Qsource performed a trend and summary analysis of the critical incident data to assist DHS in the prevention, detection, and remediation of critical incidents. The summary analysis will assist in critical incident awareness and appropriate detection.

Data layouts from the data submissions are available upon request.

Data Quality Test Plan

Qsource used SAS® software to manage critical incident data and statistically determine frequencies and rates on specific fields or variables created explicitly for data validation. Analyzing DDS-submitted critical incident data, Qsource conducted basic integrity checks to determine if the data existed, if the data met expectations, and if they were of sufficient quality to proceed with more complex analyses.

Having no data present in one of these fields counted as an incomplete record. Within completed fields, Qsource examined data for accuracy as determined by specified accuracy checks to reveal overall data quality.

Qsource applied accuracy checks to critical incident data to verify that critical data fields contained non-missing values in

the correct format and specificity, within required ranges. The validation techniques employed for analyses addressed field-specific questions:

1. Is there information in the field, and is it the type of information that was requested? Validators checked each data field to determine if the information was the correct type (i.e., values in the incident date and time fields should be a valid date and time).
2. Are the data elements available? All required data elements should be reported, and the data should exist with no gaps.
3. Is the information for each critical field within reasonable ranges? Are the values in the field valid and correct? Validators checked for the ability to analyze data to provide information such as the Discovery Evidence Measures and the frequency of critical incident types during the measurement period.

Findings

Performance Results

Table 134 presents results of the Discovery Evidence Performance Measure analysis.

Table 134. MY 2020 Critical Incident Discovery Evidence Measure Analysis Results

Measure Name	ARTC	Empower	Summit
Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect, including unexplained death, training for staff	19.77%	19.77%	19.77%
Number and percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DMS or DDS within required time frames	57.3%	60.5%	69.1%
Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions	*	*	*
Percentage of PASSE Care Coordinators and HCBS Providers who took required corrective actions regarding critical incidents to protect the health and welfare of the member	65.8%	61.1%	60.5%

** No result as denominator was zero.*

Only 19.77% of the HCBS providers that were active in 2020 received the required Abuse and Neglect training, which indicates an area of opportunity regarding quality of care. The total percentage of reported critical incidents to DMS or DDS within required timeframes ranged from 57.3% to 69.1%. Summit had the highest individual percentage. None of the PASSEs had any individuals for whom the provider utilized

restrictive interventions. The total percentage of PASSE Care Coordinators and HCBS providers who took corrective actions regarding critical incidents to protect the health and welfare of the enrollee ranged from 60.5% to 65.8%. ARTC had the highest individual percentage among the three PASSEs.

Validation Results

Submission

Table 135 presents the critical incidents reported and which party was responsible for submitting the incidents.

Table 135. MY 2020 Critical Incidents Submission

Responsible Party	ARTC		Empower		Summit	
	#	%	#	%	#	%
PASSE Care Coordinators	76	14.8%	31	5.7%	2	0.3%
HCBS Providers	389	75.5%	420	77.5%	656	88.2%
Unknown	50	9.7%	91	16.8%	86	11.6%
Total	**515**	**100%**	**542**	**100%**	**744**	**100%**

The majority of the incidents in 2020 were submitted by HCBS providers.

Volume

Table 136 presents the incidents reported for the PASSEs and the percentage of the total incidents for all PASSEs reported versus enrollment for the measurement period.

Table 136. MY 2020 Percentage of Incidents Versus Enrollment

PASSE	Total Incidents for 2020*	Enrollment
ARTC	515 (28.5%)	15,687 (28.0%)
Empower	542 (29.9%)	22,601 (40.4%)
Summit	744 (41.1%)	18,761 (33.5%)

** The sum of total incidents is less than 100% due to incidents with an unknown PASSE assignment.*

Incidents for enrollees assigned to Summit accounted for 41.1% of the aggregate total of all critical incidents, the highest percentage of all three PASSEs. This was significantly higher than Summit's percentage of total PASSE enrollment of 33.5%. Incidents for enrollees assigned to ARTC accounted for the lowest percentage of the aggregate total of all critical incidents at 28.5%, as well as the lowest percentage of total PASSE enrollment at 28.0%.

Qsource analyzed the completeness and validity of critical data fields. Completeness rates were calculated as the number of data fields with data present, and validity rates were calculated as the number of valid data points as a percentage of those with data present (completeness). A list of these fields and the validation criteria are available upon request. The completeness and validity rates are detailed in Appendix F.

Trends and Summary

ARTC

Enrollees assigned to ARTC had a total of 515 incidents for the measurement period, with an average of 43 incidents per month and a slightly upward trend through the reporting period. More than half, 57.3%, of the incidents were reported within required time frames.

Empower

Enrollees assigned to Empower had 542 incidents with an average of 45 incidents per month and a slight downward trend throughout the reporting period. More than half, 60.5%, of the incidents were reported within the required time frames.

Summit

Enrollees assigned to Summit had the highest number of incidents at 744 with an average of 62 incidents per month and a slight downward trend during the reporting period. More than half, 69.1%, of the incidents were reported within required time frames.

Qsource analyzed the completeness and validity of critical data fields for the critical incident reporting process. Completeness rates for critical fields were above 95.0% for five fields: First Name, Last Name, Incident Date, Incident Type, and PASSE Provider. However, there was a wide range of completeness rates for other fields, with the lowest being 16.0% and the highest at 100%. Accuracy (Validity) rates for completed fields were mostly above the 95.0% threshold.

Qsource also completed an analysis of results by demographics and incident type. A larger percentage of reported incidents involved adults, ranging from 69.7% to 84.8% compared to children under the age of 21, whose range was from 6.5% to 17.7%.

There was also a larger percentage of incidents involving males rather than females and Caucasian enrollees rather than other races.

For MY 2020, DDS's critical incident reporting system required more detail regarding critical incident types than the previous measurement year. The majority of incident types across all PASSEs were reported as Other. Incident types included in the Other category were any events that might have resulted in harm to an enrollee or could have reasonably endangered the health, safety, and/or welfare of the enrollee not otherwise listed on the reporting form. The next most common types of incidents were Physician Visit, Hospitalization, and ER Visit.

The majority of incident designations across all PASSEs were Member to Self, with Other being the next most common designation.

There were 1,229 active HCBS providers in MY 2020. Of those providers, 364 individuals were documented on the attendee log for Abuse and Neglect Training on April 18, 2019. Of those 364 individuals, 54 of them were from the State and were therefore not included as HCBS providers in Qsource's calculations. Of the 310 individuals on the training attendee log, 67 individuals

representing 27 organizations were not listed as active HCBS providers in MY 2020. Therefore, when comparing the 243 remaining individuals representing 88 organizations on the training attendee log to the list of active HCBS providers, Qsource determined that 19.77% of HCBS providers met the requirement for abuse and neglect training in MY 2020.

Critical incident trends are located in Appendix F.

Strengths and Weaknesses

Although improvement was demonstrated, Discovery Evidence Measures showed opportunities for improvement with meeting required reporting time frames and taking required corrective action.

Critical incidents for enrollees assigned to Empower and Summit showed a downward trend over the reporting period while enrollees assigned to ARTC trended upward. Completed field validity was above 95.0% for almost all fields evaluated. Critical field completeness was below 95.0% for several of the fields evaluated.

Limiting the value of the analysis of incidents was the volume of incident types that fell into the Other category and the volume of incident designations that fell into the Other and Unknown categories. One of Qsource's recommendations in the previous measurement year was to educate providers and staff on the appropriate categorization of all incidents and require an explanation for any incident types or designations reported in the Other and Unknown categories. Qsource found that the majority of incidents where Other was selected as the incident type, there was no further information provided. When Other was selected for the Incident Designation field, details were provided in most instances. The details provided varied but about a third of the details provided revolved around COVID-19.

Of the 1,229 active HCBS providers in 2020, only 243 (19.77%) met the requirement for abuse and neglect training.

Improvements

The PASSE care coordinators and providers demonstrated an effort to increase the quality of care for enrollees by improving critical incident reporting in MY 2020 and implementing recommendations made in the previous measurement year.

For MY 2020, DDS provided more categories for critical incident types and designations than the previous measurement year, resulting in a reduction of incidents categorized as Other and Unknown.

Table 137 presents a summary of improvements from the previous measurement year's AONs (MY 2019). Any performance measures not listed had no AONs identified in the previous measurement year. Direct quotes from the PASSEs are in italics.

Table 137. Critical Incidents Progress Update	
Enrollees Assigned to ARTC	
MY 2019 AON	The percentage of incidents reported within the required timeframes was low.
PASSE Response	*Based on 2019 findings, ARTC reported that there were significant areas for improvement in the analysis of incident reports. Per ARTC, it primarily collects incident reports from HCBS providers. If those providers have not yet submitted to DHS, ARTC forwards the incident reports on behalf of the providers. However, most providers submit the incident reports to DHS directly. To properly assess PASSE performance, ARTC believes the analysis should delineate between the reports submitted by providers and reports submitted by the PASSEs. The data elements on the DHS Incident Report form do not align with the EQRO report. For example, one line on the DHS form states, "Date of Birth or age." The EQRO report identified "date of birth" and "age" as two separate criteria. ARTC identified a substantial process change to improve the incident report AOD. Currently, incident reports are remitted to the Compliance Department for submission to DHS. ARTC will remove the Compliance Department's role and will hire a full-time employee within the Care Coordination/Quality Assurance department whose primary responsibilities will be monitoring and oversight of the incident report process. The new role will ensure:* ♦ *Timeliness of submissions* ♦ *Follow-up and final reports are requested and received when necessary* ♦ *All critical data fields on the report are completed appropriately* *Additionally, ARTC's Provider Relations team will conduct an Incident Report training webinar available to all providers.*
Results from Analysis	The percentage of incidents reported within required time frames increased from 44.9% to 57.3%.
MY 2019 AON	Corrective actions to protect the health and wellbeing of enrollees were low.
PASSE Response	ARTC responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Corrective actions to protect the health and wellbeing of enrollees improved from 56.8% to 65.8%.
MY 2019 AON	Data completion rates for all critical fields were low.
PASSE Response	ARTC responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Data completion rates for all critical fields improved significantly when compared to 2019 data, except for the Findings/Outcome/Disposition field, which fell from 37.1% to 24.7%.

Table 137. Critical Incidents Progress Update	
Enrollees Assigned to Empower	
MY 2019 AON	The percentage of incidents reported within the required timeframes was low.
PASSE Response	*Empower is currently working with DHS on incident report submission protocols and provider requirements re: incident reporting. Empower does evaluate and update "other" category on internal trackers used to report out on from provider incident reports (based on the details of the incident). Continued provider trainings on incident reporting may be helpful. Empower does process Incident Reports within set timeframes (1 hour for deaths/24 hours for all others); however, providers do not always submit these to Empower within timeframes. More provider education on this process is needed. Empower currently submits Incident Reports as Potential Quality of Care (PQOC) cases to the Quality Team for review/investigation. Depending on outcome of PQOC investigation, a Corrective Action Plan (CAP) for the provider may be implemented. DHS owns Incident Report forms and would drive the inclusion of Medicaid IDs. DHS owns Incident Report forms and would drive the inclusion of a unique ID #. Empower is working with DHS on critical field completion. Empower staff are currently being trained on proper way to complete form. Empower tracks via time reporting of incidents in our Incident Report Tracker (i.e., all incident reporting activity is time stamped). Empower currently trains staff on Incident Reporting on a weekly/monthly basis. There is a need to initiate further provider trainings on this topic.*
Results from Analysis	The percentage of incidents reported within required time frames increased from 43.5% to 60.5%.
MY 2019 AON	Corrective actions to protect the health and wellbeing of enrollees were low.
PASSE Response	Empower responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Corrective actions to protect the health and wellbeing of enrollees improved from 54.7% to 61.1%.
MY 2019 AON	Data completion rates for all critical fields were low.
PASSE Response	Empower responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Data completion rates for all critical fields improved significantly when compared to 2019 data, except for the Findings/Outcome/Disposition field, which fell from 29.3% to 21.8%.

Table 137. Critical Incidents Progress Update	
Enrollees Assigned to Summit	
MY 2019 AON	The percentage of incidents reported within the required timeframes was low.
PASSE Response	*Implementation planning of a new SharePoint site for critical incidents was initiated in December 2020 with the goal to change to a platform called PEGA.* ♦ *The SharePoint site was completed and will begin use for critical incidents the week of 05/10/2021.* ♦ *The SharePoint site will enable better tracking and reporting of critical incidents as well as provide a unique identification number for internal tracking.* *The quality team held a meeting with the IT and PEGA team in April regarding using PEGA as the ultimate platform for critical incidents.* ♦ *The PEGA system will further improve reporting timeframes, auto populate the members age, gender, and race when tied to a member ID, provide a unique identification number for each incident and assist with improving the completion rate of all critical fields.* ♦ *It was advised in the meeting the PEGA system will take some time before this system can be placed into production and an anticipated go-live date of September 2021 was given by the PEGA implementation team.* *The quality department will work with Provider Relations to inquire on a blast mailing to providers to educate them on the critical incident process as well as the timeframes for reporting by the end of Q2 2021.*
Results from Analysis	The percentage of incidents reported within required time frames increased from 50.6% to 69.1%.
MY 2019 AON	Corrective actions to protect the health and wellbeing of enrollees were low.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Corrective actions to protect the health and wellbeing of enrollees also improved from 53.6% to 60.5%.
MY 2019 AON	Data completion rates for all critical fields were low.
PASSE Response	Summit responded to all AONs in one statement. See PASSE response here.
Results from Analysis	Data completion rates for all critical fields improved significantly when compared to 2019 data, except for the Findings/Outcome/Disposition field, which fell from 28.0% to 16.0%.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

ARTC

ARTC should work with providers to continue to improve reporting time frames to meet standards and ensure timely follow up. Continuing to improve corrective actions when appropriate for the incident will help ensure the quality of care. ARTC should work with DDS to ensure that all active HCBS providers meet the abuse and neglect training requirement. ARTC should continue improvement in data completion rates for all critical fields. ARTC should educate providers and staff on the appropriate categorization of all incidents and require an explanation for any incident types or designations reported in the Other and Unknown categories. Continung to work with providers to improve overall reporting accuracy by identifying unknown age, gender, and race will help ensure the quality of care.

Empower

Empower should work with providers to continue to improve reporting time frames to meet standards and ensure timely follow up. Empower should ensure providers and care coordinators are educated on PASSE policies regarding the use of restrictive interventions. Working with providers to continue to improve corrective actions when appropriate for the incident will help ensure the quality of care. Empower should work with DDS to ensure that all active HCBS providers meet the abuse and neglect training requirement. Empower should encourage HCBS providers and care coordinators to identify themselves when submitting an incident report. Working with providers to continue improvement in data completion rates for all critical fields will help ensure the quality of care. Empower should educate providers and staff on the appropriate categorization of all incidents and require an explanation for any incident types or designations reported in the Other and Unknown categories. Continung to work with providers to improve overall reporting accuracy by identifying unknown age, gender, and race will help ensure the quality of care.

Summit

Summit should work with providers to continue to improve reporting time frames to meet standards and ensure timely follow up. Working with providers to continue to improve corrective actions when appropriate for the incident will help ensure the quality of care. Summit should work with DDS to ensure that all active HCBS providers meet the abuse and neglect training requirement. Summit should encourage HCBS providers and care coordinators to identify themselves when submitting an incident report. Summit should work with providers to continue improvement in data completion rates for all critical fields. Summit should educate providers and staff on the appropriate categorization of all incidents and require an explanation for any incident types or designations reported in the Other and Unknown categories. Continung to work with

providers to improve overall reporting accuracy by identifying unknown age, gender, and race will help ensure the quality of care.

DDS and DHS

DDS and DHS should continue to improve the reporting form to include detailed incident categories and types therefore reducing the necessity of the Other category. DDS and DHS should work with the PASSEs to ensure that all active HCBS providers meet the abuse and neglect training requirement so the training documentation is accurate, including organizations represented. DDS and DHS should ensure understanding of PASSE vs DDS roles in meeting critical incident waiver requirements, such as HCBS provider training. DDS and DHS should ensure there is a unique incident identification number as well as the Medicaid ID for each incident, so follow-up reporting can be tied back to the original incident and timely follow-up is being conducted for the enrollees. DDS and DHS should consider including Time Reported in the incident database to allow for identification of immediate reporting requirements (within one hour of occurrence) from all other incident reports (no later than two days following the incident) to ensure the timeliness of care. DDS and DHS should consider adding a field to the reporting form for enrollee designation. Identifying the enrollee population may allow for more precise monitoring.

Utilization Analysis

Objectives

Qsource prepared a *2021 Utilization Analysis Report* for DHS to document performance in regard to potential over- and underutilization of services as well as to identify areas for improvement and make recommendations.

Per the 1915(b) waiver regarding DHS's Quality Improvement Strategy and as required by 42 CFR § 447.203, DHS monitors the PASSE organization network providers to ensure enrollees have timely and adequate access to quality care. In this report, Qsource reviewed over-utilization measures directly related to the quality of care delivered and under-utilization measures related to increasing access to care. Sections 1902(a)(30)(A), 1932(c), and 1903(a) of the Social Security Act requires the state Medicaid Agency to provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy, and quality of care." As part of this strategy, analysis was performed on behavioral health services, services for individuals with developmental disabilities, and preventable emergency room visits, hospitalization, and readmissions.

DHS identified the following services to review for over- and underutilization by the PASSEs.

- Inpatient Hospital and Psychiatric Stays (Overutilization)
- Emergency Services (Overutilization)
- Occupational Therapy (Underutilization)
- Physical Therapy (Underutilization)
- Speech-Language Pathology (Underutilization)
- Augmentative Communication Device (Underutilization)
- Durable Medical Equipment (DME) (Underutilization)
- Behavioral Health (Underutilization)

DHS identified the following services to review for over- and underutilization by the DMOs.

- Crown - Restorations and other restorative services (Overutilization)
- Extraction (Overutilization)
- Anesthesia 1—Quantity of 3 or more (Overutilization)
- Anesthesia 2—Quantity of 2 or more (Overutilization)
- Non-surgical Periodontal Service (Underutilization)

This report includes findings from the calculations of applicable measures selected by DHS. The measurement year for this analysis was January 1, 2020 through December 31, 2020 (MY 2020) for both the PASSEs and DMOs.

Technical Methods of Data Collection and Analysis

Qsource obtained the list of services to review for potential over- and underutilization and data files from DHS. Qsource processed the data files using code tables provided by DHS. As requested by DHS for services that were reviewed in the previous measurement year's report, Qsource has included the

MY 2019 baseline data as benchmarks. A comparison of MY 2020 and MY 2019 data is included in each applicable table.

Findings

PASSE Overutilization

Based on the review of services, Qsource determined results for potential overutilization of inpatient and emergency services for developmentally disabled (DD) enrollees. **Table 138** displays the key review results for each PASSE. Notable improvements from the previous measurement year are indicated using a downward arrow (↓) and notable decreases in performance are indicated using an upward arrow (↑).

Table 138. MY 2020 PASSE Overutilization for Developmentally Disabled

Services	Number of DD Enrollees Receiving Services	MY 2020 Rate for all DD Enrollees*	MY 2019 Baseline Rate for All DD Enrollees
ARTC			
Inpatient Hospital and Psychiatric Stays	20	0.8%↑	0.4%
Emergency Services	579	23.9%↑	23.6%
Empower			
Inpatient Hospital and Psychiatric Stays	52	1.8%↓	2.1%
Emergency Services	738	25.5%↑	24.4%
Summit			
Inpatient Hospital and Psychiatric Stays	46	1.1%↑	0.8%

Table 138. MY 2020 PASSE Overutilization for Developmentally Disabled

Services	Number of DD Enrollees Receiving Services	MY 2020 Rate for all DD Enrollees*	MY 2019 Baseline Rate for All DD Enrollees
Emergency Services	1,008	23.7%↑	20.4%

**Denominator is all DD enrollees*

For this report, DHS asked Qsource to review services to determine potential overutilization of inpatient and emergency services for behavioral health (BH) enrollees as well. **Table 139** presents the key review results for each PASSE. This will be the baseline data in order to provide a comparison in future years.

Table 139. MY 2020 PASSE Overutilization for Behavioral Health

Services	Number of BH Enrollees Receiving Services	Rate for all BH Enrollees
ARTC		
Inpatient Hospital and Psychiatric Stays	47	0.4%
Emergency Services	3,309	27.5%
Empower		
Inpatient Hospital and Psychiatric Stays	145	0.8%
Emergency Services	5,382	29.1%
Summit		
Inpatient Hospital and Psychiatric Stays	119	0.8%
Emergency Services	4,290	27.2%

PASSE Underutilization

Table 140 displays the key review results for potentially underutilized services for DD enrollees and all enrollees. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases are indicated using a downward arrow (↓).

Table 140. MY 2020 PASSE Underutilization

Services/ Units	Number of DD Enrollees Receiving Services	MY 2020 Rate for all DD Enrollees (units paid)*	MY 2019 Baseline Rate for all DD Enrollees	Number of Enrollees Receiving Services	MY 2020 Rate for all Enrollees (units paid)**	MY 2019 Baseline Rate for all Enrollees
	Developmentally Disabled			All Enrollees		
ARTC						
Occupational Therapy						
0	2,154	88.9%↑	87.3%	15,376	98.0%↑	97.6%
1–30	117	4.8%↓	6.0%	144	0.9%↓	1.2%
≥ 31	151	6.2%↓	6.7%	167	1.1%↓	1.2%
Physical Therapy						
0	2,047	84.5%↑	82.6%	15,128	96.4%↑	96.2%
1–30	116	4.8%↓	6.3%	223	1.4%↓	1.7%
≥ 31	259	10.7%↓	11.1%	336	2.1%	2.1%
Speech-Language Pathology						
0	1859	76.8%↑	73.0%	15004	95.7%↑	95.1%
1–30	184	7.6%↓	9.9%	251	1.6%↓	1.9%
≥ 31	379	15.7%↓	17.1%	432	2.8%↓	3.0%
Augmentative Communication Device	3	0.1%↑	0.0%	3	0.02%↑	0.01%

** Denominator value is all enrollees with DD*
*** Denominator value is all enrollees*

Table 140. MY 2020 PASSE Underutilization						
Services/ Units	Number of DD Enrollees Receiving Services	MY 2020 Rate for all DD Enrollees (units paid)*	MY 2019 Baseline Rate for all DD Enrollees	Number of Enrollees Receiving Services	MY 2020 Rate for all Enrollees (units paid)**	MY 2019 Baseline Rate for all Enrollees
	Developmentally Disabled			All Enrollees		
Durable Medical Equipment (DME)	8	0.3%↑	0.1%	18	0.1%↑	0.0%
Empower						
Occupational Therapy						
0	2,538	87.8%↑	84.0%	22,167	98.1%↑	97.7%
1–30	162	5.6%↓	7.8%	212	0.9%↓	1.2%
≥ 31	191	6.6%↓	8.2%	222	1.0%↓	1.1%
Physical Therapy						
0	2,403	83.1%↑	81.6%	21,853	96.7%	97.0%
1–30	143	5.0%↓	5.4%	317	1.4%↑	1.2%
≥ 31	345	11.9%↓	13.0%	431	1.9%↑	1.8%
Speech-Language Pathology						
0	2,234	77.3%↑	72.9%	21,804	96.5%↑	96.2%
1–30	230	8.0%↓	9.9%	312	1.4%↓	1.5%
≥ 31	427	14.8%↓	17.3%	485	2.2%↓	2.3%
Augmentative Communication Device	3	0.1%	0.1%	3	0.01%	0.01%
Durable Medical Equipment (DME)	10	0.4%↑	0.2%	29	0.1%↑	0.0%

Table 140. MY 2020 PASSE Underutilization						
Services/ Units	Number of DD Enrollees Receiving Services	MY 2020 Rate for all DD Enrollees (units paid)*	MY 2019 Baseline Rate for all DD Enrollees	Number of Enrollees Receiving Services	MY 2020 Rate for all Enrollees (units paid)**	MY 2019 Baseline Rate for all Enrollees
	Developmentally Disabled			All Enrollees		
Summit						
Occupational Therapy						
0	3,894	91.7%↑	90.5%	18,363	97.9%↑	97.5%
1–30	163	3.8%↓	4.4%	194	1.0%↓	1.2%
≥ 31	190	4.5%↓	5.2%	204	1.1%↓	1.3%
Physical Therapy						
0	3,775	88.9%↑	86.9%	18,144	96.7%↑	96.2%
1–30	168	4.0%↑	3.8%	263	1.4%	1.4%
≥ 31	304	7.2%↓	9.3%	354	1.9%↓	2.4%
Speech-Language Pathology						
0	3,649	85.9%↑	82.9%	18,090	96.4%↑	95.6%
1–30	214	5.0%↓	6.5%	254	1.4%↓	1.8%
≥ 31	384	9.0%↓	10.6%	417	2.2%↓	2.6%
Augmentative Communication Device	2	0.05%↑	0%	2	0.01%↑	0%
Durable Medical Equipment (DME)	11	0.3%↑	0.1%	24	0.1%↓	0.02%

** Denominator value is all enrollees with DD*
*** Denominator value is all enrollees*

For this report, DHS asked Qsource to review services to determine potential underutilization of behavioral health outpatient services for DD enrollees and BH enrollees. **Tables 141-142** display the key review results for each PASSE by age group. This will be the baseline data in order to provide a comparison in future years.

Table 141. MY 2020 Developmentally Disabled Outpatient Utilization

Services Received	ARTC		Empower		Summit	
	Number of DD Enrollees Receiving Services	Results	Number of DD Enrollees Receiving Services	Results	Number of DD Enrollees Receiving Services	Results
Child under age 21						
0	649	48.5%	726	41.3%	529	39.4%
1–4	197	14.7%	161	9.2%	142	10.6%
≥5	491	36.7%	872	49.6%	673	50.1%
Adult						
0	832	77.4%	837	75.0%	2,162	75.3%
1–4	116	10.8%	96	8.6%	336	11.7%
≥5	127	11.8%	183	16.4%	373	13.0%

Table 142 presents the rates of behavioral health outpatient service utilization for all BH enrollees by age group.

Table 142. MY 2020 Behavioral Health Outpatient Utilization

Services Received	ARTC		Empower		Summit	
	Number of BH Enrollees Receiving Services	Results	Number of BH Enrollees Receiving Services	Results	Number of BH Enrollees Receiving Services	Results
Child under age 21						
0	1,752	19.4%	1,813	13.0%	1,255	12.3%
1–4	2,156	23.9%	1,901	13.6%	1,810	17.7%
≥5	5,128	56.8%	10,242	73.4%	7,150	70.0%

Table 142. MY 2020 Behavioral Health Outpatient Utilization						
Services Received	ARTC		Empower		Summit	
	Number of BH Enrollees Receiving Services	Results	Number of BH Enrollees Receiving Services	Results	Number of BH Enrollees Receiving Services	Results
Adult						
0	1,207	41.2%	1,492	34.4%	2,356	44.7%
1–4	570	19.5%	699	16.1%	819	15.5%
≥5	1,154	39.4%	2,151	49.5%	2,126	39.8%

DMO Overutilization

Table 143 presents the findings from the overutilization analyses for both DMOs. Notable improvements from the previous measurement year are indicated using a downward arrow (↓) and notable decreases in performance are indicated using an upward arrow (↑).

Table 143. MY 2020 DMO Overutilization			
Services/Units	Number of Encounters Receiving Services or Units	MY 2020 Results	MY 2019 Baseline Results
Delta Dental			
Crown - Restorations and other restorative services	10,721	3.9%↓	4.1%
Extraction	3,358	1.2%	1.2%
Anesthesia 1—Quantity of 3 or more	2	0.0%*	0.0%
Anesthesia 2—Quantity of 2 or more	0	0.0%↓	0.05%
MCNA			
Crown - Restorations and other restorative services	8,231	3.9%↓	4.3%
Extraction	3,140	1.5%↑	1.3%
Anesthesia 1—Quantity of 3 or more	2	0.0%*	0.0%*
Anesthesia 2—Quantity of 2 or more	63	2.6%↑	0.1%

** Rate was too small to yield a percentage.*

For this report, DHS asked that Qsource further analyze crown and extraction findings. **Table 144** presents the findings from the overutilization analyses for both DMOs by age group. This will be the baseline data for comparison in future years.

Table 144. MY 2020 DMO Overutilization: Percentage of Encounters Receiving Services by Age Group

Services	Child under 21**	Adult**
Delta Dental		
Crown - Restorations and other restorative services	4.5%	0.0%*
Extraction	0.4%	6.8%
MCNA		
Crown - Restorations and other restorative services	4.5%	0.0%*
Extraction	0.4%	8.3%

**Rate was too small to yield a percentage*
***An encounter was excluded for this analysis if an enrollee's age was missing*

Table 145 presents the rate of crown services per enrollee greater than seven by providers for both DMOs.

Table 145. MY 2020 Rate of Average Number of Crowns Per Enrollee by Provider

DMO	Number of Dental Providers*	Rate of Crowns Per Enrollee Greater Than 7
Delta Dental	305	1.0%
MCNA	287	0.0%

**Only Dental and EPSDT specialty providers provided crown services*

Table 125 presents the rate of extraction services per enrollee greater than seven by providers for both DMOs.

Table 125. MY 2020 Rate of Average Number of Extractions Per Enrollee by Provider

DMO	Number of Dental Providers*	Rate of Extractions Per Enrollee Greater Than 7
Delta Dental	357	0.0%
MCNA	345	0.9%

**Only Dental and Oral Surgeon specialty providers provided extraction services.*

DMO Underutilization

Tables 146 and 147 present the findings from the DMO underutilization analyses.

Table 146. MY 2020 DMO Underutilization

Services	Number of Encounters Receiving Services or Units	2020 Results	2019 Baseline Results
Delta Dental			
Non-surgical periodontal service	276	0.1%	0.1%
MCNA			
Non-surgical periodontal service	244	0.1%	0.1%

For this report, DHS asked that Qsource further analyze non-surgical periodontal service findings. **Table 147** presents the findings from the underutilization analyses for both DMOs by age group. This will be the baseline data for comparison in future years.

Table 147. MY 2020 DMO Underutilization: Percentage of Encounters Receiving Services by Age Group

Services	Child under 21	Adult
Delta Dental		
Non-surgical periodontal service	0%	0.8%
MCNA		
Non-surgical periodontal service	0.02%	0.7%

Strengths and Weaknesses

Tables 148 and 149 present strengths and weaknesses discovered in the analysis.

Table 148. Utilization Analysis Strengths

ARTC

- ARTC had the lowest rate of inpatient hospital and psychiatric stays for DD and BH enrollees.
- There was a slight downward trend of emergency visits per DD enrollee.
- ARTC had the highest rate of utilization for occupational therapy, physical therapy, speech-language pathology, and usage of augmentative communication devices and DME for all enrollees.

Table 148. Utilization Analysis Strengths

- ARTC had the highest rate of DD and BH children receiving 1-4 behavioral health services.

Empower

- The rate of inpatient and psychiatric stays and average emergency services per DD enrollee decreased overall compared to 2019.
- Empower had the highest rate of occupational therapy and physical therapy usage for DD enrollees.
- The rate of physical therapy, augmentative communication devices, and DME for all enrollees and the rate of augmentative communication devices and DME for DD enrollees increased compared to 2019.
- Empower had the highest rate of both children and adult BH enrollees receiving greater than 5 behavioral health services.

Summit

- Summit had the lowest number of emergency room services usage for DD enrollees.
- Summit had an overall downward trend for emergency services usage for BH enrollees in 2020.
- Summit had the highest rate of occupational therapy usage for all enrollees.

Delta Dental

- The rate of claims for crowns, restorations, and other restorative services decreased from 2019.

MCNA

- The rate of claims for crowns, restorations, and other restorative services decreased from 2019.

Table 149. Utilization Analysis Weaknesses
ARTC
♦ There was a decrease in all areas reviewed for underutilization except augmentative communication devices and DME for both DD and all enrollees compared to 2019.
♦ ARTC had the lowest rate of DD and BH children and adults receiving greater than 5 behavioral health services.
Empower
♦ Empower had the highest rate of emergency services usage, as well as the most frequently reported inpatient hospital and psychiatric stays for DD enrollees.
♦ Empower had the highest rate of emergency services usage for BH enrollees.
♦ Empower had the lowest rate of both children and adult DD enrollees receiving 1-4 behavioral health services.
Summit
♦ There was an increase in both inpatient hospital and psychiatric stays, as well as emergency room visits, compared to 2019.
♦ There was an upward trend for emergency room visits per DD enrollee compared to 2019.
♦ Summit had the lowest utilization for occupational therapy, physical therapy, speech-language pathology, and usage of augmentative communication devices for DD enrollees.
Delta Dental
♦ Delta Dental had providers who fell outside of the established benchmark for crowns.
MCNA
♦ The rate of extractions and the use of 2 units or more of anesthesia increased compared to 2019.
♦ MCNA had providers who fell outside of the established benchmark for extractions.

Improvements

Overall, little improvement in over- and underutilization was observed from MY 2019 to MY 2020. This was likely due to the COVID-19 pandemic and its impact on healthcare utilization. Some improvements to note for overutilization of services include a decrease in DD inpatient hospital and psychiatric stays for Empower and a downward trend of emergency services per DD enrollee for both Empower and ARTC. All three PASSEs had a slight increase in DME and one to four behavioral health services for both children and adults. Both DMOs had a decrease in crowns, restorations, and other restorative services.

ARTC

In the 2019 report, Qsource recommended that ARTC consider measures to promote preventive care for DD enrollees with the goal of curtailing the need for emergency services and hospitalization. ARTC's response was, "*ARTC believes we successfully promote preventative care for our enrollees and ensure we properly follow up with enrollees after emergency visits. ARTC Care Coordinators discuss with enrollees the need for avoiding unnecessary emergency department use, assist enrollees in planning and scheduling preventative appointments, and collaborate with clinical Case Managers when necessary. Additionally, ARTC began utilizing a report in November 2020 that identifies enrollees who receive services in an emergency setting 3 or more times within a 6-month period to target prevention outreach to those enrollees.*"

In 2020, ARTC had a slight increase in both inpatient and psychiatric hospital stays and emergency services for DD enrollees of 0.04% and 0.03%, respectively. ARTC had a slight downward overall trend of ED visits per DD enrollee compared to 2019.

In the 2019 report, Qsource noted that ARTC had the lowest behavioral health services utilization rates for enrollees less than 21 years old. ARTC's response was that they will closely monitor the utilization of behavioral health services for our enrollees less than 21 years old to identify areas for improvement. In 2020, ARTC had the highest rate of both enrollees less than 21 years old and adults with one to four behavioral health services at 14.5%.

In the 2019 report, Qsource suggested that the PASSE could develop strategies to increase awareness of the services reviewed for underutilization by improving communication throughout care coordination teams and facilitating recommendations and referrals. ARTC's response was that it would consider suggestions for developing strategies to increase awareness of services. In 2020, Qsource found that while ARTC had the highest rate of services in multiple categories, overall, it had a decrease in all areas reviewed for underutilization except augmentative communication devices and DME for both DD and all enrollees compared to 2019.

Empower

In 2019, Qsource suggested that Empower could consider measures to promote preventive care for DD enrollees with the goal of curtailing the need for emergency services and hospitalization. Empower's response was that it would develop reports that give a picture of utilization for its enrollees. In 2020, while the rate of inpatient and psychiatric stays and average emergency services per DD enrollee decreased overall compared to 2019, Empower had the highest rate of emergency services usage, as well as the most frequently reported inpatient hospital and psychiatric stays.

In the 2019 report, Qsource suggested that the PASSE could develop strategies to increase awareness of services reviewed for underutilization by improving communication throughout care coordination teams and facilitating recommendations and referrals. Empower noted that the workflow exists for UM/CM collaboration and that it would update case notes to capture recommendations more clearly. In 2020, Empower had the highest rate of occupational therapy and physical therapy usage for DD enrollees. The PASSE's rate of physical therapy, augmentative communication devices, and DME for all enrollees and augmentative communication devices and DME for DD enrollees increased compared to 2019. Empower had the highest increase in the category for one to four behavioral health services for adults and the highest rate of both children and adults receiving greater than five behavioral health services.

However, the PASSE had the lowest rate of both children and adults receiving one to four behavioral health services.

Summit

In the 2019 report, Qsource reported that Summit had the lowest utilization rates of occupational therapy, physical therapy, speech-language pathology, and usage of augmentative communication devices for DD enrollees. Summit also had the lowest utilization rate of behavioral services usage for adult enrollees. Qsource suggested that the PASSE could develop strategies to increase awareness of these services by improving communication throughout care coordination teams and facilitating recommendations and referrals. Summit reported that in order to improve rates of occupational, speech, and physical therapy, it would work with providers to develop strategies for payment mechanisms for rehabilitative and habilitative services for enrollees. Summit stated beginning June 2021, it would incorporate services and documentation training into existing Utilization Management and Care Coordination meetings, which included new hire sessions and clinical rounds meetings. In 2020, while Summit had an increase in physical therapy and augmentative communication devices for DD enrollees compared to 2019, the PASSE had the lowest utilization rates of occupational therapy, physical therapy, speech-language therapy, and augmentative communication devices. Summit had an increase in the category of one to four behavioral health services in both children and adults.

Delta Dental

In 2019, Qsource reported that Delta Dental had a larger number of claims for crown and extraction services. Delta Dental's response was that it was not aware of defined metrics for crown utilization services, but it will continue to monitor these services appropriately. In 2020, in an effort to identify a threshold for crown and extraction services, Qsource reviewed the encounters for both DMOs. Trending from year to year as well as between the two DMOs will be reported in subsequent measurement years. Qsource will then collaborate with DHS to determine more benchmarks. When analyzing the data for 2020, Qsource found that the majority of dental providers had less than seven crowns per enrollee. Therefore, for this report, Qsource used services per enrollee greater than seven as a benchmark. Based on the distribution of the average number of crowns and average number of extractions by all providers who provided those two services, Qsource identified a small number that fell outside of the benchmark. Three Delta Dental providers had an average number of crowns per enrollee greater than seven in 2020.

MCNA

In 2019, Qsource reported that MCNA's rate of crowns per enrollee per visit was higher than Delta Dental's. MCNA's response was that the area of deficiencies identified by the EQRO did not appear to define any deficient behaviors nor were they supported by any industry-recognized dental utilization standards. MCNA noted that it would continue to apply the existing Utilization Management practices and policies. All pre- and post-authorization reviews were conducted by Arkansas

licensed dentists based on MCNA guidelines and the Arkansas Dental Practice Act. There was no scientific or statistical evidence at this time to support an observation that any of the identified dental services were over- or underutilized. MCNA stated that they would be happy to participate in a comprehensive statistically-sound evaluation of dental service utilization. Qsource suggested that MCNA could encourage preventive oral care and warn against behaviors that may chip or break teeth to help reduce the need for crowns. MCNA's response was that they would continue to evaluate this suggestion. In 2020, in an effort to identify a threshold for crown and extraction services, Qsource reviewed the encounters for both DMOs. Trending from year to year as well as between the two DMOs will be reported in subsequent measurement years. Qsource will then collaborate with DHS to determine more benchmarks. When analyzing the data for 2020, Qsource found that the majority of dental providers had less than seven crowns per enrollee. Therefore, for this report, Qsource used services per enrollee greater than seven as a benchmark. Qsource found that MCNA had no providers who had greater than seven crowns per enrollee.

Conclusions

While Empower had the highest rate of emergency services usage for DD enrollees, all three PASSEs showed an increase compared to 2019. Empower showed a decrease in inpatient hospital and psychiatric stays for DD enrollees compared to 2019, however, it had the highest rate compared to the other PASSEs for both DD and BH enrollees. Both ARTC and Summit had an increase in inpatient hospital and psychiatric stays for DD enrollees compared to 2019. All three PASSEs had an overall downward trend in emergency services usage for BH enrollees in 2020. Augmentative communication devices and DME services were used by a very small percentage of DD enrollees in all three PASSEs. For DD enrollees and all enrollees, all three PASSEs had low and similar rates for augmentative communication devices and DME service usage. While ARTC had the highest rate of DD children and BH adult and children receiving 1-4 behavioral health services, they had the lowest rate of greater than 5 behavioral health services in all populations in 2020.While Empower had the highest rate of greater than 5 behavioral health services for DD adults and BH adults and children, they had the lowest rate of 1-4 behavioral health services in DD children and adults and in BH children. Summit had the highest rate of 1-4 behavioral health services in DD adults but the lowest in BH adults.

When looking at the average use of crowns and extractions on the provider level, a range was established using the distribution analysis. Based on this range, Delta Dental had providers who fell outside of the benchmark for crowns and MCNA had providers who fell outside of the benchmark for extractions. Both DMOs had the same low rate of non-surgical periodontal services. There was a spike in utilization for dental extractions and crowns from March 2020 to May 2020. This is likely the result of a sudden decrease in the total number of claims due to

COVID-19 restrictions. The decrease in the total number of all dental visits during this time period affected the denominator for Qsource calculations. This combined with the assumption that the majority of those visits were deemed urgent and therefore likely required services resulted in the pronounced rise in utilization for dental extractions.

Regarding access to care, the decreases in the services reviewed for underutilization were likely due to COVID-19. This will be tracked annually to determine if there was an increase in utilization of services when restrictions due to the pandemic were lifted.

Recommendations

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

Without a standard or target for the PASSEs/DMOs to compare their performance, there was no way to determine if services were over- or underutilized and ultimately whether access to quality care was provided. DHS could work with Qsource to develop targets for utilization measures to ensure access to care.

DHS could clearly communicate expected targets for both over- and under-utilization measures to the PASSEs and DMOs.

DHS could work with the DMOs to review the providers who fell outside the defined benchmark for crowns and extractions to ensure quality of care.

PASSE

The PASSEs could promote preventive and primary care for enrollees with the goal of reducing the need for emergency services and hospitalizations.

All three PASSEs had a higher rate of emergency services for BH enrollees compared to DD enrollees. The PASSEs could focus on this specific population to ensure quality of care.

The PASSES could educate enrollees on alternatives to hospitalization such as day hospitals, short-term crisis units, and community treatment services.

Inpatient hospital and psychiatric stays for DD enrollees increased for both ARTC and Summit compared to 2019. The PASSEs could focus education and outreach for this population to ensure quality of care.

The PASSEs could improve enrollee access to care by developing strategies to increase awareness of occupational therapy, physical therapy, speech-language pathology services.

All three PASSEs had less occupational therapy, physical therapy, and speech-language pathology services compared to 2019. This could be due to the pandemic restrictions. The PASSEs should continue to track this to ensure access to care.

The PASSEs could educate enrollees on the availability of augmentative communication devices and DME.

The PASSEs could utilize care coordination strategies and outreach to enrollees to encourage use of available behavioral health services.

DMO

Delta Dental could track and follow up with providers who fell outside of the benchmark for crown services to determine the cause, if any, of overutilization.

MCNA could track and follow up with providers who fell outside of the benchmark for extractions to determine the cause, if any, of overutilization.

Both DMOs could educate enrollees on the availability of periodontal services to increase access to care.

Effectiveness Analysis

Objectives

As part of the EQR activities, DHS requested that Qsource analyze the effectiveness of the PASSEs and DMOs by evaluating and providing feedback to the State as to why one PASSE or DMO within a single program achieved better success or outcomes in quality metrics contained in their respective agreements. Qsource has included recommendations, strengths, and weaknesses in each Protocol section throughout this report. See the Conclusions and Recommendations section for Qsource's overall observations and suggestions for improvement.

DHS identified Care Coordination Quality Measures and NCQA HEDIS performance measures, including age-stratifications where applicable, to be calculated and reported by the PASSEs. PASSEs were held accountable for performance standards outside those measures for PMV that were defined by DHS. The measures included network adequacy, call center, website and portal availability, grievances, claims processing, encounter data, reporting, key personnel, prior authorizations, and utilization management.

DHS identified dental Quality Metrics to be calculated and reported by the DMOs. DMOs were held accountable for performance standards outside those metrics for PMV that were defined by DHS, including network adequacy, call center, website and portal availability, grievances, claims processing, encounter data, reporting, and key persons.

Activity results that contributed to this analysis included but were not limited to: PMV, PCSP Assessment, Satisfaction Survey Results, CA, PIP Validation, EDV, and ANA Review. Detailed comparative findings are located in this report under each specific activity.

PASSE Findings

ARTC

Quality Care Coordination Measures

ARTC achieved a validation rating of high confidence for four of the five Care Coordination Quality Measures, despite the public health emergency declaration. ARTC's non-clinical PIP involved enrollee to care coordinator ratios, however the validation process resulted in a no confidence level for the PIP, down from a low confidence rating the previous measurement year. DHS's Quality Strategy included a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those enrollees will have a PCSP that includes all needed HCBS services. Qsource found that 24.2% of ARTC's enrollees either did not have a PCSP or did not have a current PCSP at the time of its review. Of those reviewable PCSPs, 100% included all needed HCBS services. Enrollee satisfaction survey results demonstrated that enrollees were mostly satisfied with care coordination services. Overall,

individual metrics were met and aligned with DHS's Quality Strategy, however, ensuring each enrollee has a current PCSP is an area of opportunity.

HEDIS Measures

For the HEDIS measures reported by ARTC, Qsource looked specifically at measures that fell into two domains of care: Effectiveness of Care and Access/Availability of Care. In the Effectiveness of Care domain, ARTC met or exceeded the national benchmarks for 58 (approximately 60%) of the 97 reportable HEDIS measures. The clinical PIP topic selected by ARTC was Immunizations for Children and Adolescents, which is a HEDIS measure. However, ARTC did not report on this measure for this year's HEDIS submission because the denominator was below 30. Based only on the rates versus percentiles for the measures reported, the effectiveness of the strategies in place to achieve goal rates was minimal.

Other Quality Measures

Overall, the IS capabilities assessment found that ARTC fully met requirements, indicating the systems have the capability to provide quality and timely care. Website and portal availability received a high confidence rating in the measurement period. Grievance metrics received high or moderate confidence ratings, and ARTC achieved 100% compliance on the complaints, grievances, and appeals file review for the CA activity. For the CA Grievance and Appeal standard, ARTC achieved a 98.39% up from 90.33% the previous year, resulting in a high compliance rating. A majority of the claims processing metrics achieved a high or moderate confidence rating. These results suggest that processes in place reflected in these measures were highly effective.

Required data and report submissions to DHS had a high confidence rating. Completeness of encounter data received a moderate confidence rating and encounters passing MMIS edits received a high confidence rating. These results imply the encounter data integrity processes and timely report submissions were effective.

ARTC achieved a validation rating of high or moderate confidence for 28 of the 34 applicable additional performance measures from DHS. These results indicated an overall high confidence in ARTC's ability to provide quality care, timely care, and access to care for its enrollees.

Encounters

Overall, ARTC's completeness rates for selected encounter fields were above DHS's threshold of 95% for distinct encounter lines and distinct encounters. ARTC improved the completeness rate for professional distinct encounters from the baseline year (92.7%) to the current measurement year (96.2%). Validity rates remained at 100% for all fields.

ARTC achieved a validation rating of moderate or high confidence on five of the seven encounter data standards required by DHS. The two remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters. Overall, Qsource found that the

ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was high.

Network Adequacy

ARTC met standards for 49 of the 56 urban distance standards, resulting in a rating of high adequacy. ARTC met standards for 40 of the 56 rural distance standards, resulting in a rating of moderate adequacy. ARTC achieved a high adequacy rating for provider to enrollee ratios and a moderate adequacy rating for access to care/wait times.

Empower

Quality Care Coordination Measures

Empower achieved a validation rating of high confidence for all of the Care Coordination Quality Measures, despite the public health emergency declaration. DHS's Quality Strategy included a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those enrollees will have a PCSP that includes all needed HCBS services. Qsource found that 78% of Empower's enrollees either did not have a PCSP or did not have a current PCSP at the time of its review. Of those reviewable PCSPs, 97.6% included all needed HCBS services. Empower's clinical PIP on care coordination employee satisfaction achieved a moderate validation rating down from a high validation rating the previous year. Overall, individual metrics were met and aligned with DHS's Quality Strategy, however, ensuring each enrollee has a current PCSP is an area of opportunity.

HEDIS Measures

For the HEDIS measures reported by Empower, Qsource looked specifically at measures that fell into two domains of care: Effectiveness of Care and Access/Availability of Care. In the Effectiveness of Care domain, Empower met or exceeded the national benchmarks for 56 (approximately 53%) of the 105 reportable HEDIS measures. Based only on the rates versus percentiles for the measures reported, the effectiveness of the strategies in place to achieve goal rates was minimal.

Other Quality Measures

Overall, the IS capabilities assessment found that Empower fully met requirements indicating the systems have the capability to provide quality and timely care. Website and portal availability received a high confidence rating in the measurement period. Empower received a no confidence rating in all of the investigation and resolution of grievance standards. Empower's CA Grievance and Appeals standard received a 100%, up from 95.16% the previous year, resulting in a high compliance rating. Empower scored 100% on the grievance file review and 100% on the appeals file review. The findings indicated that adequate policies and procedures were in place, however implementation of those policies and procedures is an area of opportunity - specifically timeliness of investigation and grievance resolution.

The majority of claims processing measures achieved a validation rating of moderate or high confidence during the review period. Empower had a validation rating of moderate confidence for submitting 100% of encounters and no less than

95% of encounters passing MMIS edits. Required report submissions had a high confidence rating. Call center and website and portal availability operational processes were highly effective, as were claims processing operational practices. Timely report submission to DHS was effective. There is an opportunity for improvement in timely investigation and resolution of grievances.

Empower achieved a validation rating of high or moderate confidence for 31 of the 36 applicable additional performance metrics from DHS. These results indicated an overall high confidence in Empower's ability to provide quality care, timely care, and access to care for its enrollees.

Encounters

Overall, Empower's completeness rates for selected encounter fields were above DHS's threshold of 95% for distinct encounter lines and distinct encounters. Empower improved the completeness rate for professional distinct encounters from the baseline year (93.6%) to the current measurement year (95.1%). Validity rates remained at 100% for all fields.

Empower achieved a validation rating of moderate or high confidence on five of the seven encounter data standards required by DHS. The two remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters. Overall, Qsource found that the ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was high.

Network Adequacy

Empower met 47 of the 56 urban distance standards and 42 of the 56 for the rural distance standards, resulting in a rating of high adequacy for both categories. Empower achieved a high adequacy rating for provider to enrollee ratios and a moderate adequacy rating for access to care/wait times.

Summit

Quality Care Coordination Measures

Summit achieved a validation rating of high confidence for all of the Care Coordination Quality Measures, despite the public health emergency declaration. DHS's Quality Strategy included a performance metric stating that ≥90% of enrollees will have a PCSP or Interim Plan of Care and that ≥80% of those enrollees will have a PCSP that includes all needed HCBS services. Qsource found that 23.1% of Summit's enrollees either did not have a PCSP or did not have a current PCSP at the time of the review. Of those reviewable PCSPs, 98.6% included all needed HCBS services. Overall, individual metrics were met and aligned with DHS's Quality Strategy, however, ensuring each enrollee has a current PCSP is an area of opportunity.

HEDIS Measures

For the HEDIS measures reported by Summit, Qsource looked specifically at measures that fell into two domains of care: Effectiveness of Care and Access/Availability of Care. In the

Effectiveness of Care domain, Summit met or exceeded the national benchmarks for 66 (approximately 60%) of the 111 reportable HEDIS measures. Summit's clinical PIP involved the HEDIS measure for Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) and received a low confidence validation rating down from a high confidence rating the previous year. Summit's reported rate for this measure was above the 75th percentile when compared to national benchmarks. Based only on the rates versus percentiles for the measures reported, the effectiveness of the strategies in place to achieve goal rates was minimal.

Other Measures

Overall, the IS capabilities assessment found that Summit fully met requirements indicating the systems have the capability to provide quality and timely care. Website and portal availability achieved a validation rating of high confidence in the measurement period. Summit achieved a high or moderate confidence rating on all of the issue and grievance resolution metrics throughout the measurement period. The Grievance and Appeals standard of the CA received 100%. Summit scored 100% on the grievance file review and 100% on the appeals file review, which showed adequate compliance with the Grievance and Appeals standard. Overall claims processing measures achieved a moderate confidence rating. Encounter data for encounter line submissions passing MMIS system edits received a no confidence rating. This suggests effective standards and operational practice in all areas except encounter data.

Summit achieved a validation rating of high or moderate confidence for 28 of the 33 applicable additional performance metrics from DHS. These results indicated an overall high confidence in Summit's ability to provide quality care, timely care, and access to care for its enrollees.

Encounters

Overall, Summit's completeness rates for selected encounter fields were above DHS's threshold of 95% for distinct encounter lines and distinct encounters. Summit improved the completeness rate for professional distinct encounters from the baseline year (94.9%) to the current measurement year (96.2%). Validity rates remained at 100% for all fields.

Summit achieved a validation rating of moderate or high confidence on four of the seven encounter data standards required by DHS. The three remaining standards indicated an opportunity for improvement in timely and accurate resubmission of encounters as well as encounters passing MMIS system edits. Overall, Qsource found that the ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was high.

Network Adequacy

Summit met 43 of the 56 urban distance standards, resulting in a rating of high adequacy. Summit met 34 of the 56 rural distance standards, resulting in a rating of moderate adequacy. Summit achieved a high adequacy rating for provider to enrollee

ratios and a moderate adequacy rating for access to care/wait times.

DMO Findings

Delta Dental

Quality Metrics

Delta Dental failed to meet any of DHS's quality metric targets resulting in a validation rating of low to no confidence. Delta Dental submitted two PIPs for review, one of which involved preventive dental care for children in foster care which received a moderate confidence rating up from a low confidence rating the previous year. Overall, these indicated an area of opportunity for Delta Dental to more closely align with DHS's Quality Strategy as well as meet DHS determined targets for quality of care.

Other Metrics

Delta Dental achieved a high or moderate confidence validation rating on all of the other performance metrics outlined by DHS. The CA resulted in a score of 100%, up from 98.68%, on the Grievance and Appeals standard resulting in a high confidence rating. Delta Dental achieved a score of 100% on both the grievance and appeal file reviews, which showed adequate compliance with policies and procedures. Along with the high confidence rating for the call center metrics, this suggests that the DMO was effectively utilizing policies and procedures to resolve grievances and provide quality care to its enrollees.

Encounters

Overall, Qsource found that Delta Dental's selected encounter field completeness rates were above 95% and the validity rates were above DHS's threshold of 99% in both encounter lines and encounters.

Delta Dental achieved a validation rating of moderate or high confidence on four of the seven encounter data standards required by DHS. The three remaining standards indicated an opportunity for improvement in timely and accurate submission and resubmission of encounters. Overall, Qsource found that the ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was high.

Network Adequacy

Three of DHS's Quality Strategy metrics for the DMOs relate to network adequacy. Delta Dental received a high adequacy rating for urban and rural distance standards. However, Delta Dental received a rating of no adequacy for the Access to Service/Wait Time for Existing Patient Appointments standards. There are opportunities for improvement regarding timely care for urgent dental needs, routine dental care, dental emergencies, and after-hours dental needs.

MCNA

Quality Metrics

MCNA failed to meet any of DHS's quality metric targets resulting in a validation rating of no confidence. MCNA

submitted two PIPs for review, Annual Dental Visits and Preventive Dental Visits for ages 1-20 years. Both submitted PIPs received a high confidence validation rating. This indicated that steps were taken to improve the metric results.

Other Metrics

MCNA achieved high to moderate confidence ratings on the majority of DHS's performance measure. Overall, call center received high confidence ratings with the exception of call wait time longer than two minutes receiving a moderate confidence rating and the abandoned call rate receiving a no confidence rating. The website and portal availability achieved a high confidence rating. Reported investigation and resolution of grievance standards received a high confidence rating. The CA resulted in 100% compliance (high confidence rating) for the Grievance and Appeal standard, as well as the grievance and appeal file reviews, indicating adequate compliance with policies and procedures relative to contractual and regulatory standards. Encounter accuracy and timeliness received a low confidence rating. The results indicated effective standards and operational practice in all areas except encounter data.

Encounters

Overall, Qsource found that MCNA's selected encounter field completeness rates were above DHS's threshold of 95% for distinct encounter lines and distinct encounters. Validity rates remained at 100% for all fields.

MCNA achieved a validation rating of moderate or high confidence on three of the seven encounter data standards required by DHS. The four remaining standards indicated an opportunity for improvement in timely and accurate submission and resubmission of encounters. Overall, Qsource found that the ability to meet the quality standards for submission to the state and contribute to providing reliable and valid performance measures was moderate.

Network Adequacy

Three of DHS's Quality Strategy metrics for the DMOs relate to network adequacy. MCNA received a high adequacy rating for urban and rural distance standards. However, MCNA received a rating of no adequacy for the Access to Service/Wait Time for Existing Patient Appointments standards. There are opportunities for improvement regarding timely care for urgent dental needs, routine dental care, dental emergencies, and after-hours dental needs.

Conclusions and Recommendations

Each of CMS's EQR Protocols is a learning opportunity for the PASSEs, DMOs, and DHS. Qsource used a collaborative approach to assist the State and plans with developing best practices for future reviews and ensuring enrollee quality of care was paramount. Qsource is available to collaborate with DHS and directly assist the PASSEs and DMOs in accomplishing the following recommendations for improvement. While each activity included specific comparisons and observations, these recommendations are overarching opportunities across all of the activities performed by Qsource. See the Quality Strategy Evaluation for Qsource's findings regarding the effectiveness of DHS's Quality Strategy and its progress toward the strategy's primary goals and objectives.

In order to improve the quality of health for all enrollees, Qsource made the following recommendations.

Goal 4 of DHS's Quality Strategy is to continuously advance plan models to improve the health of enrollees and it includes Objective 4.1: Monitor implementation of performance improvement projects. 2021 was the second measurement year for the PASSEs to complete a PIP, therefore steps seven through nine were new. This could account for the overall low PIP scores for the PASSES. Qsource views these results as a learning opportunity and anticipates a marked improvement in the next measurement year. The DMO PIPs achieved high scores. DHS should continue to monitor both the PASSE and DMO PIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

Overall, the PASSEs met individual Care Coordinator performance measures, however; the PCSP assessment findings continued to be deficient. Goal 1 of DHS's Quality Strategy is to focus on person-centered, coordinated care, and outreach. Objective 1.3 is to improve PCSP development for enrollees. It states that PCSPs must adhere to 42 CFR 441.540, include outlined treatment goals and objectives, and contain medical and nonmedical community supports and services (NCSS) necessary as identified through the functional needs assessment and crisis plan. DHS and Qsource have worked together to target this specific goal from the Quality Strategy to improve quality, timeliness, and care for the enrollees. DHS asked Qsource to work with the PASSEs to implement a performance improvement project in 2022. Qsource will continue its concurrent review of the PCSPs in order to provide real-time feedback to the PASSEs and DHS. DHS should continue to focus on working with the PASSEs to improve the PCSPs and thus align with the Quality Strategy.

Both of the DMOs failed to meet quality metrics. This could be due to the COVID-19 pandemic. Objective 2.2: Improve prevention among enrollees under Goal 2 of DHS's Quality Strategy should be an area of focus for DHS and the DMOs. The DMOs should focus on increasing preventive care to not only

align with DHS's goals and objectives but also to ensure access to quality care for enrollees. Goal 2 of the Quality Strategy is to improve access to needed services and safety for all enrollees and includes Objective 2.3: Decrease per capita emergency room (due to dental emergencies) visits. The DMOs were asked to report on rates of dental emergencies, but according to the DMOs, they were unable to bill these through their systems and were unable to track these metrics. DHS's standard regarding access to care and time also includes emergent/urgent care. DHS should review these metrics and determine whether or not the DMOs should be required to report them in the future.

Overall, each PASSE and DMO improved performance on the compliance assessment compared to the previous measurement period, resulting in high confidence ratings.

The PASSEs and DMOs met or almost met the majority of DHS's network adequacy standards. DHS's Quality Strategy Goal 2 is to improve access to needed services and safety for all enrollees and applies to both the PASSEs and DMOs. The PASSEs and DMOs should continue to focus on those provider types which consistently did not meet network adequacy standards to ensure alignment with DHS's Quality Strategy and improve access to care for enrollees.

Goal 3 of DHS's Quality Strategy is to continuously increase enrollee satisfaction with services. Objective 3.1 is to increase satisfaction with the PASSEs and DMOs as reflected on the enrollee surveys. DHS is working with Qsource to implement standardized enrollee and provider satisfaction surveys for both PASSEs and DMOs. This will allow for comparison of performance and an evaluation of quality of care. Enrollee satisfaction is directly impacted by the additional performance standards evaluated in PMV. Overall, the investigation and resolution of grievances metrics are an area of opportunity. DHS should work with the PASSEs and DMOs to target these metrics to improve quality of care.

In the IS Capabilities Assessment, Qsource found that all of the PASSEs and DMOs were capable of reporting measures and had the capacity to produce accurate and complete encounter data. When reviewing selected encounter fields, the PASSEs and DMOs were mostly accurate and complete. However, all of the PASSEs and DMOs should continue to focus on resubmitting encounters timely and accurately.

DHS should develop targets for measures where possible (e.g., utilization, depression measures). Without designated targets, the PASSEs and DMOs had no incentive to improve performance and measuring improvement was difficult due to inconsistencies.

Qsource found that the critical incident reporting process was improved. DHS should continue to focus on improving the reporting format and the PASSEs should ensure providers are educated on updated processes. Only 19.77% of the HCBS

providers that were active in 2020 received the required Abuse and Neglect training, which indicates an area of opportunity regarding quality of care.

Although COVID-19 likely affected the utilization of preventive dental services, the DMOs should continue to focus on educating enrollees and providers on the availability of value-added services. The PASSEs should continue to focus on ensuring both Behavioral Health and Developmentally Disabled populations are receiving the services that are traditionally under-utilized.

Overall, the results of the 2021 EQR activities demonstrated that the PASSEs and DMOs were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

APPENDIX A | Protocol 1: PIP Validation Findings

Table A-1 includes the full PIP title, study population, study variables and performance measures, improvement strategies, and measurement results. The overall validation status, type of PIP, summary of performance, and strengths and weaknesses are provided in the PIP section of the report for each PASSE and DMO. More detailed individual PASSE/DMO scores are provided for the nonclinical PIPs in Table A-2 and for the clinical PIPs in Table A-3. Note that the table contains information directly from the PASSEs and DMOs.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
PASSEs	
ARTC: Enrollee to Care Coordinator Ratio (Nonclinical)	
Study Population	The entire eligible enrollee population, with no age, diagnoses, or procedure exclusions, was included.
Study Variables and Performance Measures	The variable and performance measure is the enrollee to care coordinator ratio.
Improvement Strategies	Improvement Strategy 1: Ensure we have the appropriate number of qualified Care Coordinators hired to meet caseload metric requirement. Improvement Strategy 2: Create Workforce Analyst role within the Care Coordination department who oversees assignments of caseloads and monitors individual and program-wide caseload metric on a daily basis. Improvement Strategy 3: Weekly review of metric data with leadership to ensure progress is on track and being maintained. CAP progress will be tracked as well.
Measurement Results	Performance Measure 1: PA § 8.2.3(a). Quality Metrics (Care Coordination) Enrollee to Care Coordinator Ratio Goal: 90.0%, Baseline: 92.12%, Remeasurement 1: 98.11%
ARTC: Immunizations for Children and Adolescents (Clinical)	
Study Population	Enrollees who remain continuously enrolled for 12 months and who will turn either two or 13 years old during the measurement year were included. The PIP population included the entire population. No sampling was used.
Study Variables and Performance Measures	Both variables are immunization status, and the performance measures include HEDIS measures for CIS-CH and IMA-CH.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
Improvement Strategies	Improvement Strategy 1: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Notify parent/guardian/member of EPSDT benefit within 60 days of enrollment as well as yearly. Provider education on proper billing, coding, and benefit structure as well as ensuring resources are available. Internal staff education on proper way to discuss the need for EPSDT visits and how to assist with appointment scheduling. Improvement Strategy 2: Increase closure of immunizations measures by claims and medical record review. Provider education piece needs development. State Immunization Registry access needed to improve numerator by showing higher member compliance. Work with largest provider groups for year-round medical record abstraction.
Measurement Results	Performance Measure 1: Childhood Immunization Status (CIS) Goal: 39.1%, Baseline: 0.0%, Remeasurement 1: 0.0% Performance Measure 2: Immunizations for Adolescents (IMA) Goal: 38.2%, Baseline: 0.0%, Remeasurement 1: 30.61%
Empower: Care Coordination: Employee Satisfaction (Nonclinical)	
Study Population	All care coordinators were included in the study.
Study Variables and Performance Measures	The variable and performance measure is the annual care coordination satisfaction survey results.
Improvement Strategies	Improvement Strategy 1: Improve the care coordinator training manual. Improvement Strategy 2: Implement team caseload reconciliation meetings. Improvement Strategy 3: Implement self-care supports. Improvement Strategy 4: Redesign the Multidisciplinary form to include a spreadsheet for case load. Improvement Strategy 5: Develop Tools and Resources to help Care Coordinators find resources and information to help members.
Measurement Results	Performance Measure 1: Annual Care Coordination Employee Satisfaction Survey Composite “Role Clarity” Goal: 85%, Baseline: 77.0%, Remeasurement 1: 75.7% Performance Measure 2: Annual Care Coordination Employee Satisfaction Survey Composite “Resources and Information” Goal: 85.0%, Baseline: 78.4%, Remeasurement 1: 78.3%
Empower: Improving Member Access to Primary Care Well Visits (Clinical)	
Study Population	All enrollees continuously enrolled during the measurement year were included.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
Study Variables and Performance Measures	The variable and performance measure is physician well visits paid through claims.
Improvement Strategies	Improvement Strategy 1: Care Coordinator assistance with scheduling Well Care Visits with a member's assigned PCP. Improvement Strategy 2: Provider Education on appropriate coding to qualify a claim for service as a Well Care Visit.
Measurement Results	Performance Measure 1: Improving Member Access to Primary Care Well Visits Physician Services Well Visits Goal: 39.9%, Baseline: 31.0%, Remeasurement 1: 8.0%, Remeasurement 2: 13.0%, Remeasurement 3: 38.0%
Summit: Improving Reportable Incident Notification Timeframes (Nonclinical)	
Study Population	All enrollees that are enrolled with the health plan at the time of a reportable incident were included.
Study Variables and Performance Measures	The variable and performance measure is the percentage of reportable incidents reported to the health plan within 24 hours in the category of abuse.
Improvement Strategies	The incident report tracking tool is utilized to log in 100% of the incident reports reported to the health plan in the category of abuse. The incidents are entered daily, tracked monthly, trended quarterly, and reported to the Quality Management Committee at least semi-annually. The results also allow for year over year comparisons, and comparison to the established goal. The incident report tracking tool captures all of the essential elements to determine time frame reporting within established criteria.
Measurement Results	Performance Measure 1: Incidents Reported Within 48 Hours of Occurrence Goal: 100%, Baseline: 70.2%, Remeasurement 1: 65.3%
Summit: Improving Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Clinical)	
Study Population	All enrollees who are 18 years of age and older as of January 1 of the measurement year with schizophrenia or schizoaffective disorders who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period were included.
Study Variables and Performance Measures	The variable and the performance measure is the percentage of enrollees 18 years and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period (HEDIS SAA).
Improvement Strategies	Provider and member medication fail lists and gaps in care lists were produced for enrollees who missed a refill of an antipsychotic medication for at least 80% of the treatment period. The appropriate prescribing providers were faxed lists and/or received provider email blasts, and provider newsletters. The Arkansas Pharmacists Association submitted fax blast newsletter to providers. The health plan quality department communicated with Care Coordinator Team leads to provide member specific gaps in care.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
Measurement Results	Performance Measure 1: Improving Adherence to Antipsychotic Medications Goal: 65.42%, Baseline: 6.96%, Remeasurement 1: 75.6%
DMOs	
Delta Dental: Beneficiary Missed Appointments (Nonclinical)	
Study Population	All enrollees who missed a scheduled dental appointment were included.
Study Variables and Performance Measures	The variable and performance measure is the number of enrollees who missed a preventive dental appointment while having a paid claim within 90 days of outreach.
Improvement Strategies	The work of public health is centered on promoting healthy lifestyles through health education, protecting against environmental hazards, controlling infectious diseases, preparing for and responding to disasters, and promoting healthcare equity, quality, and accessibility. Medicaid is in a special position to bridge public health efforts to the patient level. The Beneficiary Missed Appointments PIP addresses one of the Institute for Healthcare Improvement's Triple Aim Framework: Improving the health of populations. Prevention is the underlying driver of health system transformation. It is what will ultimately lower costs, improve patient care, and improve the health of populations. Annual dental visits play a vital role in diagnosing and preventing dental disease (ASTHO). Education is a fundamental social determinant of health and health education is a central tool of public health (Hahn, R.A. & Truman, B.I.). Therefore, we designed our Beneficiary Missed Appointment PIP around educating Delta Dental Smiles members that had been reported as having missed a scheduled dental appointment. We believed that we would see more of these members make and keep a dental appointment with 90 days of outreach efforts, due to the causality between education and health outcomes.
Measurement Results	Performance Measure 1: Percentage of beneficiaries who received a dental service rate after outreach Goal: 27.5%, Baseline: 16.5%, Remeasurement 1: 24.5%, Remeasurement 2: 10.8%
Delta Dental: Department of Children & Family Services: Foster Care Children with a Preventive Dental Service (DCFS) (Clinical)	
Study Population	All DCFS foster children enrolled in the DMO were included.
Study Variables and Performance Measures	The variable is preventative dental service, and the performance measure is the percentage of foster children who received a preventative dental service, CMS-416 PDENT-CH.
Improvement Strategies	DCFS creates a list of all Foster Children enrolled in Delta Dental Smiles and shares that with DDAR on a monthly basis. We then identify those Foster Children who have and have not had a preventive dental service in our claims/encounter data any time in the most recent 12-month period. DDAR then shares this data back with DCFS staff. DCFS then uses that data to inform regional Health Services workers on Foster Children that need to have dental appointments scheduled. Copies of these reports are available upon request.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
Measurement Results	Performance Measure 1: Percentage of Foster Children Who Received Preventive Dental Services Goal: 52.1%, Baseline: 42.8%, Remeasurement 1: 46.9%
MCNA: Annual Dental Visits (Nonclinical)	
Study Population	All enrollees ages 2–20 years continuously enrolled 12 months during the reporting year with no more than a one-month break in coverage were included.
Study Variables and Performance Measures	The variable is the number of enrollees with at least one dental encounter during the measurement year, and the performance measure is annual dental visit for enrollees 2–20 years, HEDIS ADV.
Improvement Strategies	Improvement Strategy 1: MCNA Member Service Representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a dental visit. The MSR educates the member on their available benefits and the importance of routine dental checkups to prevent gum disease. They also offer to locate a provider if the member does not already have one and performs a three-way call if necessary with the provider office to schedule an appointment. Improvement Strategy 2: Conduct and/or participate in a minimum of 80 outreach events annually in areas identified as a high-volume opportunity. Education and assistance will be coordinated and members needing additional assistance beyond what can be provided at the event will be referred to the Care Connections team. Improvement Strategy 3: Text messages will be sent once a month to members who have not received a dental checkup within the last six months. Members will continue to receive a text message until an encounter is received or the member "opts out" of text messaging. The text messages will educate the members on preventive care and encourage them to schedule an appointment.
Measurement Results	Performance Measure 1: Annual Dental Visit (ADV) – Ages 2-20 Goal: 61.6%, Baseline: 61.3%, Remeasurement 1: 62.2%, Remeasurement 2: 52.7%
MCNA: Preventive Dental Visits (Clinical)	
Study Population	All enrollees ages 1–20 years continuously enrolled at least 90 days during the reporting year were included.
Study Variables and Performance Measures	The variable is the number of enrollees that utilized preventive dental services during the measurement year, and the performance measure is preventative dental services ages 1–20, CMS-416.
Improvement Strategies	Improvement Strategy 1: Text messages will be sent once a month to members who have not received a preventive checkup within the last six months. Members will continue to receive a text message until an encounter is received or the member "opts out" of text messaging. The text messages will educate the members on preventive care and encourage them to schedule an appointment. Improvement Strategy 2: Quarterly provider profiling report that shows providers how they are performing against their peers. The report includes a clinical component assessing a provider's performance against clinical guidelines to that of his/her peers.

Table A-1. 2021 PIP Details for PASSEs and DMOs	
Measurement Results	Performance Measure 1: Preventive Dental Services – Ages 1-20 Goal: 48.9%, Baseline: 50.6%, Remeasurement 1: 44.2%

For each applicable step, **Tables A-2** and A-3 summarize PIP validation scores, including the total number of applicable elements assessed and met, and the overall validation rating. The actual number of steps validated for each plan depended on various factors, including the progress of the PIP study and sampling methods. **Table A-2** includes scores for the nonclinical PIPs, and Table A-3 includes scores for the clinical PIPs.

Table A-2. 2021 Nonclinical PIP Validation Scores by Review Step

Review Steps	Elements Met / Elements Applicable				
	ARTC	Empower	Summit	Delta Dental	MCNA
1. Review the Selected PIP Topic	2/3	4/4	3/3	5/5	5/5
2. Review the PIP Aim Statement	2/6	3/6	5/6	6/6	6/6
3. Review the Identified PIP Population	3/3	3/3	3/3	3/3	3/3
4. Review the Sampling Method	0/0	0/0	0/0	0/0	0/0
5. Review the Selected PIP Variables and Performance Measures	3/7	7/8	7/7	8/8	7/7
6. Review the Data Collection Procedures	7/7	7/7	7/7	7/7	7/7
7. Review Data Analysis and Interpretation of PIP Results	5/7	4/7	6/7	7/7	7/7
8. Assess the Improvement Strategies	4/6	5/6	6/6	5/5	6/6
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2/4	2/2	0/5	3/3	3/3
Total Elements Met of Total Elements Applicable	**28/43**	**35/43**	**37/44**	**44/44**	**44/44**
Validation Score	**65.1%**	**81.4%**	**84.1%**	**100%**	**100%**

Table A-2. 2021 Nonclinical PIP Validation Scores by Review Step					
Review Steps	**Elements Met / Elements Applicable**				
	ARTC	**Empower**	**Summit**	**Delta Dental**	**MCNA**
Overall Validation Rating	**No Confidence**	**Moderate Confidence**	**Moderate Confidence**	**High Confidence**	**High Confidence**

Table A-3. 2021 Clinical PIP Validation Scores by Review Step					
Review Steps	**Elements Met / Elements Applicable**				
	ARTC	**Empower**	**Summit**	**Delta Dental**	**MCNA**
1. Review the Selected PIP Topic	5/5	5/5	4/4	5/5	5/5
2. Review the PIP Aim Statement	5/6	5/6	5/6	5/6	6/6
3. Review the Identified PIP Population	2/2	3/3	3/3	3/3	3/3
4. Review the Sampling Method	0/0	0/0	0/0	0/0	0/0
5. Review the Selected PIP Variables and Performance Measures	6/7	8/8	8/8	6/7	7/7
6. Review the Data Collection Procedures	9/9	6/7	7/7	7/7	7/7
7. Review Data Analysis and Interpretation of PIP Results	7/7	2/7	2/6	4/6	7/7
8. Assess the Improvement Strategies	4/6	2/6	4/6	6/6	6/6
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3/3	2/5	2/5	4/5	1/3
Total Elements Met of Total Elements Applicable	**41/45**	**33/47**	**35/45**	**40/45**	**42/44**
Validation Score	**89.1%**	**70.2%**	**77.8%**	**88.9%**	**95.5%**
Overall Validation Rating	**Moderate Confidence**	**Low Confidence**	**Low Confidence**	**Moderate Confidence**	**High Confidence**

APPENDIX B | Protocol 2: PMV Findings

PASSE PMV Results

Tables B-1 through **B-38** present the findings from the performance measure validation for the PASSEs.

Table B-1. MY 2020 PMV Results: DHS Care Coordination Quality Metrics				
Month or Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
Care Coordinator Caseload				
January 2020	92.9%	95.1%	99.7%	≥90%
February 2020	91.9%	97.5%	99.7%	≥90%
March 2020	93.4%	95.0%	99.7%	≥90%
April 2020	92.9%	97.8%	99.7%	≥90%
May 2020	93.4%	96.4%	99.1%	≥90%
June 2020	85.8%	96.7%	98.5%	≥90%
July 2020	49.3%	96.7%	98.1%	≥90%
August 2020	43.8%	98.3%	97.6%	≥90%
September 2020	29.0%	97.5%	97.6%	≥90%
October 2020	21.1%	97.3%	97.0%	≥90%
November 2020	96.2%	97.5%	98.6%	≥90%
December 2020	98.1%	97.8%	97.6%	≥90%
Initial Contact with Enrolled Member				
2020 Q2	68.9%	80.5%	91.0%	≥75%
2019 Q2	79.3%	90.2%	96.6%	≥75%
2019 Q3	79.6%	86.3%	81.2%	≥75%
2019 Q4	82.9%	77.3%	73.1%	≥75%
Monthly Contact with Enrolled Member				
January 2020	83.1%	86.8%	87.7%	≥75%
February 2020	82.5%	90.7%	88.8%	≥75%
March 2020	87.2%	90.0%	92.7%	≥75%

Table B-1. MY 2020 PMV Results: DHS Care Coordination Quality Metrics				
Month or Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
April 2020	88.0%	88.7%	92.1%	≥75%
May 2020	88.0%	86.6%	90.6%	≥75%
June 2020	89.1%	87.5%	88.0%	≥75%
July 2020	89.3%	87.6%	83.8%	≥75%
August 2020	88.6%	84.9%	82.2%	≥75%
September 2020	88.4%	84.5%	81.1%	≥75%
October 2020	85.0%	83.7%	84.2%	≥75%
November 2020	84.8%	81.9%	83.6%	≥75%
December 2020	83.2%	79.1%	81.3%	≥75%
Quarterly Contact with Enrolled Member				
2020 Q2	*	*	*	≥75%
2020 Q2	*	*	*	≥75%
2020Q3	*	*	*	≥75%
2020 Q4	*	*	*	≥75%
Primary Care Physician (PCP) Assignment				
2020 Q1	90.8%	84%	100%	≥80%
2020 Q2	95.7%	89%	100%	≥80%
2020 Q3	92.0%	89%	99.9%	≥80%
2020 Q4	91.2%	86%	99.95%	≥80%
Follow-Up Care				
2020 Q1	92.4%	84.6%	69.9%	≥50%
2020 Q2	92.3%	86.7%	71.0%	≥50%
2020 Q3	76.7%	86.5%	83.1%	≥50%
2020 Q4	74.1%	78.4%	53.4%	≥50%

**DHS Waived Quarterly Contact measure due to the COVID-19 pandemic, thus, no results are reported.*

Table B-2 provides the color and measure designation used in this report. Per NCQA HEDIS Measurement Year 2020 Volume 5; HEDIS Compliance Audit™: Standards, Policies and Procedures, rates are not reported if the denominator is too small (<30).

Table B-2. MY 2020 PMV Results: HEDIS Color and Measure Designations	
Color Designation	**National Percentile Achieved**
■	Greater than 75th percentile
□	25th to 75th percentile
■	Less than 25th percentile
Measure Designation	**Definition**
R	Reportable: a reportable rate was submitted for the measure.
NA	Not Applicable: the PASSE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
NB	No Benefit: the PASSE did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported: the PASSE chose not to report the measure.
NQ	Not Required: the PASSE was not required to report the measure.
BR	Biased Rate: the calculated rate was materially biased.
UN	Un-Audited: the PASSE chose to report a measure that is not required to be audited. This result applies to only a limited set of measures.

ARTC

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC

Measure Code	Measure Name	Rate	Measure Designation	25th Percentile	75th Percentile
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	26.9%	R	54.3%	69.0%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	41.0%	R	32.8%	41.8%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	32.3%	R	45.1%	58.2%
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	42.0%	R	36.6%	48.1%

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	50.0%	R	46.1%	61.5%
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	51.4%	R	50.4%	58.9%
AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment	39.6%	R	34.2%	43.1%
AMR	Asthma Medication Ratio (5-11)		NA	68.4%	79.2%
AMR	Asthma Medication Ratio (12-18)		NA	60.4%	71.2%
AMR	Asthma Medication Ratio (19-50)		NA	49.1%	57.5%
AMR	Asthma Medication Ratio (51-64)		NA	51.7%	59.9%
AMR	Asthma Medication Ratio (Total)		NA	57.6%	68.1%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)	59.7%	R	39.1%	52.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)	56.5%	R	27.0%	40.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)	54.6%	R	24.5%	38.8%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)	62.5%	R	54.9%	65.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)	52.1%	R	33.6%	47.7%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)	49.4%	R	32.3%	46.5%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	61.7%	R	49.4%	61.0%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	53.3%	R	31.8%	45.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	50.9%	R	29.4%	44.3%
BCS	Breast Cancer Screening		NA	52.9%	64.1%
CBP	Controlling High Blood Pressure	59.1%	R	54.0%	67.6%
CCS	Cervical Cancer Screening	26.0%	R	55.2%	67.4%
CDC	Comprehensive Diabetes Care - HbA1c Testing	86.9%	R	86.0%	91.0%
CDC	Comprehensive Diabetes Care - HbA1c Control (<8%)	41.4%	R	44.8%	56.0%

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CDC	Comprehensive Diabetes Care - Eye Exams	49.6%	R	52.1%	64.5%
CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	62.3%	R	55.7%	71.1%
CHL	Chlamydia Screening in Women (16-20)	39.5%	R	46.9%	63.4%
CHL	Chlamydia Screening in Women (21-24)	35.9%	R	59.5%	70.0%
CHL	Chlamydia Screening in Women (Total)	39.2%	R	51.3%	66.3%
CIS	Childhood Immunization Status - DTaP		NA	73.2%	81.7%
CIS	Childhood Immunization Status - IPV		NA	86.6%	91.9%
CIS	Childhood Immunization Status - MMR		NA	87.3%	91.7%
CIS	Childhood Immunization Status - HiB		NA	84.7%	91.0%
CIS	Childhood Immunization Status - Hepatitis B		NA	86.1%	92.7%
CIS	Childhood Immunization Status - VZV		NA	86.4%	91.5%
CIS	Childhood Immunization Status - Pneumococcal Conjugate		NA	73.3%	82.2%
CIS	Childhood Immunization Status - Hepatitis A		NA	82.7%	89.3%
CIS	Childhood Immunization Status - Rotavirus		NA	67.4%	76.4%
CIS	Childhood Immunization Status - Influenza		NA	40.8%	58.4%
CIS	Childhood Immunization Status - Combo 2		NA	70.2%	77.9%
CIS	Childhood Immunization Status - Combo 3		NA	66.7%	75.2%
CIS	Childhood Immunization Status - Combo 4		NA	64.7%	73.7%
CIS	Childhood Immunization Status - Combo 5		NA	56.7%	65.9%
CIS	Childhood Immunization Status - Combo 6		NA	34.6%	49.2%
CIS	Childhood Immunization Status - Combo 7		NA	55.7%	64.5%
CIS	Childhood Immunization Status - Combo 8		NA	34.3%	48.7%
CIS	Childhood Immunization Status - Combo 9		NA	30.7%	44.3%
CIS	Childhood Immunization Status - Combo 10		NA	30.2%	44.8%
CWP	Appropriate Testing for Pharyngitis (3-17)	74.6%	R	76.5%	86.7%
CWP	Appropriate Testing for Pharyngitis (18-64)	60.2%	R	55.1%	74.1%
CWP	Appropriate Testing for Pharyngitis (Total)	73.3%	R	71.0%	83.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		NA	5.0%	13.9%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		NA	3.1%	8.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		NA	11.4%	28.2%

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		NA	7.4%	18.3%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		NA	10.8%	27.8%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		NA	7.1%	17.8%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)	73.1%	R	62.2%	77.2%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)	49.0%	R	37.5%	53.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	56.1%	R	42.4%	61.3%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	37.8%	R	24.4%	38.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	67.7%	R	50.0%	67.0%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	45.5%	R	28.3%	43.2%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	81.0%	R	56.5%	78.8%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	64.3%	R	38.6%	64.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	59.0%	R	39.9%	59.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	37.9%	R	25.8%	44.7%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	65.9%	R	46.8%	65.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	46.4%	R	30.4%	49.7%
IMA	Immunizations for Adolescents - Meningococcal	90.3%	R	79.0%	89.1%
IMA	Immunizations for Adolescents - Tdap	91.7%	R	85.0%	91.5%
IMA	Immunizations for Adolescents - HPV	31.6%	R	33.6%	45.6%
IMA	Immunizations for Adolescents - Combination 1	88.8%	R	76.6%	87.3%
IMA	Immunizations for Adolescents - Combination 2	30.7%	R	31.0%	43.1%
LBP	Use of Imaging Studies for Low Back Pain	68.4%	R	71.3%	78.1%
LSC	Lead Screening in Children		NA	63.5%	81.0%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack		NA	76.1%	86.7%
PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	58.0%	R	64.6%	76.8%

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
PCE	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	58.0%	R	80.1%	88.5%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.0%	R	55.6%	68.0%
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		NA	72.1%	83.1%
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	70.9%	R	67.2%	75.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		NA	77.4%	84.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		NA	64.1%	73.4%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		NA	73.2%	80.6%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		NA	61.5%	72.2%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		NA	76.2%	83.1%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		NA	62.3%	73.1%
SPD	Statin Therapy for Patients With Diabetes - Received Statin Therapy		NA	61.5%	68.7%
SPD	Statin Therapy for Patients With Diabetes - Statin Adherence 80%		NA	59.0%	69.6%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD		NA	25.6%	34.0%
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.2%	R	78.7%	84.8%
URI	Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	84.6%	R	88.3%	94.2%
URI	Appropriate Treatment for Upper Respiratory Infection (18-64)	70.3%	R	68.8%	82.3%
URI	Appropriate Treatment for Upper Respiratory Infection (Total)	81.7%	R	85.6%	91.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11)	61.3%	R	72.2%	88.0%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17)	55.3%	R	70.0%	86.2%

Table B-3. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	58.2%	R	71.3%	87.2%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11)	54.1%	R	64.1%	80.7%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17)	44.7%	R	58.9%	78.7%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	49.2%	R	63.0%	80.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11)	43.8%	R	55.3%	75.8%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17)	40.1%	R	60.1%	77.3%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	41.9%	R	57.4%	76.3%

Table B-4. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures-ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CDC	Comprehensive Diabetes Care - Poor HbA1c Control	53.0%	R	46.0%	32.9%
COU	Risk of Continued Opioid Use - >=15 Days (18-64)	7.3%	R	9.4%	4.0%
COU	Risk of Continued Opioid Use - >=31 Days (18-64)	6.9%	R	4.6%	2.1%
COU	Risk of Continued Opioid Use - >=15 Days (Total)	7.3%	R	9.6%	4.1%
COU	Risk of Continued Opioid Use - >=31 Days (Total)	7.3%	R	4.7%	2.1%
HDO	Use of Opioids at High Dosage	0.0%	R	9.7%	3.0%
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	0.5%	R	1.2%	0.4%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers	15.9%	R	24.0%	16.6%
UOP	Use of Opioids From Multiple Providers - Multiple Pharmacies	1.6%	R	6.7%	3.1%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	1.6%	R	4.1%	1.7%

Table B-4. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	94.5%	R	73.1%	82.5%
AAP	Adults' Access to Preventive/Ambulatory Health Services (45-64)	96.2%	R	83.0%	88.9%
AAP	Adults' Access to Preventive/Ambulatory Health Services (Total)	95.2%	R	77.2%	85.2%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)	89.5%	R	53.6%	72.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)	75.4%	R	52.6%	73.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	79.5%	R	53.9%	72.5%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)		NA	34.0%	49.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)		NA	5.9%	16.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)	81.1%	R	37.8%	50.9%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)	3.3%	R	9.9%	21.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)	79.8%	R	34.7%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)	3.0%	R	8.9%	18.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	55.6%	R	38.1%	46.1%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	2.2%	R	7.5%	14.3%

Table B-4. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		NA	46.6%	64.6%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		NA	17.1%	39.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	58.1%	R	37.9%	46.8%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	4.4%	R	7.2%	15.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	55.1%	R	39.2%	48.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	5.1%	R	9.5%	18.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	67.7%	R	38.0%	46.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	1.5%	R	7.5%	14.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		NA	46.6%	64.6%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		NA	17.1%	39.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	67.3%	R	38.4%	47.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	4.0%	R	8.0%	15.4%

Table B-4. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	63.9%	R	39.5%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	4.3%	R	9.7%	18.6%
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	67.4%	R	84.2%	92.9%
PPC	Prenatal and Postpartum Care - Postpartum Care	67.4%	R	71.3%	80.9%

Table B-5. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AMBa*	Ambulatory Care - Outpatient Visits/1000 MM (Total)	611.6	R	309.8	414.5
AMBa	Ambulatory Care - Emergency Dept Visits/1000 MM (Total)	46.9	R	47.6	66.5
FSP**	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 0-19)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 0-19)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 20-44)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 20-44)	0.0	R	0.1	0.2
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 45-64)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 45-64)	0.1	R	0.1	0.3
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 0-9)	1.0	R	0.4	0.8
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 10-19)	0.4	R	0.2	0.3
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (15-44)	0.0	R	0.1	0.1
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (45-64)	0.1	R	0.1	0.2
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (15-44)	0.1	R	0.0	0.1
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (45-64)	0.0	R	0.1	0.2

Table B-5. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 15-44)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (M 30-64)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 45-64)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 15-44)	0.8	R	0.4	0.6
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (M 30-64)	0.9	R	0.2	0.3
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 45-64)	0.6	R	0.4	0.6
FSP	Frequency of Selected Procedures - Back Surgery (M 20-44)	0.6	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (F 20-44)	0.4	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (M 45-64)	0.0	R	0.4	0.7
FSP	Frequency of Selected Procedures - Back Surgery (F 45-64)	0.7	R	0.3	0.7
FSP	Frequency of Selected Procedures - Mastectomy (F 15-44)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Mastectomy (F 45-64)	0.7	R	0.1	0.2
FSP	Frequency of Selected Procedures - Lumpectomy (F 15-44)	0.1	R	0.1	0.1
FSP	Frequency of Selected Procedures - Lumpectomy (F 45-64)	0.4	R	0.3	0.4
IADa***	Identification of Alcohol and Other Drug Services - Alcohol Any Service (Total)	1.7	R	1.1	3.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Inpatient (Total)	0.8	R	0.3	0.8
IADa	Identification of Alcohol and Other Drug Services - Alcohol Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.2
IADa	Identification of Alcohol and Other Drug Services - Alcohol Emergency Department (Total)	0.2	R	0.3	1.0
IADa	Identification of Alcohol and Other Drug Services - Alcohol Outpatient or Medication Treatment (Total)	0.8	R	0.6	2.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Telehealth (Total)	0.3	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Any Service (Total)	0.8	R	0.8	3.5

Table B-5. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IADa	Identification of Alcohol and Other Drug Services - Opioid Inpatient (Total)	0.1	R	0.1	0.5
IADa	Identification of Alcohol and Other Drug Services - Opioid Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Emergency Department (Total)	0.1	R	0.1	0.4
IADa	Identification of Alcohol and Other Drug Services - Opioid Outpatient or Medication Treatment (Total)	0.6	R	0.7	3.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Telehealth (Total)	0.1	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Other Any Service (Total)	5.2	R	1.9	4.5
IADa	Identification of Alcohol and Other Drug Services - Other Inpatient (Total)	2.6	R	0.5	1.2
IADa	Identification of Alcohol and Other Drug Services - Other Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.3
IADa	Identification of Alcohol and Other Drug Services - Other Emergency Department (Total)	1.1	R	0.5	1.5
IADa	Identification of Alcohol and Other Drug Services - Other Outpatient or Medication Treatment (Total)	2.5	R	0.9	2.7
IADa	Identification of Alcohol and Other Drug Services - Other Telehealth (Total)	1.3	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Total Any Service (Total)	6.2	R	3.8	9.2
IADa	Identification of Alcohol and Other Drug Services - Total Inpatient (Total)	2.9	R	0.9	2.1
IADa	Identification of Alcohol and Other Drug Services - Total Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.5
IADa	Identification of Alcohol and Other Drug Services - Total Emergency Department (Total)	1.3	R	1.0	2.8
IADa	Identification of Alcohol and Other Drug Services - Total Outpatient or Medication Treatment (Total)	3.3	R	2.4	7.3
IADa	Identification of Alcohol and Other Drug Services - Total Telehealth (Total)	1.4	R	0.0	0.2
MPTa***	Mental Health Utilization - Any Service (Total)	94.1	R	10.0	17.6

Table B-5. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- ARTC					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
MPTa	Mental Health Utilization - Inpatient (Total)	11.9	R	0.6	1.4
MPTa	Mental Health Utilization - Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.1	0.8
MPTa	Mental Health Utilization - Emergency Department (Total)	0.1	R	0.0	0.4
MPTa	Mental Health Utilization - Outpatient (Total)	88.5	R	9.5	16.9
MPTa	Mental Health Utilization - Telehealth (Total)	64.2	R	0.1	0.4

**AMBa Rate: Per 1,000 Member Months*
***FSP Rate: Per 1,000 Member Years*
****IADa and MPTa Rate: %*

Table B-6. MY 2020 PMV Results: PASSE Medicaid Population Reported in Member Months- ARTC			
Measure Code	**Measure Name**	**Gender**	**Member Months**
ENPa	Enrollment By Product Line - Male	M	71,276
ENPa	Enrollment By Product Line - Female	F	60,326
ENPa	Enrollment By Product Line - Total	F,M	131,602

Empower

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	45.6%	R	54.3%	69.0%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	59.0%	R	32.8%	41.8%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	50.8%	R	45.1%	58.2%
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	78.4%	R	36.6%	48.1%
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	81.3%	R	46.1%	61.5%

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	57.3%	R	50.4%	58.9%
AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment	39.2%	R	34.2%	43.1%
AMR	Asthma Medication Ratio (5-11)		NA	68.4%	79.2%
AMR	Asthma Medication Ratio (12-18)		NA	60.4%	71.2%
AMR	Asthma Medication Ratio (19-50)		NA	49.1%	57.5%
AMR	Asthma Medication Ratio (51-64)		NA	51.7%	59.9%
AMR	Asthma Medication Ratio (Total)		NA	57.6%	68.1%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)	56.2%	R	39.1%	52.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)	48.9%	R	27.0%	40.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)	46.1%	R	24.5%	38.8%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)	65.7%	R	54.9%	65.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)	52.0%	R	33.6%	47.7%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)	50.6%	R	32.3%	46.5%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	63.2%	R	49.4%	61.0%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	51.2%	R	31.8%	45.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	49.4%	R	29.4%	44.3%
BCS	Breast Cancer Screening		NA	52.9%	64.1%
CBP	Controlling High Blood Pressure	7.9%	R	54.0%	67.6%
CCS	Cervical Cancer Screening	17.5%	R	55.2%	67.4%
CDC	Comprehensive Diabetes Care - HbA1c Testing	75.3%	R	86.0%	91.0%
CDC	Comprehensive Diabetes Care - HbA1c Control (<8%)	7.6%	R	44.8%	56.0%
CDC	Comprehensive Diabetes Care - Eye Exams	46.9%	R	52.1%	64.5%
CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	6.5%	R	55.7%	71.1%

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CHL	Chlamydia Screening in Women (16-20)	41.5%	R	46.9%	63.4%
CHL	Chlamydia Screening in Women (21-24)	37.1%	R	59.5%	70.0%
CHL	Chlamydia Screening in Women (Total)	41.2%	R	51.3%	66.3%
CIS	Childhood Immunization Status - DTaP		NA	73.2%	81.7%
CIS	Childhood Immunization Status - IPV		NA	86.6%	91.9%
CIS	Childhood Immunization Status - MMR		NA	87.3%	91.7%
CIS	Childhood Immunization Status - HiB		NA	84.7%	91.0%
CIS	Childhood Immunization Status - Hepatitis B		NA	86.1%	92.7%
CIS	Childhood Immunization Status - VZV		NA	86.4%	91.5%
CIS	Childhood Immunization Status - Pneumococcal Conjugate		NA	73.3%	82.2%
CIS	Childhood Immunization Status - Hepatitis A		NA	82.7%	89.3%
CIS	Childhood Immunization Status - Rotavirus		NA	67.4%	76.4%
CIS	Childhood Immunization Status - Influenza		NA	40.8%	58.4%
CIS	Childhood Immunization Status - Combo 2		NA	70.2%	77.9%
CIS	Childhood Immunization Status - Combo 3		NA	66.7%	75.2%
CIS	Childhood Immunization Status - Combo 4		NA	64.7%	73.7%
CIS	Childhood Immunization Status - Combo 5		NA	56.7%	65.9%
CIS	Childhood Immunization Status - Combo 6		NA	34.6%	49.2%
CIS	Childhood Immunization Status - Combo 7		NA	55.7%	64.5%
CIS	Childhood Immunization Status - Combo 8		NA	34.3%	48.7%
CIS	Childhood Immunization Status - Combo 9		NA	30.7%	44.3%
CIS	Childhood Immunization Status - Combo 10		NA	30.2%	44.8%
CWP	Appropriate Testing for Pharyngitis (3-17)	72.1%	R	76.5%	86.7%
CWP	Appropriate Testing for Pharyngitis (18-64)	50.4%	R	55.1%	74.1%
CWP	Appropriate Testing for Pharyngitis (Total)	68.9%	R	71.0%	83.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		NA	5.0%	13.9%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		NA	3.1%	8.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	2.2%	R	11.4%	28.2%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	2.2%	R	7.4%	18.3%

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	1.8%	R	10.8%	27.8%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	1.8%	R	7.1%	17.8%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)	71.2%	R	62.2%	77.2%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)	44.6%	R	37.5%	53.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	53.6%	R	42.4%	61.3%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	31.1%	R	24.4%	38.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	65.2%	R	50.0%	67.0%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	40.1%	R	28.3%	43.2%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	87.3%	R	56.5%	78.8%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	65.1%	R	38.6%	64.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	64.5%	R	39.9%	59.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	46.7%	R	25.8%	44.7%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	72.4%	R	46.8%	65.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	52.9%	R	30.4%	49.7%
IMA	Immunizations for Adolescents - Meningococcal	26.6%	R	79.0%	89.1%
IMA	Immunizations for Adolescents - Tdap	24.5%	R	85.0%	91.5%
IMA	Immunizations for Adolescents - HPV	5.9%	R	33.6%	45.6%
IMA	Immunizations for Adolescents - Combination 1	23.9%	R	76.6%	87.3%
IMA	Immunizations for Adolescents - Combination 2	4.3%	R	31.0%	43.1%
LBP	Use of Imaging Studies for Low Back Pain	68.6%	R	71.3%	78.1%
LSC	Lead Screening in Children		NA	63.5%	81.0%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack		NA	76.1%	86.7%
PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	23.1%	R	64.6%	76.8%
PCE	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	50.4%	R	80.1%	88.5%

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	72.2%	R	55.6%	68.0%
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		NA	72.1%	83.1%
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	57.1%	R	67.2%	75.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		NA	77.4%	84.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		NA	64.1%	73.4%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		NA	73.2%	80.6%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		NA	61.5%	72.2%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		NA	76.2%	83.1%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		NA	62.3%	73.1%
SPD	Statin Therapy for Patients With Diabetes - Received Statin Therapy		NA	61.5%	68.7%
SPD	Statin Therapy for Patients With Diabetes - Statin Adherence 80%		NA	59.0%	69.6%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD		NA	25.6%	34.0%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	75.9%	R	78.7%	84.8%
URI	Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	89.4%	R	88.3%	94.2%
URI	Appropriate Treatment for Upper Respiratory Infection (18-64)	81.0%	R	68.8%	82.3%
URI	Appropriate Treatment for Upper Respiratory Infection (Total)	87.8%	R	85.6%	91.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11)	15.5%	R	72.2%	88.0%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17)	16.6%	R	70.0%	86.2%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	16.1%	R	71.3%	87.2%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11)	1.6%	R	64.1%	80.7%

Table B-7. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17)	1.9%	R	58.9%	78.7%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	1.7%	R	63.0%	80.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11)	0.9%	R	55.3%	75.8%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17)	2.9%	R	60.1%	77.3%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	2.0%	R	57.4%	76.3%

Table B-8. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CDC	Comprehensive Diabetes Care - Poor HbA1c Control	91.6%	R	46.0%	32.9%
COU	Risk of Continued Opioid Use - >=15 Days (18-64)	17.3%	R	9.4%	4.0%
COU	Risk of Continued Opioid Use - >=31 Days (18-64)	10.0%	R	4.6%	2.1%
COU	Risk of Continued Opioid Use - >=15 Days (Total)	17.3%	R	9.6%	4.1%
COU	Risk of Continued Opioid Use - >=31 Days (Total)	10.0%	R	4.7%	2.1%
HDO	Use of Opioids at High Dosage	0.0%	R	9.7%	3.0%
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	0.9%	R	1.2%	0.4%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers	7.5%	R	24.0%	16.6%
UOP	Use of Opioids From Multiple Providers - Multiple Pharmacies	0.0%	R	6.7%	3.1%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	0.0%	R	4.1%	1.7%

Table B-9. 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	94.6%	R	73.1%	82.5%
AAP	Adults' Access to Preventive/Ambulatory Health Services (45-64)	97.5%	R	83.0%	88.9%
AAP	Adults' Access to Preventive/Ambulatory Health Services (Total)	95.8%	R	77.2%	85.2%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)	87.3%	R	53.6%	72.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)	86.1%	R	52.6%	73.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	86.4%	R	53.9%	72.5%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)	83.3%	R	34.0%	49.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)	0.0%	R	5.9%	16.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)	79.0%	R	37.8%	50.9%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)	10.9%	R	9.9%	21.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)	77.4%	R	34.7%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)	9.8%	R	8.9%	18.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	45.8%	R	38.1%	46.1%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	4.2%	R	7.5%	14.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)	53.9%	R	46.6%	64.6%

Table B-9. 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)	20.5%	R	17.1%	39.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	56.8%	R	37.9%	46.8%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	4.2%	R	7.2%	15.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	51.9%	R	39.2%	48.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	6.6%	R	9.5%	18.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	58.3%	R	38.0%	46.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	2.8%	R	7.5%	14.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	59.1%	R	46.6%	64.6%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	18.2%	R	17.1%	39.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	64.2%	R	38.4%	47.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	6.5%	R	8.0%	15.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		NR	39.5%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		NR	9.7%	18.6%

Table B-9. 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	14.1%	R	84.2%	92.9%
PPC	Prenatal and Postpartum Care - Postpartum Care	29.5%	R	71.3%	80.9%

Table B-10. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AMBa*	Ambulatory Care - Outpatient Visits/1000 MM (Total)	548.7	R	309.8	414.5
AMBa	Ambulatory Care - Emergency Dept Visits/1000 MM (Total)	47.0	R	47.6	66.5
FSP**	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 0-19)		NR	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 0-19)		NR	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 20-44)		NR	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 20-44)	0.3071	R	0.1	0.2
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 45-64)		NR	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 45-64)	0.1597	R	0.1	0.3
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 0-9)		NR	0.4	0.8
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 10-19)	0.4371	R	0.2	0.3
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (15-44)	0.0526	R	0.1	0.1
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (45-64)		NR	0.1	0.2
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (15-44)	0.1052	R	0.0	0.1
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (45-64)	0.1597	R	0.1	0.2
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 15-44)		NR	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (M 30-64)		NR	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 45-64)	0.0798	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 15-44)	0.7625	R	0.4	0.6
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (M 30-64)	0.4148	R	0.2	0.3
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 45-64)	0.5588	R	0.4	0.6
FSP	Frequency of Selected Procedures - Back Surgery (M 20-44)	0.1441	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (F 20-44)	0.3685	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (M 45-64)	0.5895	R	0.4	0.7

Table B-10. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Empower					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FSP	Frequency of Selected Procedures - Back Surgery (F 45-64)	1.0378	R	0.3	0.7
FSP	Frequency of Selected Procedures - Mastectomy (F 15-44)		R	0.0	0.1
FSP	Frequency of Selected Procedures - Mastectomy (F 45-64)	0.1597	R	0.1	0.2
FSP	Frequency of Selected Procedures - Lumpectomy (F 15-44)	0.1052	R	0.1	0.1
FSP	Frequency of Selected Procedures - Lumpectomy (F 45-64)	0.2395	R	0.3	0.4
IADa***	Identification of Alcohol and Other Drug Services - Alcohol Any Service (Total)	0.1	R	1.1	3.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Inpatient (Total)	0.1	R	0.3	0.8
IADa	Identification of Alcohol and Other Drug Services - Alcohol Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.2
IADa	Identification of Alcohol and Other Drug Services - Alcohol Emergency Department (Total)	0.0	R	0.3	1.0
IADa	Identification of Alcohol and Other Drug Services - Alcohol Outpatient or Medication Treatment (Total)	5.00%	R	0.6	2.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Telehealth (Total)	0.0	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Any Service (Total)	0.1	R	0.8	3.5
IADa	Identification of Alcohol and Other Drug Services - Opioid Inpatient (Total)	0.0	R	0.1	0.5
IADa	Identification of Alcohol and Other Drug Services - Opioid Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Emergency Department (Total)	0.0	R	0.1	0.4
IADa	Identification of Alcohol and Other Drug Services - Opioid Outpatient or Medication Treatment (Total)	0.0	R	0.7	3.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Telehealth (Total)	0.0	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Other Any Service (Total)	0.4	R	1.9	4.5
IADa	Identification of Alcohol and Other Drug Services - Other Inpatient (Total)	0.2	R	0.5	1.2
IADa	Identification of Alcohol and Other Drug Services - Other Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.3
IADa	Identification of Alcohol and Other Drug Services - Other Emergency Department (Total)	0.1	R	0.5	1.5
IADa	Identification of Alcohol and Other Drug Services - Other Outpatient or Medication Treatment (Total)	0.2	R	0.9	2.7
IADa	Identification of Alcohol and Other Drug Services - Other Telehealth (Total)	0.1	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Total Any Service (Total)	0.5	R	3.8	9.2

Table B-10. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Empower

Measure Code	Measure Name	Rate	Measure Designation	25th Percentile	75th Percentile
IADa	Identification of Alcohol and Other Drug Services - Total Inpatient (Total)	0.2	R	0.9	2.1
IADa	Identification of Alcohol and Other Drug Services - Total Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.5
IADa	Identification of Alcohol and Other Drug Services - Total Emergency Department (Total)	0.1	R	1.0	2.8
IADa	Identification of Alcohol and Other Drug Services - Total Outpatient or Medication Treatment (Total)	0.3	R	2.4	7.3
IADa	Identification of Alcohol and Other Drug Services - Total Telehealth (Total)	0.1	R	0.0	0.2
MPTa***	Mental Health Utilization - Any Service (Total)	7.7	R	10.0	17.6
MPTa	Mental Health Utilization - Inpatient (Total)	0.9	R	0.6	1.4
MPTa	Mental Health Utilization - Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.1	0.8
MPTa	Mental Health Utilization - Emergency Department (Total)	0.0	R	0.0	0.4
MPTa	Mental Health Utilization - Outpatient (Total)	7.4	R	9.5	16.9
MPTa	Mental Health Utilization - Telehealth (Total)	5.5	R	0.1	0.4

**AMBa Rate: Per 1,000 Member Months*
***FSP Rate: Per 1,000 Member Years*
****IADa and MPTa Rate: %*

Table B-11. MY 2020 PMV Results: Electronic Clinical Data Systems*-Empower

Measure Code	Measure Name	Rate	Measure Designation
ADDE	Follow-Up Care for Children Prescribed ADHD Medication-ECDS Initiation phase	78.4%	R
ADDE	Follow-Up Care for Children Prescribed ADHD Medication-ECDS Continuation and Maintenance (C&M) phase	81.3%	R
ASFE	Unhealthy Alcohol Use Screening and Follow-Up-ECDS Unhealthy Alcohol Use Screening (ECDS) - 18 to 44 years old	0.0%	R
ASFE	Unhealthy Alcohol Use Screening and Follow-Up-ECDS Unhealthy Alcohol Use Screening (ECDS) - 45 to 64 years old	0.0%	R
ASFE	Unhealthy Alcohol Use Screening and Follow-Up-ECDS Unhealthy Alcohol Use Screening (ECDS) - 65+ years old	0.0%	R
ASFE	Unhealthy Alcohol Use Screening and Follow-Up-ECDS Unhealthy Alcohol Use Screening (ECDS)	0.0%	R

Table B-11. MY 2020 PMV Results: Electronic Clinical Data Systems*-Empower			
Measure Code	**Measure Name**	**Rate**	**Measure Designation**
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 1	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 1: 12-17 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 1: 18-44 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 1: 45-64 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 1: 65+ years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 2	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 2: 12-17 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 2: 18-44 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 2: 45-64 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 2: 65+ years old		NA
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 3	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 3: 12-17 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 3: 18-44 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 3: 45-64 years old	0.0%	R
DMSE	Monitor Depression Symptoms for Adolescents and Adults-ECDS Utilization of PHQ-9 - Assessment Period 3: 65+ years old	0.0%	R
DSFE	Depression Screening and Follow-up for Adolescents and Adults-ECDS Depression Screening - 12-17 years old	0.0%	R
DSFE	Depression Screening and Follow-up for Adolescents and Adults-ECDS Depression Screening - 18-64 years old	0.0%	R

Table B-11. MY 2020 PMV Results: Electronic Clinical Data Systems*-Empower			
Measure Code	**Measure Name**	**Rate**	**Measure Designation**
DSFE	Depression Screening and Follow-up for Adolescents and Adults-ECDS Depression Screening - 65+ years old	0.0%	R
DSFE	Depression Screening and Follow-up for Adolescents and Adults-ECDS Depression Screening	0.0%	R
PDSE	Postpartum Depression Screening and Follow-Up-ECDS Depression Screen (ECDS)	0.0%	R
PNDE	Prenatal Depression Screening and Follow-Up-ECDS Depression Screen (ECDS)	0.0%	R

** Electronic Clinical Data Systems does not have national benchmarks.*
**Note: Only reported measures included.*

Summit

Table B-12. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	28.8%	R	54.3%	69.0%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	61.9%	R	32.8%	41.8%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	47.4%	R	45.1%	58.2%
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	34.3%	R	36.6%	48.1%
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	43.9%	R	46.1%	61.5%
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	52.6%	R	50.4%	58.9%
AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment	36.5%	R	34.2%	43.1%
AMR	Asthma Medication Ratio (5-11)	75.8%	R	68.4%	79.2%
AMR	Asthma Medication Ratio (12-18)	80.0%	R	60.4%	71.2%
AMR	Asthma Medication Ratio (19-50)	56.8%	R	49.1%	57.5%
AMR	Asthma Medication Ratio (51-64)		NA	51.7%	59.9%
AMR	Asthma Medication Ratio (Total)	71.6%	R	57.6%	68.1%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)	53.1%	R	39.1%	52.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)	45.3%	R	27.0%	40.6%

Table B-12. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)	43.7%	R	24.5%	38.8%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)	59.8%	R	54.9%	65.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)	44.3%	R	33.6%	47.7%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)	43.8%	R	32.3%	46.5%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	57.7%	R	49.4%	61.0%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	44.6%	R	31.8%	45.6%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	43.8%	R	29.4%	44.3%
BCS	Breast Cancer Screening	25.3%	R	52.9%	64.1%
CBP	Controlling High Blood Pressure	61.6%	R	54.0%	67.6%
CCS	Cervical Cancer Screening	20.9%	R	55.2%	67.4%
CDC	Comprehensive Diabetes Care - HbA1c Testing	79.3%	R	86.0%	91.0%
CDC	Comprehensive Diabetes Care - HbA1c Control (<8%)	46.7%	R	44.8%	56.0%
CDC	Comprehensive Diabetes Care - Eye Exams	47.7%	R	52.1%	64.5%
CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	58.6%	R	55.7%	71.1%
CHL	Chlamydia Screening in Women (16-20)	39.6%	R	46.9%	63.4%
CHL	Chlamydia Screening in Women (21-24)	28.0%	R	59.5%	70.0%
CHL	Chlamydia Screening in Women (Total)	38.2%	R	51.3%	66.3%
CIS	Childhood Immunization Status - DTaP		NA	73.2%	81.7%
CIS	Childhood Immunization Status - IPV		NA	86.6%	91.9%
CIS	Childhood Immunization Status - MMR		NA	87.3%	91.7%
CIS	Childhood Immunization Status - HiB		NA	84.7%	91.0%
CIS	Childhood Immunization Status - Hepatitis B		NA	86.1%	92.7%
CIS	Childhood Immunization Status - VZV		NA	86.4%	91.5%
CIS	Childhood Immunization Status - Pneumococcal Conjugate		NA	73.3%	82.2%
CIS	Childhood Immunization Status - Hepatitis A		NA	82.7%	89.3%
CIS	Childhood Immunization Status - Rotavirus		NA	67.4%	76.4%
CIS	Childhood Immunization Status - Influenza		NA	40.8%	58.4%

Table B-12. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CIS	Childhood Immunization Status - Combo 2		NA	70.2%	77.9%
CIS	Childhood Immunization Status - Combo 3		NA	66.7%	75.2%
CIS	Childhood Immunization Status - Combo 4		NA	64.7%	73.7%
CIS	Childhood Immunization Status - Combo 5		NA	56.7%	65.9%
CIS	Childhood Immunization Status - Combo 6		NA	34.6%	49.2%
CIS	Childhood Immunization Status - Combo 7		NA	55.7%	64.5%
CIS	Childhood Immunization Status - Combo 8		NA	34.3%	48.7%
CIS	Childhood Immunization Status - Combo 9		NA	30.7%	44.3%
CIS	Childhood Immunization Status - Combo 10		NA	30.2%	44.8%
CWP	Appropriate Testing for Pharyngitis (3-17)	74.7%	R	76.5%	86.7%
CWP	Appropriate Testing for Pharyngitis (18-64)	60.2%	R	55.1%	74.1%
CWP	Appropriate Testing for Pharyngitis (Total)	72.9%	R	71.0%	83.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		NA	5.0%	13.9%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		NA	3.1%	8.6%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	6.3%	R	11.4%	28.2%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	6.3%	R	7.4%	18.3%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	4.9%	R	10.8%	27.8%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	4.9%	R	7.1%	17.8%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)	65.8%	R	62.2%	77.2%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)	40.9%	R	37.5%	53.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	51.2%	R	42.4%	61.3%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	33.1%	R	24.4%	38.5%
FUH	Follow-Up After Hospitalization For Mental Illness - 30 days (Total)	59.5%	R	50.0%	67.0%
FUH	Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	37.7%	R	28.3%	43.2%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)	72.7%	R	56.5%	78.8%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)	54.6%	R	38.6%	64.4%

Table B-12. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	68.8%	R	39.9%	59.6%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	47.3%	R	25.8%	44.7%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	70.4%	R	46.8%	65.4%
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	49.7%	R	30.4%	49.7%
IMA	Immunizations for Adolescents - Meningococcal	70.1%	R	79.0%	89.1%
IMA	Immunizations for Adolescents - Tdap	69.6%	R	85.0%	91.5%
IMA	Immunizations for Adolescents - HPV	27.3%	R	33.6%	45.6%
IMA	Immunizations for Adolescents - Combination 1	68.1%	R	76.6%	87.3%
IMA	Immunizations for Adolescents - Combination 2	25.8%	R	31.0%	43.1%
LBP	Use of Imaging Studies for Low Back Pain	79.8%	R	71.3%	78.1%
LSC	Lead Screening in Children		NA	63.5%	81.0%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack		NA	76.1%	86.7%
PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	32.3%	R	64.6%	76.8%
PCE	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	46.8%	R	80.1%	88.5%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.6%	R	55.6%	68.0%
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		NA	72.1%	83.1%
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	47.8%	R	67.2%	75.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		NA	77.4%	84.3%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		NA	64.1%	73.4%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		NA	73.2%	80.6%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		NA	61.5%	72.2%
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	27.9%	R	76.2%	83.1%

Table B-12. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		NA	62.3%	73.1%
SPD	Statin Therapy for Patients With Diabetes - Received Statin Therapy	22.1%	R	61.5%	68.7%
SPD	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	81.9%	R	59.0%	69.6%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD		NA	25.6%	34.0%
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.0%	R	78.7%	84.8%
URI	Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	83.5%	R	88.3%	94.2%
URI	Appropriate Treatment for Upper Respiratory Infection (18-64)	83.2%	R	68.8%	82.3%
URI	Appropriate Treatment for Upper Respiratory Infection (Total)	83.5%	R	85.6%	91.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11)	70.3%	R	72.2%	88.0%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17)	71.9%	R	70.0%	86.2%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	71.1%	R	71.3%	87.2%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11)	58.5%	R	64.1%	80.7%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17)	59.8%	R	58.9%	78.7%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	59.1%	R	63.0%	80.1%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11)	55.7%	R	55.3%	75.8%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17)	56.8%	R	60.1%	77.3%
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	56.2%	R	57.4%	76.3%

Table B-13. MY 2020 PMV Results: HEDIS Effectiveness of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
CDC	Comprehensive Diabetes Care - Poor HbA1c Control	46.7%	R	46.0%	32.9%
COU	Risk of Continued Opioid Use - >=15 Days (18-64)	7.8%	R	9.4%	4.0%
COU	Risk of Continued Opioid Use - >=31 Days (18-64)	5.1%	R	4.6%	2.1%
COU	Risk of Continued Opioid Use - >=15 Days (Total)	7.7%	R	9.6%	4.1%
COU	Risk of Continued Opioid Use - >=31 Days (Total)	5.0%	R	4.7%	2.1%
HDO	Use of Opioids at High Dosage	0.0%	R	9.7%	3.0%
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	0.0%	R	1.2%	0.4%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers	18.8%	R	24.0%	16.6%
UOP	Use of Opioids From Multiple Providers - Multiple Pharmacies	1.8%	R	6.7%	3.1%
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	1.8%	R	4.1%	1.7%

Table B-14. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	95.0%	R	73.1%	82.5%
AAP	Adults' Access to Preventive/Ambulatory Health Services (45-64)	95.7%	R	83.0%	88.9%
AAP	Adults' Access to Preventive/Ambulatory Health Services (Total)	95.3%	R	77.2%	85.2%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)	86.1%	R	53.6%	72.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)	82.0%	R	52.6%	73.0%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	83.5%	R	53.9%	72.5%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)	67.7%	R	34.0%	49.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)	5.9%	R	5.9%	16.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)	76.3%	R	37.8%	50.9%

Table B-14. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)	3.2%	R	9.9%	21.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)	69.6%	R	34.7%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)	3.6%	R	8.9%	18.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	48.5%	R	38.1%	46.1%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	11.8%	R	7.5%	14.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		NA	46.6%	64.6%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		NA	17.1%	39.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	42.3%	R	37.9%	46.8%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	5.2%	R	7.2%	15.0%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	41.5%	R	39.2%	48.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	7.0%	R	9.5%	18.7%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	54.9%	R	38.0%	46.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	9.8%	R	7.5%	14.2%

Table B-14. MY 2020 PMV Results: HEDIS Access/Availability of Care Domain Measures- Summit

Measure Code	Measure Name	Rate	Measure Designation	25th Percentile	75th Percentile
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		NA	46.6%	64.6%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		NA	17.1%	39.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)	52.6%	R	38.4%	47.2%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	4.6%	R	8.0%	15.4%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	49.7%	R	39.5%	48.3%
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	6.0%	R	9.7%	18.6%
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	78.4%	R	84.2%	92.9%
PPC	Prenatal and Postpartum Care - Postpartum Care	64.7%	R	71.3%	80.9%

Table B-15. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Summit

Measure Code	Measure Name	Rate	Measure Designation	25th Percentile	75th Percentile
AMBa*	Ambulatory Care - Outpatient Visits/1000 MM (Total)	1073.2	R	309.8	414.5
AMBa	Ambulatory Care - Emergency Dept Visits/1000 MM (Total)	42.3	R	47.6	66.5
FSP**	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 0-19)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 0-19)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 20-44)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 20-44)	0.1	R	0.1	0.2
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (M 45-64)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Bariatric Weight Loss Surgery (F 45-64)	0.1	R	0.1	0.3
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 0-9)	0.7	R	0.4	0.8
FSP	Frequency of Selected Procedures - Tonsillectomy (M/F 10-19)	0.4	R	0.2	0.3
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (15-44)	0.0	R	0.1	0.1

Table B-15. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
FSP	Frequency of Selected Procedures - Hysterectomy Abdominal (45-64)	0.0	R	0.1	0.2
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (15-44)	0.0	R	0.0	0.1
FSP	Frequency of Selected Procedures - Hysterectomy Vaginal (45-64)	0.1	R	0.1	0.2
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 15-44)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (M 30-64)	0.0	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Open (F 45-64)	0.3	R	0.0	0.0
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 15-44)	0.3	R	0.4	0.6
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (M 30-64)	0.1	R	0.2	0.3
FSP	Frequency of Selected Procedures - Cholecystectomy Laparoscopic (F 45-64)	0.5	R	0.4	0.6
FSP	Frequency of Selected Procedures - Back Surgery (M 20-44)	0.2	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (F 20-44)	0.2	R	0.1	0.2
FSP	Frequency of Selected Procedures - Back Surgery (M 45-64)	0.1	R	0.4	0.7
FSP	Frequency of Selected Procedures - Back Surgery (F 45-64)	0.6	R	0.3	0.7
FSP	Frequency of Selected Procedures - Mastectomy (F 15-44)	0.1	R	0.0	0.1
FSP	Frequency of Selected Procedures - Mastectomy (F 45-64)	0.1	R	0.1	0.2
FSP	Frequency of Selected Procedures - Lumpectomy (F 15-44)	0.0	R	0.1	0.1
FSP	Frequency of Selected Procedures - Lumpectomy (F 45-64)	0.2	R	0.3	0.4
IADa***	Identification of Alcohol and Other Drug Services - Alcohol Any Service (Total)	2.2	R	1.1	3.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Inpatient (Total)	0.7	R	0.3	0.8
IADa	Identification of Alcohol and Other Drug Services - Alcohol Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.2
IADa	Identification of Alcohol and Other Drug Services - Alcohol Emergency Department (Total)	0.2	R	0.3	1.0
IADa	Identification of Alcohol and Other Drug Services - Alcohol Outpatient or Medication Treatment (Total)	1.3	R	0.6	2.4
IADa	Identification of Alcohol and Other Drug Services - Alcohol Telehealth (Total)	0.8	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Any Service (Total)	0.6	R	0.8	3.5
IADa	Identification of Alcohol and Other Drug Services - Opioid Inpatient (Total)	0.2	R	0.1	0.5
IADa	Identification of Alcohol and Other Drug Services - Opioid Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Opioid Emergency Department (Total)	0.0	R	0.1	0.4
IADa	Identification of Alcohol and Other Drug Services - Opioid Outpatient or Medication Treatment (Total)	0.4	R	0.7	3.1

Table B-15. MY 2020 PMV Results: HEDIS Utilization and Risk-Adjusted Utilization Domain Measures- Summit					
Measure Code	**Measure Name**	**Rate**	**Measure Designation**	**25th Percentile**	**75th Percentile**
IADa	Identification of Alcohol and Other Drug Services - Opioid Telehealth (Total)	0.1	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Other Any Service (Total)	5.7	R	1.9	4.5
IADa	Identification of Alcohol and Other Drug Services - Other Inpatient (Total)	2.2	R	0.5	1.2
IADa	Identification of Alcohol and Other Drug Services - Other Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.3
IADa	Identification of Alcohol and Other Drug Services - Other Emergency Department (Total)	1.1	R	0.5	1.5
IADa	Identification of Alcohol and Other Drug Services - Other Outpatient or Medication Treatment (Total)	3.0	R	0.9	2.7
IADa	Identification of Alcohol and Other Drug Services - Other Telehealth (Total)	1.7	R	0.0	0.1
IADa	Identification of Alcohol and Other Drug Services - Total Any Service (Total)	7.0	R	3.8	9.2
IADa	Identification of Alcohol and Other Drug Services - Total Inpatient (Total)	2.5	R	0.9	2.1
IADa	Identification of Alcohol and Other Drug Services - Total Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.0	0.5
IADa	Identification of Alcohol and Other Drug Services - Total Emergency Department (Total)	1.3	R	1.0	2.8
IADa	Identification of Alcohol and Other Drug Services - Total Outpatient or Medication Treatment (Total)	4.1	R	2.4	7.3
IADa	Identification of Alcohol and Other Drug Services - Total Telehealth (Total)	2.2	R	0.0	0.2
MPTa***	Mental Health Utilization - Any Service (Total)	85.6	R	10.0	17.6
MPTa	Mental Health Utilization - Inpatient (Total)	10.5	R	0.6	1.4
MPTa	Mental Health Utilization - Intensive Outpatient or Partial Hospitalization (Total)	0.0	R	0.1	0.8
MPTa	Mental Health Utilization - Emergency Department (Total)	0.0	R	0.0	0.4
MPTa	Mental Health Utilization - Outpatient (Total)	81.2	R	9.5	16.9
MPTa	Mental Health Utilization - Telehealth (Total)	58.1	R	0.1	0.4

**AMBa Rate: Per 1,000 Member Months*
***FSP Rate: Per 1,000 Member Years*
****IADa and MPTa Rate: %*

Table B-16. MY 2020 PMV Results: PASSE Medicaid Population Reported in Member Months- Summit			
Measure Code	**Measure Name**	**Gender**	**Member Months**
ENPa	Enrollment By Product Line - Male	M	98,223
ENPa	Enrollment By Product Line - Female	F	74,574
ENPa	Enrollment By Product Line - Total	F,M	172,797

Performance Measures

Table B-16. MY 2020 PMV Results: Out-of-Network Provider Billing				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
No greater than 20% of the total dollars billed to the PASSE for outpatient services billed by out-of-network providers				
2020 Q1	1.23%	1.6%	1.2%	≤20%
2020 & Q2	0.96%	1.3%	0.7%	≤20%
2020 Q3	0.85%	0.8%	0.6%	≤20%
2020 Q4	1.59%	1.8%	0.3%	≤20%

Table B-17. MY 2020 PMV Results: Call Center Answer and Abandonment Rates				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) All calls answered within three rings or 15 seconds				
January 2020	100%	100%	99.9%	95%
February 2020	100%	100%	99.6%	95%
March 2020	100%	100%	98.3%	95%
April 2020	100%	100%	96.8%	95%
May 2020	100%	100%	99.8%	95%
June 2020	100%	100%	99.7%	95%
July 2020	100%	100%	99.9%	95%
August 2020	100%	100%	99.2%	95%
September 2020	100%	100%	99.7%	95%

Table B-17. MY 2020 PMV Results: Call Center Answer and Abandonment Rates				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
October 2020	100%	100%	99.3%	95%
November 2020	100%	100%	99.8%	95%
December 2020	100%	100%	99.8%	95%
(ii) Number of busy signals not exceeding 5% of total incoming calls				
January 2020	0%	0%	0%	≤5%
February 2020	0%	0%	0%	≤5%
March 2020	0%	0%	0%	≤5%
April 2020	0%	0%	0%	≤5%
May 2020	0%	0%	0%	≤5%
June 2020	0%	0%	0%	≤5%
July 2020	0%	0%	0%	≤5%
August 2020	0%	0%	0%	≤5%
September 2020	0%	0%	0%	≤5%
October 2020	0%	0%	0%	≤5%
November 2020	0%	0%	0%	≤5%
December 2020	0%	0%	0%	≤5%
(iii) Wait time in queue not longer than two minutes for incoming calls				
January 2020	88.5%	95.1%	99.9%	95%
February 2020	97.4%	97.4%	99.6%	95%
March 2020	97.5%	98.1%	98.3%	95%
April 2020	98.3%	98.5%	96.8%	95%
May 2020	94.9%	98.2%	99.8%	95%
June 2020	92.7%	97.6%	99.7%	95%
July 2020	90.8%	98.6%	99.9%	95%
August 2020	94.7%	97.2%	97.2%	95%
September 2020	97.4%	96.3%	99.7%	95%

Table B-17. MY 2020 PMV Results: Call Center Answer and Abandonment Rates				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
October 2020	93.0%	96.7%	98.6%	95%
November 2020	95.2%	98.3%	99.8%	95%
December 2020	95.2%	98.4%	99.8%	95%
(iv) Monthly abandoned call rate				
January 2020	1.6%	2.5%	0.1%	≤5%
February 2020	0.3%	0.6%	0.4%	≤5%
March 2020	0.3%	0.9%	1.7%	≤5%
April 2020	0.2%	1.3%	3.2%	≤5%
May 2020	0.2%	1.6%	0.2%	≤5%
June 2020	0.3%	2.1%	0.3%	≤5%
July 2020	0.1%	1.1%	0.1%	≤5%
August 2020	3.0%	1.7%	0.8%	≤5%
September 2020	1.8%	1.9%	0.3%	≤5%
October 2020	0.4%	1.4%	0.7%	≤5%
November 2020	0.0%	0.5%	0.2%	≤5%
December 2020	0.1%	0.6%	0.2%	≤5%

Table B-18. MY 2020 PMV Results: Call Center Return Calls				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) All calls requiring a call back to the enrollee or provider returned within one business day of receipt				
January 2020	NA*	100%	*	100%
February 2020	NA	100%	*	100%
March 2020	NA	100%	*	100%
April 2020	NA	100%	*	100%
May 2020	NA	100%	*	100%

Table B-18. MY 2020 PMV Results: Call Center Return Calls				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
June 2020	NA	100%	*	100%
July 2020	NA	100%	*	100%
August 2020	NA	100%	*	100%
September 2020	NA	100%	*	100%
October 202	NA	100%	*	100%
November 2020	NA	100%	*	100%
December 2020	NA	100%	*	100%
(ii) For calls received during non-business hours, return calls to enrollees and providers made on the next business day				
January 2020	100%	100%	*	100%
February 2020	100%	100%	*	100%
March 2020	100%	100%	*	100%
April 2020	100%	100%	*	100%
May 2020	100%	100%	*	100%
June 2020	100%	100%	*	100%
July 2020	NA	100%	*	100%
August 2020	NA	100%	*	100%
September 2020	NA	100%	*	100%
October 2020	NA	100%	*	100%
November 2020	NA	100%	*	100%
December 2020	NA	100%	*	100%

**Not applicable because denominator was zero.*
** No data was reported, therefore no results are reported.*

Table B-19. MY 2020 PMV Results: Website and Portal Availability				
Month and Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
PASSE's website online each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance				
January 2020	99.6%	99.5%	99.5%	≥99%
February 2020	99.8%	100%	99.98%	≥99%
March 2020	99.98%	100%	99.2%	≥99%
April 2020	99.99%	100%	99.9%	≥99%
May 2020	99.96%	100%	99.2%	≥99%
June 2020	99.8%	97.8%	99.9%	≥99%
July 2020	99.5%	100%	99.6%	≥99%
August 2020	99.5%	99.9%	99.4%	≥99%
September 2020	99.9%	100%	99.8%	≥99%
October 2020	99.7%	100%	99.9%	≥99%
November 2020	99.5%	100%	99.9%	≥99%
December 2020	99.8%	100%	99.97%	≥99%

Table B-20. MY 2020 PMV Results: Investigation and Resolution of Grievances				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Acknowledgement in writing within five business days of receipt of each grievance				
2020 Q1	100%	40.4%	100%	100%
2020Q2	100%	37.5%	67.0%	100%
2020 Q3	100%	55.9%	100%	100%
2020 Q4	92.0%	47.3%	100%	100%
(ii) Completion and resolution of grievances within 30 days of receipt				
2020 Q1	100%	49.1%	100%	100%
2020Q2	100%	47.9%	100%	100%
2020 Q3	100%	79.7%	100%	100%

Table B-20. MY 2020 PMV Results: Investigation and Resolution of Grievances				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
2020 Q4	96.0%	94.6%	100%	100%
(iii) Grievance log submitted with quarterly report				
2020 Q1	100%	52.6%	100%	100%
2020Q2	100%	93.8%	100%	100%
2020 Q3	100%	52.5%	100%	100%
2020 Q4	100%	95.0%	100%	100%

Table B-21. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Timeliness				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Clean claims submitted within 365 days of service				
2020 Q1	99.9%	99.98%	99.9%	100%
2020 Q2	99.7%	99.8%	99.6%	100%
2020 Q3	99.8%	99.99%	99.7%	100%
2020 Q4	99.7%	99.99%	99.6%	100%
(ii) Claims not submitted within 365 days of date of service denied				
2020 Q1	84.6%	100%	36.6%	100%
2020 Q2	78.2%	100%	22.7%	100%
2020 Q3	88.6%	100%	21.3%	100%
2020 Q4	86.9%	100%	16.4%	100%

Table B-22. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Processing Clean Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) 70% of all clean claims submitted processed within seven days				
2020 Q1	77.6%	81.5%	87.2	70%
2020 Q2	76.2%	80.3%	82.8%	70%

Table B-22. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Processing Clean Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
2020 Q3	80.2%	71.1%	87.7%	70%
2020 Q4	75.2%	75.6%	92.7%	70%
(ii) 95% of all clean claims submitted processed within 30 days				
2020 Q1	97.0%	98.6%	99.9%	95%
2020 Q2	96.7%	97.3%	99.3%	95%
2020 Q3	99.5%	95.8%	98.3%	95%
2020 Q4	99.6%	98.0%	99.9%	95%
(iii) 99% of all clean claims submitted processed within 60 days				
2020 Q1	98.8%	99.7%	100%	99%
2020 Q2	99.4%	99.3%	99.8%	99%
2020 Q3	99.9%	99.7%	99.6%	99%
2020 Q4	99.8%	99.3%	99.96%	99%

Table B-23. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Electronically Submitted Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim within 24 hours after the beginning of the next business day				
2020 Q1	100%	100%	87.3%	100%
2020 Q2	100%	100%	74.8%	100%
2020 Q3	100%	100%	84.8%	100%
2209 Q4	100%	100%	78.2%	100%
(ii) For contested or "unclean" claims, a list of additional information or documents necessary to process the claim included				
2020 Q1	100%	100%	100%	100%
2020 Q2	100%	100%	100%	100%
2020 Q3	100%	100%	100%	100%
2020 Q4	100%	100%	100%	100%

Table B-23. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Electronically Submitted Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(iii) All claims paid or denied within 90 calendar days after receipt, whether contested or not				
2020 Q1	99.5%	99.97%	99.96%	100%
2020 Q2	99.8%	99.9%	99.99%	100%
2020 Q3	99.3%	99.9%	100%	100%
2020 Q4	99.4%	99.7%	100%	100%
(iv) All claims not denied or paid within 120 calendar days after receipt of the claim, paid				
2020 Q1	99.8%	99.98%	99.97%	100%
2020 Q2	99.9%	99.9%	99.99%	100%
2020 Q3	99.4%	99.9%	100%	100%
2020 Q4	99.5%	99.9%	100%	100%

Table B-24. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Non-Electronically Submitted Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Electronic acknowledgement of receipt of claim to provider within 24 hours after the beginning of the next business day or mailed acknowledgement within 15 calendar days with information on how to electronically access claim status				
2020 Q1	100%	100%	0%	100%
2020 Q2	100%	100%	29.3%	100%
2020 Q3	100%	100%	30.1%	100%
2020 Q4	100%	100%	23.4%	100%
(ii) Notification to the provider of a contested claim or "unclean" claim includes a list of additional information or documents necessary to process the claim				
2020 Q1	100%	100%	97.7%	100
2020 Q2	100%	100%	97.70%	100%
2020 Q3	100%	100%	99.7%	100%
2020 Q4	100%	100%	100%	100%

Table B-24. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Non-Electronically Submitted Claims				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(iii) Claims paid or denied within 120 calendar days after receipt, whether contested or not				
2020 Q1	99.4%	96.8%	99.8%	100%
2020 Q2	99.5%	93.4%	99.8%	100%
2020 Q3	98.2%	94.8%	99.98%	100%
2020 Q4	99.6%	90.4%	100%	100%
(iv) All claims not denied or paid within 140 calendar days after receipt of the claim, paid				
2020 Q1	99.7%	97.3%	99.8%	100%
2020 Q2	99.5%	97.8%	99.94%	100%
2020 Q3	98.2%	95.7%	99.98%	100%
2020 Q4	99.6%	90.8%	100%	100%

Table B-25. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Completeness, Logic, and Consistency				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
All claims screened for completeness, logic, and consistency prior to payment				
2020 Q1	100%	100%	100%	100%
2020 Q2	100%	100%	100%	100%
2020 Q3	100%	100%	100%	100%
2020 Q4	100%	100%	100%	100%

Table B-26. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Must-Pay Items and Services				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) PASSE Provider Agreement (PA) §5.4: State Plan services				
2020 Q1	85.6%	87.8%	91.3%	100%
2020 Q2	83.7%	88.7%	92.1%	100%
2020 Q3	87.2%	85.2%	91.4%	100%

Table B-26. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Must-Pay Items and Services				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
2020 Q4	86.3%	89.8%	91.98%	100%
(ii) PA §7.1.11: Crossover claims, including Medicare co-insurance and deductibles for specific services				
2020 Q1	91.0%	91.49%	98.5%	100%
2020 Q2	88.1%	90.81%	90.9%	100%
2020 Q3	85.6%	86.80%	85.7%	100%
2020 Q4	86.7%	94.64%	88.1%	100%
(iii) PA §7.1.18: Full amount of the claim under the DHS fee-for-service (FFS) schedule or the negotiated contracted rate, and then seek reimbursement, for prenatal care for pregnant women, preventive pediatric services, or services covered by certain third-party liability (TPL) sources				
2020 Q1	74.5%	86.7%	95.4%	100%
2020 Q2	82.7%	88.2%	98.4%	100%
2020 Q3	89.8%	89.8%	95.5%	100%
2020 Q4	88.0%	90.2%	92.4%	100%
(iv) PA §7.1.29: Mental Health and Substance Abuse Parity requirements				
2020 Q1	84.6%	91.3%	95.1%	100%
2020 Q2	85.0%	95.1%	96.0%	100%
2020 Q3	90.2%	88.5%	96.0%	100%
2020 Q4	92.0%	92.4%	95.4%	100%

Table B-27. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Must-Not-Pay Items and Services				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
2020 Q1	*	1.4%	15.1%	0%
2019 Q2	*	0%	0%	0%
2019 Q3	*	0%	0%	0%
2019 Q4	*	0%	6.7%	0%

** There was no denominator for this measure; thus, no results are reported.*

Table B-28. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Provider-Preventable Conditions				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) PASSE cannot make payments for any provider-preventable conditions in accordance with 42 CFR § 438.3(g).				
2020 Q1	*	*	*	0%
2020 Q2	*	*	*	0%
2020 Q3	*	*	*	0%
2020 Q4	*	*	*	0%
(ii) PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions.				
2020 Q1	*	*	*	100%
2020 Q2	*	*	*	100%
2020 Q3	*	*	*	100%
2020 Q4	*	*	*	100%

** There was no denominator for this measure; thus, no results are reported.*

Table B-29. MY 2020 PMV Results: Encounter Data-Institutional				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Encounters submitted for 100% of the covered services by participating and non-participating providers				
2020 Q1	98.8%	99.6%	98.8%	100%
2020 Q2	98.9%	98.8%	97.9%	100%
2020 Q3	98.9%	99.4%	95.4%	100%
2020 Q4	98.2%	99.8%	97.2%	100%
(ii) No less than 95% of encounter lines submission pass MMIS system edits				
2020 Q1	83.4%	82.9%	69.1%	95%
2020 Q2	79.4%	90.8%	58.3%	95%
2020 Q3	82.4%	83.2%	59.9%	95%
2020 Q4	83.0%	89.7%	54.6%	95%

Table B-30. MY 2020 PMV Results: Encounter Data-Professional				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Encounters submitted for 100% of the covered services by participating and non-participating providers				
2020 Q1	98.0%	99.97%	99.1%	100%
2020 Q2	98.1%	99.97%	97.8%	100%
2020 Q3	97.8%	99.97%	98.4%	100%
2020 Q4	96.2%	99.96%	97.6%	100%
(ii) No less than 95% of encounter lines submission pass MMIS system edits				
2020 Q1	94.6%	92.9%	84.6%	95%
2020 Q2	99.97%	85.6%	64.4%	95%
2020 Q3	91.3%	82.4%	60.3%	95%
2020 Q4	99.9%	85.7%	58.3%	95%

Table B-31. MY 2020 PMV Results: Encounter Data-Pharmacy				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(i) Encounters submitted for 100% of the covered services by participating and non-participating providers				
2020 Q1	100%	99.99%	100%	100%
2020 Q2	100%	100%	99.98%	100%
2020 Q3	100%	100%	99.58%	100%
2020 Q4	100%	99.98%	99.7%	100%
(ii) No less than 95% of encounter lines submission pass MMIS system edits				
2020 Q1	100%	99.99%	94.2%	95%
2020 Q2	100%	100%	99.3%	95%
2020 Q3	100%	100%	99.4%	95%
2020 Q4	100%	99.98%	99.8%	95%

Table B-32. MY 2020 PMV Results: Report Submission				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
All required reports submitted in accordance with timelines established in the Agreement*				
2020 Q1	100%	100%	100%	100%
2020 Q2	98.8%	100%	100%	100%
2020 Q3	98.8%	100%	100%	100%
2020 Q4	100%	100%	94.6%	100%

** Qsource aggregated these data.*

Table B-33. MY 2020 PMV Results: Key Personnel				
Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
For a Key Personnel vacancy, propose a suitable replacement within 30 calendar days of the vacancy or from when first knew or should have known the vacancy would be occurring.				
2020 Q1	100%	*	*	100%
2020 Q2	*	100%	*	100%
2020 Q3	*	*	*	100%
2020 Q4	100%	100%	*	100%

**There was no denominator for this measure; thus, no results are reported.*

Provider Quality Metrics

Table B-34. MY 2020 PMV Results: Provider Quality Metrics Attestation-ARTC			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Accuracy of claims submission	X		
Timeliness of claims submission	X		
Provider Education and Outreach	X		
Appointment Availability and Wait Times	X		

Table B-34. MY 2020 PMV Results: Provider Quality Metrics Attestation-ARTC			
Provider Phone Call Protocol	X		
Accessibility of PCPs	X		
QAPI Elements including Credentialing, Grievances and Appeals, Utilization Management, Performance Improvement, Provider Advocacy, member Advisory, HEDIS Steering, and Pharmacy and Therapeutics		X	

Table B-35. MY 2020 PMV Results: Provider Quality Metrics Attestation-Empower			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Provider Preventable Conditions	X		
Incident Reporting	X		
QOC Issue Report	X		

Table B-36. MY 2020 PMV Results: Provider Quality Metrics Attestation-Summit			
Accuracy and timeliness of the data reports submitted by providers regarding quality metrics verified			
	Yes	**No**	**NA**
Over/Under Utilization & Coding Compliance	X		
Claims and Authorization Metrics	X		
Member Grievances	X		
HEDIS Medical Record Review	X		
Provider Quality Performance Score Card	X		

Table B-37. MY 2020 PMV Results: Provider Quality Metrics				
Quarter (Q)	**ARTC**	**Empower**	**Summit**	**DHS Target**
(ii) Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	0%	100%	0%	100%
2020 Q2	100%	100%	100%	100%
2020 Q3	100%	100%	100%	100%
2020 Q4	100%	100%	100%	100%

Table B-38. MY 2020 PMV Results: Prior Authorizations and Utilization Management				
Year	**ARTC**	**Empower**	**Summit**	**DHS Target**
All authorizations for services issued by DHS or its contractors for newly assigned enrollees must be honored and services paid.				
2020 Q1	**100%**	**100%**		**100%**
2020 Q2	**100%**	**100%**	*	**100%**
2020 Q3	**100%**	**100%**	*	**100%**
2020 Q4	**100%**	**100%**	**100%**	**100%**

DMO PMV Results

Tables B-39 through **B-49** present the findings from the performance measure validation for the DMOs.

Table B-39. MY 2020 PMV Results: DMO Quality Metrics

Measure Name	Delta Dental		MCNA		DHS Target	
	MY 2020	MY 2019	MY 2020	MY 2019	MY 2020	MY 2019
Preventive Dental Services (PDENT): 21 Years and Older	9.8%	12.8%	9.1%	11.2%	12%	10.2%
Preventive Dental Services (PDENT): Under 21 Years	49.3%	59.2%	47.7%	57.1%	64%	60.6%
Sealant Services for Children – with Exclusions (SEA – with Exclusions)	4.9%	7.9%	8.9%	13.8%	24%	20%
Dental Emergencies	*	*	*		5.5 visits/ 1,000	5,92 visits/1,000

** Data were not available to the DMO; thus, no results are reported.*

Table B-40. MY 2020 PMV Results: Access to Care – Time

Year	Delta Dental	MCNA	DHS Target
(i) Emergency care within 24 hours			
2020	*	*	100%
(ii) Urgent care, including urgent specialty care, within 48 hours			
2020	*	*	100%
(iii) Therapeutic and diagnostic care within 14 days			
2020	*	*	100%
(iv) Referrals for specialty care based on the urgency of the condition, but no later than 30 days			
2020	*	*	100%
(v) Non-urgent specialty care within 60 days of authorization			
2020	*	*	100%

** The DMO provided no data; thus, no results are reported.*

Table B-41. MY 2020 PMV Results: Out-of-Network Provider Billing			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
No greater than 20% of the total dollars billed to the DMO for outpatient services billed by out-of-network providers			
2020 Q1	1.50%	0.001%	≤20%
2020 Q2	1.59%	0.003%	≤20%
2020 Q3	2.51%	0.02%	≤20%
2020 Q4	2.39%	0.01%	≤20%

Table B-42. MY 2020 PMV Results: Call Center Answer and Abandonment Rates			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
(i) 95% of all calls answered within three rings or 15 seconds			
2020 Q1	100%	98.2%	95%
2020 Q2	100%	98.1%	95%
2020 Q3	100%	94.6%	95%
2020 Q4	100%	94.0%	95%
(ii) Number of busy signals not exceeding 5% of the total incoming calls			
2020 Q1	0%	*	≤5%
2020 Q2	0%	*	≤5%
2020 Q3	0%	*	≤5%
2020 Q4	0.0%	*	≤5%
(iii) Wait time in queue not longer than two minutes for 95% of the incoming calls			
2020 Q1	96.7%	93.9%	95%
2020 Q2	95.8%	96.7%	95%
2020 Q3	97.7%	89.5%	95%
2020 Q4	98.1%	87.6%	95%
(iv) Abandoned call rate not to exceed 3% for any month			
2020 Q1	0.8%	1.8%	≤3%

Table B-42. MY 2020 PMV Results: Call Center Answer and Abandonment Rates			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
2020 Q2	1.0%	1.9%	≤3%
2020 Q3	0.5%	5.4%	≤3%
2020 Q4	0.6%	6.0%	≤3%

** The DMO provided no data; thus, no results are reported.*

Table B-43. MY 2020 PMV Results: Call Center Return Calls			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
(i) All calls requiring a call back to the enrollee or provider returned within one business day of receipt			
2020 Q1	100%	100%	100%
2020 Q2	100%	100%	100%
2020 Q3	100%	100%	100%
2020 Q4	100%	100%	100%
(ii) For calls received during non-business hours, return calls to enrollees and providers made on the next business day			
2020 Q1	100%	100%	100%
2020 Q2	100%	100%	100%
2020 Q3	100%	100%	100%
2020 Q4	100%	100%	100%

Table B-44. MY 2020 PMV: Website and Portal Availability			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
DMO's website, enrollee portal, and provider portal online each month, except that the DMO may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance			
2020 Q1	92.5%	100%	≥99%
2020 Q2	98.2%	100%	≥99%
2020 Q3	98.0%	100%	≥99%
2020 Q4	98.1%	100%	≥99%

Table B-45. MY 2020 PMV Results: Investigation and Resolution of Grievances			
Month and Year	**Delta Dental**	**MCNA**	**DHS Target**
(i) Emergency or urgent clinical issues: within 24 hours of receipt or by the close of the next business day			
2020 Q1	*	NA**	100%
2020 Q2	*	NA	100%
2020 Q3	*	0%	100%
2020 Q4	*	NA	100%
(ii) Non-emergency or non-urgent clinical issues: within five days of receipt			
2020 Q1	*	NA	100%
2020 Q2	*	NA	100%
2020 Q3	*	100%	100%
2020 Q4	*	100%	100%
(iii) Nonclinical issues: within 30 days of receipt			
January 2019	100%	100%	100%
February 2019	100%	100.0%	100%
March 2019	100%	100%	100%
April 2019	100%	100%	100%

** There was no denominator for this measure; thus, no results are reported.*
*** The DMO had no grievances during this time period, therefore the measure is not applicable.*

Table B-46. MY 2020 PMV Results: Denial, Approval, and Submission of Claims			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
(i) 100% of clean paper claims submitted within 30 calendar days of receipt			
2020 Q1	100%	100%	100%
2020 Q2	100%	100%	100%
2020 Q3	100%	100%	100%
2020 Q4	100%	100%	100%

Table B-46. MY 2020 PMV Results: Denial, Approval, and Submission of Claims			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
(ii) 100% of clean electronic claims submitted within 14 calendar days of receipt			
2020 Q1	100%	100%	100%
2020 Q2	100%	100%	100%
2020 Q3	100%	100%	100%
2020 Q4	100%	100%	100%

Table B-47. MY 2020 PMV Results: Encounter Data			
Quarter (Q)	**Delta Dental**	**MCNA**	**DHS Target**
(i) At least 99% of all encounter data must be accurate.			
2020 Q1	6.5%	89.5%	≥99%
2020 Q2	89.3%	85.3%	≥99%
2020 Q3	92.4%	84.4%	≥99%
2020 Q4	87.9%	92.3%	≥99%
(ii) All encounter data submitted in accordance with the timeframes established in the contract			
2020 Q1	100%	82.6%	100%
2020 Q2	100%	81.6%	100%
2020 Q3	100%	80.1%	100%
2020 Q4	100%	88.4%	100%

Table B-48. MY 2020 PMV Results: Report Submission			
Month and Year	**Delta Dental**	**MCNA**	**DHS Target**
All required reports submitted in accordance with timeframes established in the contract; reports identified in managed care provider agreements			
2020 Q1	100%	100%	100%
2020 Q2	100%	100%	100%

Table B-48. MY 2020 PMV Results: Report Submission			
Month and Year	**Delta Dental**	**MCNA**	**DHS Target**
2020 Q3	97.8%	100%	100%
2020 Q4	100%	100%	100%

Table B-49. MY 2020 PMV Results: Key Persons			
Year	**Delta Dental**	**MCNA**	**DHS Target**
(i) For a voluntary key person vacancy, propose a suitable replacement 15 calendar days prior to the intended date of change.			
2020 Q1	*	*	100%
2020 Q2	*	*	100%
2020 Q3	*	*	100%
2020 Q4	*	*	100%
(ii) For a key person vacancy, propose a suitable replacement within 15 calendar days.			
2020 Q1	*	*	100%
2020 Q2	*	*	100%
2020 Q3	*	*	100%
2020 Q4	*	*	100%

** The plan did not report these measures.*

Validation of State PMV Calculations

Qsource reviewed the State's calculations reported to Qsource for all of the Care Coordination Quality Measures and ten of the Additional Performance Measures. Per DHS, the State's calculations were based on data reported by the PASSEs and DMOs throughout the year. The percentages may be different from the PASSE/DMO-reported data to Qsource due to the point in time that the information is pulled. Qsource utilized the data the State provided to validate their calculations below.

Tables B-50 – B<#> present the findings from Qsource's validation of DHS's PMV calculations.

ARTC

Table B-50. MY 2020 PMV Results: Care Coordination Quality Measure Validation - ARTC				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Care Coordinator Caseload (maximum of 50 enrolled members)				
January 2020	92.9%	92.9%	0%	No issues were identified.
February 2020	91.9%	91.9%	0%	No issues were identified.
March 2020	93.4%	93.4%	0%	No issues were identified.
April 2020	92.9%	92.9%	0%	No issues were identified.
May 2020	93.36%	93.43%	0.07%	Data provided did not support the State's results.
June 2020	85.8%	85.8%	0%	No issues were identified.
July 2020	49.3%	49.3%	0%	No issues were identified.
August 2020	43.8%	43.8%	0%	No issues were identified.
September 2020	29.0%	29.0%	0%	No issues were identified.
October 2020	21.1%	21.1%	0%	No issues were identified.
November 2020	96.2%	96.2%	0%	No issues were identified.
December 2020	98.1%	98.1%	0%	No issues were identified.
Initial Contact with Enrolled Member (within 15 business days of enrollment)				
2020 Q1	70.3%	70.7%	0.4%	Data provided did not support the State's results.
2020 Q2	80.1%	80.1%	0%	No issues were identified.
2020 Q3	80.1%	80.1%	0%	No issues were identified.
2020 Q4	83.4%	83.4%	0%	No issues were identified.
Monthly Contact with Enrolled Member (at least one contact monthly)				
2020 Q1	84.2%	84.2%	0%	No issues were identified.
2020 Q2	88.42%	88.39%	0.02%	Data provided did not support the State's results.
2020 Q3	88.758%	88.761%	0.003%	Data provided did not support the State's results.

Table B-50. MY 2020 PMV Results: Care Coordination Quality Measure Validation - ARTC				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q4	84.31%	84.32%	0.01%	Data provided did not support the State's results.
Quarterly Contact with Enrolled Member (at least one contact made in person quarterly)				
2020 Q1	*	*	*	DHS waived this measure.
2020 Q2	*	*	*	DHS waived this measure.
2020 Q3	*	*	*	DHS waived this measure.
2020 Q4	*	*	*	DHS waived this measure.
Primary Care Physician (PCP) Assignment (enrollees have and are seeing PCP)				
2020 Q1	92.5%	90.8%	1.7%	Data provided did not support the State's results.
2020 Q2	95.7%	95.7%	0%	No issues were identified.
2020 Q3	92.0%	92.0%	0%	No issues were identified.
2020 Q4	91.2%	91.2%	0%	No issues were identified.
Follow-Up Care (within seven business days of emergency room visit or discharge from hospital or inpatient psychiatric facility)				
2020 Q1	96.0%	95.0%	0.9%	Data provided did not support the State's results.
2020 Q2	95.5%	95.5%	0%	No issues were identified.
2020 Q3	76.7%	76.7%	0%	No issues were identified.
2020 Q4	73.7%	73.7%	0%	No issues were identified.

**DHS waived the Quarterly Contact measure due to the Covid-19 pandemic, thus, no results were reported.*
***DHS noted: November and December metrics allowed a caseload of ≤60 due to PHE.*

Table B-51. MY 2020 PMV Results: Out-of-Network Provider Payment Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
No greater than 20% of the total dollars billed to the PASSE for outpatient services billed by out-of-network providers				
2020 Q1	1.2%	1.2%	0%	No issues were identified.
2020 Q2	1.0%	1.0%	0%	No issues were identified.
2020 Q3	0.9%	0.9%	0%	No issues were identified.
2020 Q4	1.6%	1.6%	0%	No issues were identified.

Table B-52. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls answered within three rings or 15 seconds				
2020 Q1	91.1%	91.1%	0%	No issues were identified.
2020 Q2	90.6%	90.6%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
(ii) Number of busy signals not exceeding 5% of total incoming calls				
2020 Q1	0%	0%	0%	No issues were identified.
2020 Q2	0%	0%	0%	No issues were identified.
2020 Q3	0%	0%	0%	No issues were identified.
2020 Q4	0%	0%	0%	No issues were identified.
(iii) Wait time in queue not longer than two minutes for incoming calls				
2020 Q1	99.4%	99.4%	0%	No issues were identified.
2020 Q2	99.3%	99.3%	0%	No issues were identified.

Table B-52. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q3	94.0%	94.0%	0%	No issues were identified.
2020 Q4	85.6%	85.6%	0%	No issues were identified.
(iv) Monthly abandoned call rate				
2020 Q1	1.6%	1.6%	0%	No issues were identified.
2020 Q2	4.2%	4.2%	0%	No issues were identified.
2020 Q3	1.6%	1.6%	0%	No issues were identified.
2020 Q4	0.2%	0.2%	0%	No issues were identified.

Table B-53. MY 2020 PMV Results: Call Center Return Calls Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls requiring a call back to the enrollee or provider returned within one business day of receipt				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	*	*	*	No calls requiring a return call for this quarter.
2020 Q4	100%	100%	0%	No issues were identified.
(ii) For calls received during non-business hours, return calls to enrollees and providers made on the next business day				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	*	*	*	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

** The denominator was zero, thus, no results were reported.*

Table B-54. MY 2020 PMV Results: Website and Portal Availability Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE's website online each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance				
2020 Q1	99.8%	99.8%	0.002%	Data provided did not support the numerator and denominator. However the variance was very small.
2020 Q2	99.9%	99.9%	0%	No issues were identified.
2020 Q3	99.7%	99.7%	0%	No issues were identified.
2020 Q4	99.7%	99.7%	0%	No issues were identified.

Table B-55. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) Acknowledgement in writing within five business days of receipt of each grievance				
2020 Q1	*	*	*	DMS did not track acknowledgement data.
2020 Q2	*	*	*	DMS did not track acknowledgement data.
2020 Q3	*	*	*	DMS did not track acknowledgement data.
2020 Q4	*	*	*	DMS did not track acknowledgement data.
(ii) Completion and resolution of grievances within 30 days of receipt				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	50.0%	100.0%	50.0%	The numerator was not correct. The variance was large due to the small denominator.
2020 Q4	**	**	**	The denominator reported was zero.
(iii) Grievance log submitted with quarterly report				
2020 Q1	100%	100%	0%	No issues were identified.

Table B-55. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DHS did not track this measure, thus, no results were reported.*
***The denominator was zero, thus no results are reported.*

Table B-56. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Processing Clean Claims Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) 70% of all clean claims submitted processed within seven days				
2020 Q1	77.7%	77.7%	0%	No issues were identified.
2020 Q2	76.2%	76.2%	0%	No issues were identified.
2020 Q3	80.2%	80.2%	0%	No issues were identified.
2020 Q4	75.2%	75.2%	0%	No issues were identified.
(ii) 95% of all clean claims submitted processed within 30 days				
2020 Q1	97.0%	97.0%	0%	No issues were identified.
2020 Q2	96.7%	96.7%	0%	No issues were identified.
2020 Q3	99.5%	99.5%	0%	No issues were identified.
2020 Q4	99.6%	99.6%	0%	No issues were identified.
(iii) 99% of all clean claims submitted processed within 60 days				
2020 Q1	98.9%	98.9%	0%	No issues were identified.
2020 Q2	99.4%	99.4%	0%	No issues were identified.
2020 Q3	99.9%	99.9%	0%	No issues were identified.
2020 Q4	99.8%	99.8%	0%	No issues were identified.

Table B-57. MY 2020 PMV Results: Provider-Preventable Conditions Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions				
2020 Q1	*	*	*	No PPC was reported.
2020 Q2	*	*	*	No PPC was reported.
2020 Q3	*	*	*	No PPC was reported.
2020 Q4	*	*	*	No PPC was reported.

* The denominator was zero; thus, no results are reported.

Table B-58. MY 2020 PMV Results: Report Submission Validation - ARTC				
Quarter (Q)/ Time Period	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
All required reports submitted in accordance with timelines established in the Agreement				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	98.3%	98.3%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
Bi-annual	50%	50%	0%	No issues were identified.
Annual	100%	100%	0%	No issues were identified.

Table B-59. MY 2020 PMV Results: Key Personnel Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
For a Key Personnel vacancy, propose a suitable replacement within 30 calendar days of the vacancy or from when first knew or should have known the vacancy would be occurring.				
2020 Q1	100.0%	100.0%	0%	No issues were identified.
2020 Q2	*	*	*	No key personnel vacancies.
2020 Q3	*	*	*	No key personnel vacancies.
2020 Q4	100.0%	100.0%	0%	No issues were identified.

** There were no key personnel vacancies, thus, no results are reported.*

Table B-60. MY 2020 PMV Results: Provider Quality Metrics Validation - ARTC				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	*	*	*	DMS noted NA for this quarter.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DMS noted NA for this quarter, thus, no results are reported.*

Empower

Table B-61. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Empower				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Care Coordinator Caseload (maximum of 50 enrolled members)				
January 2020	93.7%	93.7%	0.02%	Data did not support the State's results.
February 2020	97.4%	97.4%	0%	No issues were identified.

Table B-61. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Empower				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
March 2020	94.5%	94.5%	0%	No issues were identified.
April 2020	97.4%	97.4%	0%	No issues were identified.
May 2020	95.0%	95.0%	0%	No issues were identified.
June 2020	95.4%	95.4%	0%	No issues were identified.
July 2020	95.95%	96.53%	0.58%	Data did not support the State's results. However, the results on excel sheet was valid.
August 2020	96.8%	97.1%	0.29%	Data did not support the State's results. However, the results on excel sheet was valid.
September 2020	97.1%	97.1%	0%	No issues were identified.
October 2020	96.87%	97.15%	0.28%	Data did not support the State's results.
November 2020**	99.2%	99.2%	0%	No issues were identified.
December 2020**	98.3%	98.3%	0%	No issues were identified.
Initial Contact with Enrolled Member (within 15 business days of enrollment)				
2020 Q1	79.9%	84.3%	4.4%	Data did not support the State's results.
2020 Q2	92.3%	92.3%	0%	No issues were identified.
2020 Q3	89.2%	89.2%	0%	No issues were identified.
2020 Q4	86.8%	86.8%	0%	No issues were identified.
Monthly Contact with Enrolled Member (at least one contact monthly)				
2020 Q1	92.6%	92.6%	0%	No issues were identified.
2020 Q2	87.9%	87.9%	0%	No issues were identified.
2020 Q3	85.8%	85.8%	0%	No issues were identified.
2020 Q4	83.80%	83.81%	0.01%	Data did not support the State's results.
Quarterly Contact with Enrolled Member (at least one contact made in person quarterly)				
2020 Q1	*	*	*	DHS waived this measure.
2020 Q2	*	*	*	DHS waived this measure.

Table B-61. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Empower				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q3	*	*	*	DHS waived this measure.
2020 Q4	*	*	*	DHS waived this measure.
Primary Care Physician (PCP) Assignment (enrollees have and are seeing PCP)				
2020 Q1	83.8%	84.2%	0.4%	Data did not support the State's results.
2020 Q2	87.1%	87.1%	0%	No issues were identified.
2020 Q3	89.4%	89.4%	0%	No issues were identified.
2020 Q4	86.0%	86.0%	0%	No issues were identified.
Follow-Up Care (within seven business days of emergency room visit or discharge from hospital or inpatient psychiatric facility)				
2020 Q1	90.7%	90.0%	0.7%	Data did not support the State's results.
2020 Q2	89.7%	89.7%	0%	No issues were identified.
2020 Q3	88.0%	88.0%	0%	No issues were identified.
2020 Q4	84.2%	84.2%	0%	No issues were identified.

**DHS waived the Quarterly Contact measure due to the Covid-19 pandemic, thus, no results were reported.*

Table B-62. MY 2020 PMV Results: Out-of-Network Provider Payment Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
No greater than 20% of the total dollars billed to the PASSE for outpatient services billed by out-of-network providers				
2020 Q1	1.6%	1.6%	0%	No issues were identified.
2020 Q2	1.5%	1.5%	0%	No issues were identified.
2020 Q3	0.9%	0.9%	0%	No issues were identified.
2020 Q4	1.9%	1.9%	0%	No issues were identified.

Table B-63. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls answered within three rings or 15 seconds				
2020 Q1	100%	100%	0%	The State needs to confirm the denominator with PASSE for this quarter. There were two different numbers (denominator) reported in the PASSE January call center report. However, Qsource used the same denominator the State chose to validate.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
(ii) Number of busy signals not exceeding 5% of total incoming calls				
2020 Q1	0%	0%	0%	The State needs to confirm the denominator with PASSE for this quarter. There were two different numbers (denominator) reported in the PASSE January call center report. However, Qsource used the same denominator the State chose to validate.
2020 Q2	0%	0%	0%	No issues were identified.
2020 Q3	0%	0%	0%	No issues were identified.
2020 Q4	0%	0%	0%	No issues were identified.
(iii) Wait time in queue not longer than two minutes for incoming calls				
2020 Q1	96.5%	96.5%	0%	The State needs to confirm the denominator with PASSE for this quarter. There were two different numbers (denominator) reported in the PASSE January call center report. However, Qsource used the same denominator the State chose to validate.
2020 Q2	98.0%	98.0%	0%	No issues were identified.
2020 Q3	97.4%	97.4%	0%	No issues were identified.
2020 Q4	97.9%	98.7%	0.8%	Data provided did not support the State's numerator.
(iv) Monthly abandoned call rate				

Table B-63. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q1	1.2%	1.2%	0%	The State needs to confirm the denominator with PASSE for this quarter. There were two different numbers (denominator) reported in the PASSE January call center report. However, Qsource used the same denominator the State chose to validate.
2020 Q2	1.7%	1.7%	0%	No issues were identified.
2020 Q3	1.5%	1.5%	0%	No issues were identified.
2020 Q4	0.9%	0.9%	0%	No issues were identified.

Table B-64. MY 2020 PMV Results: Call Center Return Calls Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls requiring a call back to the enrollee or provider returned within one business day of receipt				
2020 Q1	100%	100%	0%	No data to validate numerator and denominator for this quarter. Rate was validated based on the provided numerator and denominator.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
(ii) For calls received during non-business hours, return calls to enrollees and providers made on the next business day				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

Table B-65. MY 2020 PMV Results: Website and Portal Availability Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE's website online each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance				
2020 Q1	99.8%	99.8%	0%	No issues were identified.
2020 Q2	99.3%	99.3%	0%	No issues were identified.
2020 Q3	99.98%	99.98%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

Table B-66. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) Acknowledgement in writing within five business days of receipt of each grievance				
2020 Q1	*	*	*	DMS did not track acknowledgement data.
2020 Q2	*	*	*	DMS did not track acknowledgement data.
2020 Q3	*	*	*	DMS did not track acknowledgement data.
2020 Q4	*	*	*	DMS did not track acknowledgement data.
(ii) Completion and resolution of grievances within 30 days of receipt				
2020 Q1	100%	96.7%	3%	Data did not support the State's numerator.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	97.8%	97.8%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
(iii) Grievance log submitted with quarterly report				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.

Table B-66. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DHS did not track this measure, thus, no results were reported.*

Table B-67. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Processing Clean Claims Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) 70% of all clean claims submitted processed within seven days				
2020 Q1	81.5%	81.5%	0%	No issues were identified.
2020 Q2	80.3%	80.3%	0%	No issues were identified.
2020 Q3	71.1%	71.1%	0%	No issues were identified.
2020 Q4	75.6%	75.6%	0%	No issues were identified.
(ii) 95% of all clean claims submitted processed within 30 days				
2020 Q1	98.6%	98.6%	0%	No issues were identified.
2020 Q2	97.3%	97.3%	0%	No issues were identified.
2020 Q3	95.8%	95.8%	0%	No issues were identified.
2020 Q4	98.0%	98.0%	0%	No issues were identified.
(iii) 99% of all clean claims submitted processed within 60 days				
2020 Q1	99.7%	99.7%	0%	No issues were identified.
2020 Q2	99.3%	99.3%	0%	No issues were identified.
2020 Q3	99.7%	99.7%	0%	No issues were identified.
2020 Q4	99.3%	99.3%	0%	No issues were identified.

Table B-68. MY 2020 PMV Results: Provider-Preventable Conditions Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions				
2020 Q1	*	*	*	No PPC was reported.
2020 Q2	*	*	*	No PPC was reported.
2020 Q3	*	*	*	No PPC was reported.
2020 Q4	*	*	*	No PPC was reported.

** The denominator was zero; thus, no results are reported.*

Table B-69. MY 2020 PMV Results: Report Submission Validation - Empower				
Quarter (Q)/ Time Period	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
All required reports submitted in accordance with timelines established in the Agreement				
2020 Q1	78%	78%	0%	No issues were identified.
2020 Q2	46.0%	46.0%	0%	No issues were identified.
2020 Q3	98.3%	98.3%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
Bi-annual	50.0%	50.0%	0%	No issues were identified.
Annual	56.3%	56.3%	0%	No issues were identified.

Table B-70. MY 2020 PMV Results: Key Personnel Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
For a Key Personnel vacancy, propose a suitable replacement within 30 calendar days of the vacancy or from when first knew or should have known the vacancy would be occurring.				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	*	*	*	No key personnel vacancies.
2020 Q3	*	*	*	No key personnel vacancies.
2020 Q4	100%	100%	0%	No issues were identified.

** There were no key personnel vacancies, thus, no results are reported.*

Table B-71. MY 2020 PMV Results: Provider Quality Metrics Validation - Empower				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	*	*	*	The State noted it was not applicable for this quarter.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**The State noted NA for this quarter, thus, no results are reported.*

Summit

Table B-72. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Summit				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Care Coordinator Caseload (maximum of 50 enrolled members)				
January 2020	99.7%	99.7%	0%	No issues were identified.

Table B-72. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Summit				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
February 2020	99.7%	99.7%	0%	No issues were identified.
March 2020	99.7%	99.7%	0%	No issues were identified.
April 2020	99.7%	99.7%	0%	No issues were identified.
May 2020	99.1%	99.07%	0%	No issues were identified.
June 2020	98.4%	98.4%	0%	No issues were identified.
July 2020	98.1%	98.1%	0%	No issues were identified.
August 2020	97.6%	97.6%	0%	No issues were identified.
September 2020	97.6%	97.6%	0%	No issues were identified.
October 2020	97.0%	97.0%	0%	No issues were identified.
November 2020	98.5%	98.5%	0%	No issues were identified.
December 2020	97.6%	97.6%	0%	No issues were identified.
Initial Contact with Enrolled Member (within 15 business days of enrollment)				
2020 Q1	68.2%	70.0%	1.8%	Data provided did not support the State's results.
2020 Q2	96.8%	96.8%	0%	No issues were identified.
2020 Q3	82.7%	82.7%	0%	No issues were identified.
2020 Q4	76.6%	76.6%	0%	No issues were identified.
Monthly Contact with Enrolled Member (at least one contact monthly)				
2020 Q1	83.7%	89.8%	6.1%	Data provided did not support the State's results.
2020 Q2	89.6%	90.3%	0.7%	Data provided did not support the State's results.
2020 Q3	82.8%	86.4%	3.6%	Data provided did not support the State's results.
2020 Q4	81.8%	81.0%	0.8%	Monthly Detail data was not available. The data provided was Overall Month data, which was not consistent with Monthly Detail data throughout the measurement period. Thus, the result may not be reliable.
Quarterly Contact with Enrolled Member (at least one contact made in person quarterly)				

Table B-72. MY 2020 PMV Results: Care Coordination Quality Measure Validation - Summit				
Month or Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q1	*	*	*	DHS waived this measure.
2020 Q2	*	*	*	DHS waived this measure.
2020 Q3	*	*	*	DHS waived this measure.
2020 Q4	*	*	*	DHS waived this measure.
Primary Care Physician (PCP) Assignment (enrollees have and are seeing PCP)				
2020 Q1	100%	100.0%	0%	No issues were identified.
2020 Q2	100%	100.0%	0%	No issues were identified.
2020 Q3	99.9%	99.9%	0%	No issues were identified.
2020 Q4	99.95%	100.0%	0%	No issues were identified.
Follow-Up Care (within seven business days of emergency room visit or discharge from hospital or inpatient psychiatric facility)				
2020 Q1	57.3%	75.7%	18.4%	Data provided did not support the State's results.
2020 Q2	73.4%	73.6%	0.2%	Data provided did not support the State's results.
2020 Q3	73.6%	73.6%	0%	No issues were identified.
2020 Q4	56.9%	56.9%	0%	No issues were identified.

**DHS waived the Quarterly Contact measure due to the Covid-19 pandemic, thus, no results were reported.*

Table B-73. MY 2020 PMV Results: Out-of-Network Provider Payment Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
No greater than 20% of the total dollars billed to the PASSE for outpatient services billed by out-of-network providers				
2020 Q1	*	*	*	Summit did not provide out-of-network payment data for this quarter.
2020 Q2	0.7%	0.7%	0%	No issues were identified.
2020 Q3	0.6%	0.6%	0%	No issues were identified.
2020 Q4	0.3%	0.3%	0%	No issues were identified.

**DHS noted that Summit only submitted in-network payment for Q1, thus, no results are reported.*

Table B-74. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls answered within three rings or 15 seconds				
2020 Q1	99.3%	99.3%	0%	No issues were identified.
2020 Q2	98.7%	98.7%	0%	No issues were identified.
2020 Q3	99.6%	99.6%	0%	No issues were identified.
2020 Q4	99.6%	99.6%	0%	No issues were identified.
(ii) Number of busy signals not exceeding 5% of total incoming calls				
2020 Q1	0%	0%	0%	No issues were identified.
2020 Q2	0%	0%	0%	No issues were identified.
2020 Q3	0%	0%	0%	No issues were identified.
2020 Q4	0%	0%	0%	No issues were identified.
(iii) Wait time in queue not longer than two minutes for incoming calls				
2020 Q1	99.3%	99.3%	0%	No issues were identified.
2020 Q2	98.7%	98.7%	0%	No issues were identified.

Table B-74. MY 2020 PMV Results: Call Center Answer and Abandonment Rates Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q3	99.3%	99.3%	0%	No issues were identified.
2020 Q4	99.4%	99.4%	0%	No issues were identified.
(iv) Monthly abandoned call rate				
2020 Q1	0.7%	0.7%	0%	No issues were identified.
2020 Q2	1.3%	1.3%	0%	No issues were identified.
2020 Q3	0.4%	0.4%	0%	No issues were identified.
2020 Q4	0.4%	0.4%	0%	No issues were identified.

Table B-75. MY 2020 PMV Results: Call Center Return Calls Validation- Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) All calls requiring a call back to the enrollee or provider returned within one business day of receipt				
2020 Q1	*	*	*	Summit determined voicemail was not properly set up.
2020 Q2	*	*	*	Summit determined voicemail was not properly set up.
2020 Q3	*	*	*	Summit determined voicemail was not properly set up.
2020 Q4	*	*	*	Summit determined voicemail was not properly set up.
(ii) For calls received during non-business hours, return calls to enrollees and providers made on the next business day				
2020 Q1	*	*	*	Summit determined voicemail was not properly set up.
2020 Q2	*	*	*	Summit determined voicemail was not properly set up.
2020 Q3	*	*	*	Summit determined voicemail was not properly set up.
2020 Q4	*	*	*	Summit determined voicemail was not properly set up.

** There was no denominator for this measure; thus, no results are reported.*

Table B-76. MY 2020 PMV Results: Website and Portal Availability Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE's website online each month, except that the PASSE may take the website and portals down from 1:00 a.m. to 5:00 a.m. each Saturday for necessary maintenance				
2020 Q1	*	*	*	Summit did not provide data for this quarter.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DHS noted: Summit did not provide total minutes for numerator and denominator to DHS for Jan-Mar 2020. Thus, no results are reported.*

Table B-77. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) Acknowledgement in writing within five business days of receipt of each grievance				
2020 Q1	*	*	*	The State did not track acknowledgement data.
2020 Q2	*	*	*	The State did not track acknowledgement data.
2020 Q3	*	*	*	The State did not track acknowledgement data.
2020 Q4	*	*	*	The State did not track acknowledgement data.
(ii) Completion and resolution of grievances within 30 days of receipt				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	90.9%	90.9%	0%	No issues were identified.
(iii) Grievance log submitted with quarterly report				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	100%	100%	0%	No issues were identified.

Table B-77. MY 2020 PMV Results: Investigation and Resolution of Grievances Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DHS did not track this measure, thus, no results were reported.*

Table B-78. MY 2020 PMV Results: Denial, Approval, and Submission of Claims: Processing Clean Claims Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
(i) 70% of all clean claims submitted processed within seven days				
2020 Q1	94.0%	94.0%	0%	No issues were identified.
2020 Q2	84.8%	84.8%	0%	No issues were identified.
2020 Q3	89.0%	89.0%	0%	No issues were identified.
2020 Q4	94.2%	94.2%	0%	No issues were identified.
(ii) 95% of all clean claims submitted processed within 30 days				
2020 Q1	99.96%	99.96%	0%	No issues were identified.
2020 Q2	99.5%	99.5%	0%	No issues were identified.
2020 Q3	98.9%	98.9%	0%	No issues were identified.
2020 Q4	99.9%	99.9%	0%	No issues were identified.
(iii) 99% of all clean claims submitted processed within 60 days				
2020 Q1	100%*	100%*	0%	No issues were identified.
2020 Q2	99.8%	99.8%	0%	No issues were identified.
2020 Q3	99.8%	99.8%	0%	No issues were identified.
2020 Q4	99.97%	99.97%	0%	No issues were identified.

**Rounded to 100%*

Table B-79. MY 2020 PMV Results: Provider-Preventable Conditions Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
PASSE must track data and submit a report quarterly that identifies all provider-preventable conditions (PPC)				
2020 Q1	*	*	*	No PPC were reported.
2020 Q2	*	*	*	No PPC were reported.
2020 Q3	*	*	*	No PPC were reported.
2020 Q4	*	*	*	No PPC were reported.

**No PPC were reported for this measure; thus, no results are reported.*

Table B-80. MY 2020 PMV Results: Report Submission Validation - Summit				
Quarter (Q)/ Time Period	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
All required reports submitted in accordance with timelines established in the Agreement				
2020 Q1	100%	100%	0%	No issues were identified.
2020 Q2	98.4%	98.4%	0%	No issues were identified.
2020 Q3	98.3%	98.3%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.
Bi-annual	66.7%	66.7%	0%	No issues were identified.
Annual	87.5%	87.5%	0%	No issues were identified.

Table B-81. MY 2020 PMV Results: Key Personnel Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
For a Key Personnel vacancy, propose a suitable replacement within 30 calendar days of the vacancy or from when first knew or should have known the vacancy would be occurring.				
2020 Q1	*	*	*	No key personnel vacancies.
2020 Q2	*	*	*	No key personnel vacancies.
2020 Q3	*	*	*	No key personnel vacancies.
2020 Q4	*	*	*	No key personnel vacancies.

** There were no key personnel vacancies, thus, no results are reported.*

Table B-82. MY 2020 PMV Results: Provider Quality Metrics Validation - Summit				
Quarter (Q)	**State Results**	**Qsource Results**	**Variance**	**Key Review Findings**
Accuracy and timeliness of provider data reported to DHS with quarterly metrics report				
2020 Q1	*	*	*	The State noted NA for this quarter.
2020 Q2	0%	0%	0%	No issues were identified.
2020 Q3	100%	100%	0%	No issues were identified.
2020 Q4	100%	100%	0%	No issues were identified.

**DMS noted NA for this quarter, thus, no results are reported.*

APPENDIX C | Protocol 3: CA Findings

Table C-1 displays compliance with federal statutes, its relative contract/agreement, and additional compliance standards established by DHS. Individual results are presented for each CA standard reviewed in the 2021 assessment.

Table C-1. 2021 CA Standard Results

Standards	Elements Score / Applicable Elements Value Standard Score				
	ARTC	Empower	Summit	Delta Dental	MCNA
Coverage and Authorization of Services	50.000/51.000	51.000/51.000	51.000/51.000	17.000/17.000	18.500/19.000
	98.04%	100%	100%	100%	97.37%
Grievance and Appeals	61.000/62.000	61.000/61.000	62.000/62.000	38.000/38.000	38.000/38.000
	98.39%	100%	100%	100%	100%
Provider Selection	20.000/20.000	20.000/20.000	19.000/20.000	8.000/8.000	8.000/8.000
	100%	100%	95.00%	100%	100%
Subcontractual Relationships and Delegation	18.000/18.000	19.000/19.000	18.000/18.000	11.000/12.000	8.500/11.000
	100%	100%	100%	91.67%	77.27%
2021 Overall Compliance Standard Score	**99.11%**	**100%**	**98.75%**	**97.92%**	**93.66%**

Table C-2 displays compliance with federal statutes, its relative contract/agreement, and additional compliance standards established by DHS for the previous measurement year.

Table C-2. 2020 CA Standard Results

Standard	PASSEs			DMOs	
	ARTC	Empower	Summit	Delta Dental	MCNA
Assurances of Adequate Capacity and Services	50.00%	83.30%	100%	100%	100%
Availability of Services	77.78%	87.05%	100%	100%	100%
Confidentiality	100%	50.00%	100%	0%	100%

Table C-2. 2020 CA Standard Results

Standard	PASSEs			DMOs	
	ARTC	Empower	Summit	Delta Dental	MCNA
Coordination and Continuity of Care	96.77%	100%	100%	100%	100%
Coverage and Authorization of Services	85.71%	91.84%	100%	72.72%	100%
Grievance and Appeals	90.33%	95.16%	100%	98.68%	100%
Health Information Systems	100%	100%	100%	72.20%	100%
Practice Guidelines	100%	100%	100%	100%	100%
Provider Selection	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement	97.50%	97.50%	65.63%	93.75%	100%
Subcontractual Relationships and Delegation	87.97%	56.08%	89.47%	100%	100%
2020 Overall Compliance Standard Score	**89.64%**	**87.36%**	**95.92%**	**85.21%**	**100%**

APPENDIX D | Protocol 4: ANA Review Findings

Geographic Network Adequacy Analysis

The network adequacy information in **Tables D-1** through **D-5** presents the percentage of enrollees by geographical location type with access to the various categories of care within applicable distance standards. The standards used to assess provider networks are available upon request.

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Primary and Specialty Care									
Primary Care	30	100%	Met	60	100%	Met	1:250 enrollees	1:9.4 enrollees	Met
Pediatrics – Routine/ Primary Care	30	99.98%	Not Met	60	99.15%	Not Met	1:250 enrollees	1:33.1 enrollees	Met
Ambulatory Surgical Center	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:220.6 enrollees	Met
Allergy and Immunology	40	100%	Met	90	92.12%	Not Met	1:500 enrollees	1:390.7 enrollees	Met
Cardiothoracic Surgery	40	99.87%	Not Met	90	99.75%	Not Met	1:1,000 enrollees	1:217.1 enrollees	Met
Cardiovascular Disease	40	100%	Met	90	100%	Met	1:500 enrollees	1:37.6 enrollees	Met
Dermatology	40	100%	Met	90	99.75%	Not Met	1:1,000 enrollees	1:93.7 enrollees	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Supportive Living / Respite / Supplemental Support	NA*	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Environmental Modifications / Adaptive Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Specialized Medical Supplies	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Supported Employment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Diagnostic Radiology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:36.1 enrollees	Met
Endocrinology	40	100%	Met	90	96.29%	Not Met	1:750 enrollees	1:134.1 enrollees	Met
ENT/ Otolaryngology	40	100%	Met	90	100%	Met	1:750 enrollees	1:95.6 enrollees	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Federally Qualified Health Center (FQHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 FQHC enrolled as a network provider	Must have at least 1 FQHC enrolled as a network provider	Met
Gastroenterology	40	100%	Met	90	99.99%	Not Met	1:750 enrollees	1:112.1 enrollees	Met
General Surgery	40	100%	Met	90	100%	Met	1:500 enrollees	1:42.9 enrollees	Met
Gynecology, OB/GYN	30	99.98%	Not Met	60	99.99%	Not Met	1:250 enrollees	1:40.2 enrollees	Met
Hematology	40	100%	Met	90	99.99%	Not Met	1:750 enrollees	1:93.0 enrollees	Met
Home Health	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Hyperalimentation	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Intermediate Care Facility	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Infectious Diseases	40	100%	Met	90	96.95%	Not Met	1:1,000 enrollees	1:239.9 enrollees	Met
Nephrology	40	100%	Met	90	99.42%	Not Met	1:1,250 enrollees	1:129.0 enrollees	Met
Neurology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:107.7 enrollees	Met
Neurosurgery	40	100%	Met	90	96.86%	Not Met	1:1,000 enrollees	1:184.8 enrollees	Met
Oncology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:65.8 enrollees	Met
Ophthalmology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:60.5 enrollees	Met
Optometry	40	100%	Met	90	100%	Met	1:800 enrollees	1:27.8 enrollees	Met
Orthopedic Surgery	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:46.5 enrollees	Met
Orthotics and Prosthetics	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:57.9 enrollees	Met
Outpatient Dialysis	40	91.47%	Not Met	90	88.55%	Not Met	1:1,000 enrollees	1:911.7 enrollees	Met
Outpatient Infusion/ Chemotherapy	40	100%	Met	90	100%	Met	1:3,000 enrollees	1:379.9 enrollees	Met
Personal Care	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Pharmacy	20	100%	Met	50	100%	Met	1:1,000 enrollees	1:15.8 enrollees	Met
Physical Medicine and Rehabilitation, Physiatry	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:184.8 enrollees	Met
Plastic Surgery	40	54.59%	Not Met	90	86.48%	Not Met	1:1,000 enrollees	1:506.5 enrollees	Met
Podiatry	40	100%	Met	90	99.75%	Not Met	1:1,000 enrollees	1:142.5 enrollees	Met
Pulmonary	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:99.1 enrollees	Met
Rheumatology	40	90.90%	Not Met	90	96.87%	Not Met	1:1,500 enrollees	1:239.9 enrollees	Met
Rural Health Clinic (RHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 RHC enrolled as a network provider	Must have at least 1 RHC enrolled as a network provider	Met
Therapist (Occupational)	30	100%	Met	60	100%	Met	1:500 enrollees	1:10.9 enrollees	Met
Therapist (Physical)	30	100%	Met	60	100%	Met	1:500 enrollees	1:10.8 enrollees	Met
Therapist (Speech)	30	100%	Met	60	100%	Met	1:500 enrollees	1:10.9 enrollees	Met
Urology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:127.8 enrollees	Met
Vascular Surgery	40	90.86%	Not Met	90	96.86%	Not Met	1:1,250 enrollees	1:488.4 enrollees	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC									
Provider Specialty/ Provider Type	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Provider-to-Enrollee Ratio Standard**	**Actual Provider-to-Enrollee Ratio**	**Met/ Not Met**
Ventilator Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Facility/Group/Organization									
Acute Inpatient Hospital	30	100%	Met	60	100%	Met	1 bed: 400 enrollees	1 bed:187.3 enrollees	Met
Adult Developmental Day Treatment (ADDT)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Critical Care Services – Intensive Care Units (ICUs)	30	100%	Met	90	100%	Met	1 bed:800 enrollees	1 bed:192.6 enrollees	Met
Durable Medical Equipment (DME)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Outpatient Hospital	30	100%	Met	60	100%	Met	NA	NA	NA
Behavioral Health									
Independently Licensed Clinician – Master's/Doctoral	40	100%	Met	75	100%	Met	1:750 enrollees	1:10.2 enrollees	Met
Board Certified Psychiatrist	40	100%	Met	75	100%	Met	1:500 enrollees	1:32.3 enrollees	Met

Table D-1. MY 2021 Network Adequacy Review Results: ARTC

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Inpatient Psychiatric Facility for Individuals Under the Age of 21	NA	100%	Met	NA	100%	Met	1 bed:300 enrollees	1 bed:569.8 enrollees	Not Met
Substance Abuse Treatment Provider	40	100%	Met	120	100%	Met	1:750 enrollees	1:99.1 enrollees	Met

** Not applicable*
*** Not Reported*

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Primary and Specialty Care									
Primary Care	30	100%	Met	60	100%	Met	1:250 enrollees	1:1.1 enrollees	Met
Pediatrics – Routine/ Primary Care	30	100%	Met	60	100%	Met	1:250 enrollees	1:8.6 enrollees	Met
Ambulatory Surgical Center	40	100%	Met	90	99.99%	Not Met	1:1,000 enrollees	1:450.3 enrollees	Met
Allergy and Immunology	40	92.90%	Not Met	90	99.99%	Not Met	1:500 enrollees	1:115.9 enrollees	Met
Cardiothoracic Surgery	40	100%	Met	90	99.67%	Not Met	1:1,000 enrollees	1:133.9 enrollees	Met

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Cardiovascular Disease	40	100%	Met	90	100%	Met	1:500 enrollees	1:34.8 enrollees	Met
Dermatology	40	100%	Met	90	99.68%	Not Met	1:1,000 enrollees	1:88.9 enrollees	Met
Supportive Living / Respite / Supplemental Support	NA*	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Environmental Modifications / Adaptive Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Specialized Medical Supplies	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Supported Employment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Diagnostic Radiology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:28.8 enrollees	Met
Endocrinology	40	99.83%	Not Met	90	96.65%	Not Met	1:750 enrollees	1:230.4 enrollees	Met

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
ENT/ Otolaryngology	40	100%	Met	90	99.93%	Not Met	1:750 enrollees	1:115.2 enrollees	Met
Federally Qualified Health Center (FQHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 FQHC enrolled as a network provider	Must have at least 1 FQHC enrolled as a network provider	Met
Gastroenterology	40	100%	Met	90	100%	Met	1:750 enrollees	1:88.5 enrollees	Met
General Surgery	40	100%	Met	90	100%	Met	1:500 enrollees	1:72.1 enrollees	Met
Gynecology, OB/GYN	30	100%	Met	60	100%	Met	1:250 enrollees	25.8 enrollees	Met
Hematology	40	100%	Met	90	100%	Met	1:750 enrollees	1:77.1 enrollees	Met
Home Health	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Hyperalimentation	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Intermediate Care Facility	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Infectious Diseases	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:287.2 enrollees	Met
Nephrology	40	100%	Met	90	100%	Met	1:1,250 enrollees	1:94.8 enrollees	Met
Neurology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:80.9 enrollees	Met
Neurosurgery	40	100%	Met	90	95.92%	Not Met	1:1,000 enrollees	1:241.6 enrollees	Met
Oncology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:63.5 enrollees	Met
Ophthalmology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:57.3 enrollees	Met
Optometry	40	100%	Met	90	100%	Met	1:800 enrollees	1:27.8 enrollees	Met
Orthopedic Surgery	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:64.5 enrollees	Met
Orthotics and Prosthetics	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:54.1 enrollees	Met
Outpatient Dialysis	40	93.10%	Not Met	90	100%	Met	1:1,000 enrollees	1:430.7 enrollees	Met
Outpatient Infusion/ Chemotherapy	40	100%	Met	90	100%	Met	1:3,000 enrollees	1:257.3 enrollees	Met

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Personal Care	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Pharmacy	20	NR**	NR	50	NR	NR	1:1,000 enrollees	NR	NR
Physical Medicine and Rehabilitation, Physiatry	40	100%	Met	90	100%	Met	1:1,000 enrollees	194.3 enrollees	Met
Plastic Surgery	40	89.88%	Not Met	90	99.68%	Not Met	1:1,000 enrollees	1:264.2 enrollees	Met
Podiatry	40	100%	Met	90	99.67%	Not Met	1:1,000 enrollees	1:194.3 enrollees	Met
Pulmonary	40	100%	Met	90	99.67%	Not Met	1:1,000 enrollees	1:111.9 enrollees	Met
Rheumatology	40	92.90%	Not Met	90	96.21%	Not Met	1:1,500 enrollees	1:404.4 enrollees	Met
Rural Health Clinic (RHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 RHC enrolled as a network provider	Must have at least 1 RHC enrolled as a network provider	Met
Therapist (Occupational)	30	100%	Met	60	100%	Met	1:500 enrollees	1:9.7 enrollees	Met
Therapist (Physical)	30	100%	Met	60	100%	Met	1:500 enrollees	1:8.1 enrollees	Met

Table D-2. MY 2021 Network Adequacy Review Results: Empower									
Provider Specialty/ Provider Type	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Provider-to-Enrollee Ratio Standard**	**Actual Provider-to-Enrollee Ratio**	**Met/ Not Met**
Therapist (Speech)	30	100%	Met	60	100%	Met	1:500 enrollees	1:8.8 enrollees	Met
Urology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:80.2 enrollees	Met
Vascular Surgery	40	100%	Met	90	100%	Met	1:1,250 enrollees	1:143.6 enrollees	Met
Ventilator Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Facility/Group/Organization									
Acute Inpatient Hospital	30	100%	Met	60	100%	Met	1 bed: 400 enrollees	1 bed:163.8 enrollees	Met
Adult Developmental Day Treatment (ADDT)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Critical Care Services – Intensive Care Units (ICUs)	30	99.93%	Not Met	90	100%	Met	1 bed: 800 enrollees	1 bed:200.1 enrollees	Met
Durable Medical Equipment (DME)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Outpatient Hospital	30	100%	Met	60	100%	Met	NA	NA	NA

Table D-2. MY 2021 Network Adequacy Review Results: Empower

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Behavioral Health									
Independently Licensed Clinician – Master's/Doctoral	40	100%	Met	75	100%	Met	1:750 enrollees	1:84.0 enrollees	Met
Board Certified Psychiatrist	40	NR	NR	75	NR	NR	1:500 enrollees	NR	NR
Inpatient Psychiatric Facility for Individuals Under the Age of 21	NA	100%	Met	NA	100%	Met	1 bed: 300 enrollees	1 bed:2,476.8 enrollees	Not Met
Substance Abuse Treatment Provider	40	NR	Not Met	120	NR	Not Met	1:750 enrollees	1:143.6 enrollees	Met

** Not applicable*
*** Not Reported*

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Primary and Specialty Care									
Primary Care	30	100%	Met	60	100%	Met	1:250 enrollees	1:2.7 enrollees	Met
Pediatrics – Routine/ Primary Care	30	100%	Met	60	100%	Met	1:250 enrollees	1:2.8 enrollees	Met
Ambulatory Surgical Center	40	99.93%	Not Met	90	99.78%	Not Met	1:1,000 enrollees	1:550.1 enrollees	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Allergy and Immunology	40	100%	Met	90	97.38%	Not Met	1:500 enrollees	1:175.6 enrollees	Met
Cardiothoracic Surgery	40	99.95%	Not Met	90	100%	Met	1:1,000 enrollees	1:211.6 enrollees	Met
Cardiovascular Disease	40	100%	Met	90	100%	Met	1:500 enrollees	1:32.7 enrollees	Met
Dermatology	40	100%	Met	90	99.77%	Not Met	1:1,000 enrollees	1:138.7 enrollees	Met
Supportive Living / Respite / Supplemental Support	NA*	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Environmental Modifications / Adaptive Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Specialized Medical Supplies	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Supported Employment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Diagnostic Radiology	40	NR**	NR	90	NR	NR	1:1,000 enrollees	NR	NR
Endocrinology	40	100%	Met	90	99.25%	Not Met	1:750 enrollees	1:191.9 enrollees	Met
ENT/ Otolaryngology	40	100%	Met	90	96.09%	Not Met	1:750 enrollees	1:101.2 enrollees	Met
Federally Qualified Health Center (FQHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 FQHC enrolled as a network provider	Must have at least 1 FQHC enrolled as a network provider	Met
Gastroenterology	40	100%	Met	90	99.78%	Not Met	1:750 enrollees	1:92.7 enrollees	Met
General Surgery	40	100%	Met	90	100%	Met	1:500 enrollees	1:48.5 enrollees	Met
Gynecology, OB/GYN	30	100%	Met	60	100%	Met	1:250 enrollees	1:28.7 enrollees	Met
Hematology	40	100%	Met	90	100%	Met	1:750 enrollees	1:83.8 enrollees	Met
Home Health	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Hyperalimentation	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Intermediate Care Facility	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Infectious Diseases	40	99.97%	Not Met	90	99.19%	Not Met	1:1,000 enrollees	1:294.7 enrollees	Met
Nephrology	40	100%	Met	90	100%	Met	1:1,250 enrollees	1:86.9 enrollees	Met
Neurology	40	100%	Met	90	95.98%	Not Met	1:1,000 enrollees	1:83.3 enrollees	Met
Neurosurgery	40	99.99%	Not Met	90	98.26%	Not Met	1:1,000 enrollees	1:203.7 enrollees	Met
Oncology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:253.9 enrollees	Met
Ophthalmology	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:13.2 enrollees	Met
Optometry	40	100%	Met	90	100%	Met	1:800 enrollees	1:10.6 enrollees	Met
Orthopedic Surgery	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:43.3 enrollees	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Orthotics and Prosthetics	40	100%	Met	90	99.78%	Not Met	1:1,000 enrollees	1:366.7 enrollees	Met
Outpatient Dialysis	40	2.68%	Not Met	90	40.42%	Not Met	1:1,000 enrollees	1:8,251.5 enrollees	Not Met
Outpatient Infusion/ Chemotherapy	40	NR	NR	90	NR	NR	1:3,000 enrollees	NR	NR
Personal Care	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Pharmacy	20	NR	NR	50	NR	NR	1:1,000 enrollees	NR	NR
Physical Medicine and Rehabilitation, Physiatry	40	99.73%	Not Met	90	93.84%	Not Met	1:1,000 enrollees	1:275.1 enrollees	Met
Plastic Surgery	40	91.80%	Not Met	90	83.69%	Not Met	1:1,000 enrollees	1:351.1 enrollees	Met
Podiatry	40	100%	Met	90	97.40%	Not Met	1:1,000 enrollees	1:198.8 enrollees	Met
Pulmonary	40	100%	Met	90	100%	Met	1:1,000 enrollees	1:113.8 enrollees	Met
Rheumatology	40	91.82%	Not Met	90	95.77%	Not Met	1:1,500 enrollees	1:351.1 enrollees	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit									
Provider Specialty/ Provider Type	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met/ Not Met**	**Provider-to-Enrollee Ratio Standard**	**Actual Provider-to-Enrollee Ratio**	**Met/ Not Met**
Rural Health Clinic (RHC)	NA	100%	Met	NA	100%	Met	Must have at least 1 RHC enrolled as a network provider	Must have at least 1 RHC enrolled as a network provider	Met
Therapist (Occupational)	30	100%	Met	60	100%	Met	1:500 enrollees	1:7.9 enrollees	Met
Therapist (Physical)	30	100%	Met	60	100%	Met	1:500 enrollees	1:8.3 enrollees	Met
Therapist (Speech)	30	100%	Met	60	99.92%	Not Met	1:500 enrollees	1:7.4 enrollees	Met
Urology	40	100%	Met	90	99.79%	Not Met	1:1,000 enrollees	1:89.2 enrollees	Met
Vascular Surgery	40	99.78%	Not Met	90	92.88%	Not Met	1:1,250 enrollees	1:1,650.3 enrollees	Not Met
Ventilator Equipment	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Facility/Group/Organization									
Acute Inpatient Hospital	30	100%	Met	60	100%	Met	1 bed: 400 enrollees	1 bed:194.2 enrollees	Met
Adult Developmental Day Treatment (ADDT)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met

Table D-3. MY 2021 Network Adequacy Review Results: Summit

Provider Specialty/ Provider Type	Urban Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Rural Distance Standard (miles)	% Enrollees with Access	Met/ Not Met	Provider-to-Enrollee Ratio Standard	Actual Provider-to-Enrollee Ratio	Met/ Not Met
Critical Care Services – Intensive Care Units (ICUs)	30	100%	Met	90	100%	Met	1 bed: 800 enrollees	1 bed:458.4 enrollees	Met
Durable Medical Equipment (DME)	NA	100%	Met	NA	100%	Met	Ability to provide service in all Arkansas counties	Ability to provide service in all Arkansas counties	Met
Outpatient Hospital	30	100%	Met	60	100%	Met	NA	NA	NA
Behavioral Health									
Independently Licensed Clinician – Master's/Doctoral	40	100%	Met	75	100%	Met	1:750 enrollees	1:6.2 enrollees	Met
Board Certified Psychiatrist	40	100%	Met	75	100%	Met	1:500 enrollees	1:26.7 enrollees	Met
Inpatient Psychiatric Facility for Individuals Under the Age of 21	NA	100%	Met	NA	100%	Met	1 bed: 300 enrollees	1 bed:1,375.3 enrollees	Not Met
Substance Abuse Treatment Provider	40	11.97%	Not Met	120	84.79%	Not Met	1:750 enrollees	1:569.1 enrollees	Met

** Not applicable*
***Not reported*

Table D-4. MY 2021 Geographic Network Adequacy Results: Delta Dental							
Provider Specialty/ Provider Type	**Benchmark % for Urban and Rural Distance Standards**	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**
All Enrollees							
Primary Care Dentist	≥ 90%	2 in 30 miles	100%	Met	2 in 60 miles	100%	Met
Specialty Care Dentist	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.25%	Met
Orthodontists	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.24%	Met
Periodontists	≥ 85%	1 in 60 miles	51.86%	Not Met	1 in 60 miles	46.23%	Not Met
Oral Surgeons	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.15%	Met
Endodontists	≥ 85%	1 in 60 miles	78.60%	Not Met	1 in 60 miles	21.94%	Not Met
Pediatric Enrollees							
Pediatric Dental Services	≥ 90%	2 in 30 miles	100%	Met	2 in 60 miles	98.35%	Met

Table D-5. MY 2021 Geographic Network Adequacy Results: MCNA							
Provider Specialty/ Provider Type	**Benchmark % for Urban and Rural Distance Standards**	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**
All Enrollees							
Primary Care Dentist	≥ 90%	2 in 30 miles	100%	Met	2 in 60 miles	100%	Met
Specialty Care Dentist	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.20%	Met
Orthodontists	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.19%	Met
Periodontists	≥ 85%	1 in 60 miles	51.33%	Not Met	1 in 60 miles	46.40%	Not Met

Table D-5. MY 2021 Geographic Network Adequacy Results: MCNA							
Provider Specialty/ Provider Type	**Benchmark % for Urban and Rural Distance Standards**	**Urban Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**	**Rural Distance Standard (miles)**	**% Enrollees with Access**	**Met / Not Met**
Oral Surgeons	≥ 85%	1 in 60 miles	100%	Met	1 in 60 miles	98.12%	Met
Endodontists	≥ 85%	1 in 60 miles	78.93%	Not Met	1 in 60 miles	21.79%	Not Met
Pediatric Enrollees							
Pediatric Dental Services	≥ 90%	2 in 30 miles	100%	Met	2 in 60 miles	98.51%	Met

PCSP Assessment

Tables D-6 through **D-8** present findings from the PCSP assessment by section for each PASSE.

Table D-6. MY 2021 PCSP Assessment Findings: ARTC										
Item	**Total PCSP/ Items**	**Yes**	**Yes %**	**Baseline (2019) Yes %**	**No**	**No %**	**Baseline (2019) No %**	**NA***	**NA %**	**Baseline (2019) NA %**
Section I: Review of the PCSP Process										
1. Individual Lead	138	135	97.8%	99.6%	3	2.2%	0.4%	0	0.0%	0.0%
2. Participants	138	40	29.0%	99.2%	98	71.0%	0.8%	0	0.0%	0.0%
3. Informed Choices	138	88	63.8%	67.5%	50	36.2%	32.1%	0	0.0%	0.4%
4. Timely PCSP	138	29	21.0%	43.3%	109	79.0%	56.7%	0	0.0%	0.0%
5. Cultural Considerations	138	136	98.6%	97.9%	2	1.4%	2.1%	0	0.0%	0.0%
6. Conflict of Interest	138	117	84.8%	98.3%	21	15.2%	1.7%	0	0.0%	0.0%
7. HCBS Providers	138	138	100%	97.1%	0	0.0%	2.5%	0	0.0%	0.4%
8. Informed Choice	138	92	66.7%	60.8%	46	33.3%	38.3%	0	0.0%	0.8%
9. Requested Updates	138	31	22.5%	89.6%	107	77.5%	10.4%	0	0.0%	0.0%
10. Alternative Settings	138	96	69.6%	69.6%	42	30.4%	15.0%	0	0.0%	15.4%

Table D-6. MY 2021 PCSP Assessment Findings: ARTC										
Item	**Total PCSP/ Items**	**Yes**	**Yes %**	**Baseline (2019) Yes %**	**No**	**No %**	**Baseline (2019) No %**	**NA***	**NA %**	**Baseline (2019) NA %**
11. Medicaid and Waiver Dates	138	114	82.6%	*	9	6.5%	*	15	10.9%	*
12. Treatment Goals	138	111	80.4%	*	27	19.6%	*	0	0.0%	*
Section I Total	**1,656**	**1,127**	**68.1%**	**82.3%**	**514**	**31.0%**	**16.0%**	**15**	**0.9%**	**1.7%**
Section II: PCSP Written Plan										
1. Residence Choice	138	122	88.4%	85.8%	16	11.6%	13.8%	0	0.0%	0.4%
2. Strengths and Preferences	138	134	97.1%	97.5%	4	2.9%	2.5%	0	0.0%	0.0%
3. Functional Needs Assessment	138	128	92.8%	90.8%	10	7.2%	8.3%	0	0.0%	0.8%
4. Goals	138	128	92.8%	87.1%	10	7.2%	12.5%	0	0.0%	0.4%
5. Natural Supports	138	117	84.8%	86.3%	21	15.2%	12.9%	0	0.0%	0.8%
6. Risk Factors	138	58	42.0%	53.3%	79	57.2%	39.2%	1	0.7%	7.5%
7. Understandable PCSP	138	137	99.3%	97.9%	1	0.7%	2.1%	0	0.0%	0.0%
8. Monitoring	138	106	76.8%	89.2%	32	23.2%	10.8%	0	0.0%	0.0%
9. Finalized PCSP	138	2	1.4%	6.3%	136	98.6%	93.8%	0	0.0%	0.0%
10. Distribution	138	68	49.3%	90.8%	70	50.7%	9.2%	0	0.0%	0.0%
11. Self-Direct	138	17	12.3%	97.5%	1	0.7%	1.7%	120	87.0%	0.8%
12. Unnecessary Services	138	136	98.6%	98.3%	0	0.0%	1.7%	2	1.4%	0.0%
Section II Total	**1,656**	**1,153**	**69.6%**	**81.7%**	**380**	**22.9%**	**17.4%**	**123**	**7.4%**	**0.9%**
Section III: Behavior Support Plan										
1. Collection and Review of Data	138	6	4.3%	0.8%	23	16.7%	10.4%	109	79.0%	88.8%
2. Time Limits	138	5	3.6%	0.8%	25	18.1%	9.6%	108	78.3%	89.6%

Table D-6. MY 2021 PCSP Assessment Findings: ARTC										
Item	**Total PCSP/ Items**	**Yes**	**Yes %**	**Baseline (2019) Yes %**	**No**	**No %**	**Baseline (2019) No %**	**NA***	**NA %**	**Baseline (2019) NA %**
3. Informed Consent	138	3	2.2%	1.3%	26	18.8%	10.0%	109	79.0%	88.8%
4. No Harm	138	4	2.9%	2.5%	25	18.1%	10.0%	109	79.0%	87.5%
Section III Total	**552**	**18**	**3.3%**	**1.4%**	**99**	**17.9%**	**10.0%**	**435**	**78.8%**	**88.6%**
Section IV: PCSP Timelines										
1. PCSP Review	138	95	68.8%	37.1%	30	21.7%	9.2%	13	9.4%	53.8%
2. Support	138	59	42.8%	98.8%	64	46.4%	0.8%	15	10.9%	0.4%
3. Interim Service Plan (ISP)	138	0	0.0%	2.5%	117	84.8%	85.0%	21	15.2%	12.5%
4. PCSP Timeline	138	47	34.1%	14.6%	90	65.2%	85.4%	1	0.7%	0.0%
5. PCSP Updates	138	92	66.7%	2.1%	29	21.0%	0.4%	17	12.3%	97.5%
Section IV Total	**690**	**293**	**42.5%**	**31.0%**	**330**	**47.8%**	**36.2%**	**67**	**9.7%**	**32.8%**
Section V: PASSE Agreement Requirements										
1 a. Health Diagnoses	138	131	94.9%	85.0%	7	5.1%	15.0%	0	0.0%	0.0%
1 b. Health Information: History	138	126	91.3%	83.8%	12	8.7%	16.3%	0	0.0%	0.0%
1 c. Health Information: Providers	138	96	69.6%	78.3%	42	30.4%	21.7%	0	0.0%	0.0%
1 d. Health Information: Legal Authority	138	132	95.7%	95.0%	6	4.3%	5.0%	0	0.0%	0.0%
1 e. Health Information: Advance Directive/Living Will	138	133	96.4%	47.1%	5	3.6%	52.9%	0	0.0%	0.0%
2. Necessary Services	138	42	30.4%	43.8%	95	68.8%	55.4%	1	0.7%	0.8%
3. Providers	138	85	61.6%	71.3%	52	37.7%	28.3%	1	0.7%	0.4%
4. Crisis Plan	138	127	92.0%	67.9%	11	8.0%	32.1%	0	0.0%	0.0%

Table D-6. MY 2021 PCSP Assessment Findings: ARTC										
Item	Total PCSP/ Items	Yes	Yes %	Baseline (2019) Yes %	No	No %	Baseline (2019) No %	NA*	NA %	Baseline (2019) NA %
Section V Total	**1,104**	**872**	**79.0%**	**71.5%**	**230**	**20.8%**	**28.3%**	**2**	**0.2%**	**0.2%**
Grand Total	**5,658**	**3,463**	**61.2%**	**65.0%**	**1553**	**27.4%**	**20.9%**	**642**	**11.3%**	**14.0%**

**New questions for this measurement period, so data was not reported in 2019*

Table D-7. MY 2021 PCSP Assessment Findings: Empower										
Item	Total PCSP/ Items	Yes	Yes %	Baseline (2019) Yes %	No	No %	Baseline (2019) No %	NA*	NA %	Baseline (2019) NA %
Section I: Review of the PCSP Process										
1. Individual Lead	41	41	100%	99.6%	0	0.0%	0.4%	0	0.0%	0.0%
2. Participants	41	40	97.6%	99.6%	1	2.4%	0.4%	0	0.0%	0.0%
3. Informed Choices	41	40	97.6%	97.9%	1	2.4%	2.1%	0	0.0%	0.0%
4. Timely PCSP	41	38	92.7%	54.6%	3	7.3%	45.0%	0	0.0%	0.4%
5. Cultural Considerations	41	39	95.1%	98.9%	2	4.9%	0.4%	0	0.0%	0.7%
6. Conflict of Interest	41	40	97.6%	98.6%	1	2.4%	1.1%	0	0.0%	0.4%
7. HCBS Providers	41	40	97.6%	98.6%	1	2.4%	0.4%	0	0.0%	1.1%
8. Informed Choice	41	41	100%	96.1%	0	0.0%	3.2%	0	0.0%	0.7%
9. Requested Updates	41	41	100%	97.5%	0	0.0%	2.5%	0	0.0%	0.0%
10. Alternative Settings	41	41	100%	77.5%	0	0.0%	9.6%	0	0.0%	12.9%
11. Medicaid and Waiver Dates	41	10	24.4%	*	27	65.9%	*	4	9.8%	*
12. Treatment Goals	41	35	85.4%	*	6	14.6%	*	0	0.0%	*
Section I Total	**492**	**446**	**90.7%**	**91.9%**	**42**	**8.5%**	**6.5%**	**4**	**0.8%**	**1.6%**

Table D-7. MY 2021 PCSP Assessment Findings: Empower										
Item	Total PCSP/ Items	Yes	Yes %	Baseline (2019) Yes %	No	No %	Baseline (2019) No %	NA*	NA %	Baseline (2019) NA %
Section II: PCSP Written Plan										
1. Residence Choice	41	38	92.7%	93.6%	3	7.3%	6.1%	0	0.0%	0.4%
2. Strengths and Preferences	41	41	100%	97.9%	0	0.0%	2.1%	0	0.0%	0.0%
3. Functional Needs Assessment	41	41	100%	97.1%	0	0.0%	2.9%	0	0.0%	0.0%
4. Goals	41	31	75.6%	98.6%	10	24.4%	1.4%	0	0.0%	0.0%
5. Natural Supports	41	39	95.1%	90.7%	2	4.9%	7.5%	0	0.0%	1.8%
6. Risk Factors	41	37	90.2%	76.1%	4	9.8%	20.0%	0	0.0%	3.9%
7. Understandable PCSP	41	41	100%	100.0%	0	0.0%	0.0%	0	0.0%	0.0%
8. Monitoring	41	41	100%	98.6%	0	0.0%	1.4%	0	0.0%	0.0%
9. Finalized PCSP	41	4	9.8%	11.1%	37	90.2%	88.9%	0	0.0%	0.0%
10. Distribution	41	5	12.2%	87.9%	36	87.8%	12.1%	0	0.0%	0.0%
11. Self-Direct	41	1	2.4%	90.4%	0	0.0%	0.4%	40	97.6%	9.3%
12. Unnecessary Services	41	41	100%	98.9%	0	0.0%	0.4%	0	0.0%	0.7%
Section II Total	**492**	**360**	**73.2%**	**86.7%**	**92**	**18.7%**	**11.9%**	**40**	**8.1%**	**1.3%**
Section III: Behavior Support Plan										
1. Collection and Review of Data	41	1	2.4%	0.7%	3	7.3%	8.2%	37	90.2%	91.1%
2. Time Limits	41	1	2.4%	1.1%	4	9.8%	8.9%	36	87.8%	90.0%
3. Informed Consent	41	0	0.0%	1.4%	4	9.8%	8.6%	37	90.2%	90.0%
4. No Harm	41	1	2.4%	0.7%	3	7.3%	8.9%	37	90.2%	90.4%
Section III Total	**164**	**3**	**1.8%**	**1.0%**	**14**	**8.5%**	**8.7%**	**147**	**89.6%**	**90.4%**

Table D-7. MY 2021 PCSP Assessment Findings: Empower										
Item	**Total PCSP/ Items**	**Yes**	**Yes %**	**Baseline (2019) Yes %**	**No**	**No %**	**Baseline (2019) No %**	**NA***	**NA %**	**Baseline (2019) NA %**
Section IV: PCSP Timelines										
1. PCSP Review	41	15	36.6%	37.1%	24	58.5%	4.3%	2	4.9%	58.6%
2. Support	41	9	22.0%	99.3%	24	58.5%	0.7%	8	19.5%	0.0%
3. Interim Service Plan (ISP)	41	0	0.0%	0.4%	32	78.0%	89.6%	9	22.0%	10.0%
4. PCSP Timeline	41	10	24.4%	36.4%	31	75.6%	62.9%	0	0.0%	0.7%
5. PCSP Updates	41	16	39.0%	1.8%	23	56.1%	0.4%	2	4.9%	97.9%
Section IV Total	**205**	**50**	**24.4%**	**35.0%**	**134**	**65.4%**	**31.6%**	**21**	**10.2%**	**33.4%**
Section V: PASSE Agreement Requirements										
1 a. Health Diagnoses	41	41	100%	93.9%	0	0.0%	6.1%	0	0.0%	0.0%
1 b. Health Information: History	41	40	97.6%	96.8%	1	2.4%	3.2%	0	0.0%	0.0%
1 c. Health Information: Providers	41	39	95.1%	97.5%	2	4.9%	2.5%	0	0.0%	0.0%
1 d. Health Information: Legal Authority	41	41	100%	98.2%	0	0.0%	1.8%	0	0.0%	0.0%
1 e. Health Information: Advance Directive/Living Will	41	21	51.2%	78.9%	20	48.8%	21.1%	0	0.0%	0.0%
2. Necessary Services	41	14	34.1%	61.8%	27	65.9%	37.9%	0	0.0%	0.4%
3. Providers	41	39	95.1%	95.7%	2	4.9%	4.3%	0	0.0%	0.0%
4. Crisis Plan	41	39	95.1%	95.0%	2	4.9%	5.0%	0	0.0%	0.0%
Section V Total	**328**	**274**	**83.5%**	**89.7%**	**54**	**16.5%**	**10.2%**	**0**	**0.0%**	**0.0%**
Grand Total	**1,681**	**1,133**	**67.4%**	**73.2%**	**336**	**20.0%**	**12.4%**	**212**	**12.6%**	**14.4%**

**New questions for this measurement period, so data was not reported in 2019*

Table D-8. MY 2021 PCSP Assessment Findings: Summit										
Item	Total PCSP/ Items	Yes	Yes %	Baseline (2019) Yes %	No	No %	Baseline (2019) No %	NA*	NA %	Baseline (2019) NA %
Section I: Review of the PCSP Process										
1. Individual Lead	143	142	99.3%	91.5%	1	0.7%	8.5%	0	0.0%	0.0%
2. Participants	143	63	44.1%	90.8%	80	55.9%	9.2%	0	0.0%	0.0%
3. Informed Choices	143	142	99.3%	86.7%	1	0.7%	13.3%	0	0.0%	0.0%
4. Timely PCSP	143	49	34.3%	37.1%	94	65.7%	62.2%	0	0.0%	0.7%
5. Cultural Considerations	143	138	96.5%	69.7%	5	3.5%	29.6%	0	0.0%	0.7%
6. Conflict of Interest	143	142	99.3%	96.6%	1	0.7%	3.4%	0	0.0%	0.0%
7. HCBS Providers	143	141	98.6%	94.6%	2	1.4%	2.7%	0	0.0%	2.7%
8. Informed Choice	143	142	99.3%	84.4%	1	0.7%	15.6%	0	0.0%	0.0%
9. Requested Updates	143	81	56.6%	61.2%	62	43.4%	38.8%	0	0.0%	0.0%
10. Alternative Settings	143	126	88.1%	66.3%	17	11.9%	15.0%	0	0.0%	18.7%
11. Medicaid and Waiver Dates	143	20	14.0%	*	97	67.8%	*	26	18.2%	*
12. Treatment Goals	143	118	82.5%	*	25	17.5%	*	0	0.0%	*
Section I Total	**1,716**	**1,304**	**76.0%**	**77.9%**	**386**	**22.5%**	**19.8%**	**26**	**1.5%**	**2.3%**
Section II: PCSP Written Plan										
1. Residence Choice	143	121	84.6%	85.0%	22	15.4%	14.6%	0	0.0%	0.3%
2. Strengths and Preferences	143	133	93.0%	89.8%	10	7.0%	10.2%	0	0.0%	0.0%
3. Functional Needs Assessment	143	142	99.3%	86.1%	1	0.7%	13.9%	0	0.0%	0.0%
4. Goals	143	133	93.0%	85.7%	10	7.0%	14.3%	0	0.0%	0.0%
5. Natural Supports	143	121	84.6%	82.3%	22	15.4%	9.2%	0	0.0%	8.5%

Table D-8. MY 2021 PCSP Assessment Findings: Summit										
Item	Total PCSP/ Items	Yes	Yes %	Baseline (2019) Yes %	No	No %	Baseline (2019) No %	NA*	NA %	Baseline (2019) NA %
6. Risk Factors	143	121	84.6%	58.2%	21	14.7%	41.2%	1	0.7%	0.7%
7. Understandable PCSP	143	143	100%	93.9%	0	0.0%	6.1%	0	0.0%	0.0%
8. Monitoring	143	141	98.6%	99.0%	2	1.4%	1.0%	0	0.0%	0.0%
9. Finalized PCSP	143	7	4.9%	3.1%	136	95.1%	96.9%	0	0.0%	0.0%
10. Distribution	143	72	50.3%	48.3%	71	49.7%	51.7%	0	0.0%	0.0%
11. Self-Direct	143	29	20.3%	94.2%	0	0.0%	4.1%	114	79.7%	1.7%
12. Unnecessary Services	143	143	100%	97.3%	0	0.0%	2.0%	0	0.0%	0.7%
Section II Total	**1,716**	**1,306**	**76.1%**	**76.9%**	**295**	**17.2%**	**22.1%**	**115**	**6.7%**	**1.0%**
Section III: Behavior Support Plan										
1. Collection and Review of Data	143	9	6.3%	2.4%	28	19.6%	15.6%	106	74.1%	82.0%
2. Time Limits	143	10	7.0%	3.7%	28	19.6%	15.6%	105	73.4%	80.6%
3. Informed Consent	143	2	1.4%	3.4%	37	25.9%	15.3%	104	72.7%	81.3%
4. No Harm	143	5	3.5%	2.0%	34	23.8%	17.0%	104	72.7%	81.0%
Section III Total	**572**	**26**	**4.5%**	**2.9%**	**127**	**22.2%**	**15.9%**	**419**	**73.3%**	**81.2%**
Section IV: PCSP Timelines										
1. PCSP Review	143	26	18.2%	37.4%	105	73.4%	12.2%	12	8.4%	50.3%
2. Support	143	68	47.6%	90.1%	40	28.0%	9.2%	35	24.5%	0.7%
3. Interim Service Plan (ISP)	143	1	0.7%	3.1%	101	70.6%	92.5%	41	28.7%	4.4%
4. PCSP Timeline	143	15	10.5%	16.3%	128	89.5%	82.7%	0	0.0%	1.0%
5. PCSP Updates	143	15	10.5%	1.0%	112	78.3%	1.4%	16	11.2%	97.6%
Section IV Total	**715**	**125**	**17.5%**	**29.6%**	**486**	**68.0%**	**39.6%**	**104**	**14.5%**	**30.8%**

Table D-8. MY 2021 PCSP Assessment Findings: Summit										
Item	**Total PCSP/ Items**	**Yes**	**Yes %**	**Baseline (2019) Yes %**	**No**	**No %**	**Baseline (2019) No %**	**NA***	**NA %**	**Baseline (2019) NA %**
Section V: PASSE Agreement Requirements										
1 a. Health Diagnoses	143	118	82.5%	56.8%	25	17.5%	43.2%	0	0.0%	0.0%
1 b. Health Information: History	143	128	89.5%	71.4%	15	10.5%	28.6%	0	0.0%	0.0%
1 c. Health Information: Providers	143	131	91.6%	93.2%	12	8.4%	6.8%	0	0.0%	0.0%
1 d. Health Information: Legal Authority	143	138	96.5%	94.9%	5	3.5%	5.1%	0	0.0%	0.0%
1 e. Health Information: Advance Directive/Living Will	143	140	97.9%	93.5%	3	2.1%	6.5%	0	0.0%	0.0%
2. Necessary Services	143	66	46.2%	54.4%	77	53.8%	44.9%	0	0.0%	0.7%
3. Providers	143	115	80.4%	87.8%	28	19.6%	12.2%	0	0.0%	0.0%
4. Crisis Plan	143	137	95.8%	86.1%	6	4.2%	13.9%	0	0.0%	0.0%
Section V Total	**1,144**	**973**	**85.1%**	**79.8%**	**171**	**14.9%**	**20.2%**	**0**	**0.0%**	**0.1%**
Grand Total	**5,863**	**3,734**	**63.7%**	**64.1%**	**1465**	**25.0%**	**22.7%**	**664**	**11.3%**	**13.2%**

**New questions for this measurement period, so data was not reported in 2019*

PCSP Validation

Tables D-9 through **D-11** present the findings from Qsource calculations for Section 1.

Table D-9. MY 2020 PCSP Validation Findings Section 1: ARTC

Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section I: Review of the PCSP Process						
1. Individual Lead	7	-0.25%	-2	-0.26%	0	0.00%
2. Participants	7	-0.26%	-2	-0.26%	0	0.00%
3. Informed Choices	6	-0.24%	-2	-0.24%	0	0.00%
4. Timely PCSP	6	-0.17%	-1	-0.04%	-1	-0.13%
5. Cultural Considerations	3	-0.13%	-1	-0.13%	0	0.01%
6. Conflict of Interest	2	-0.26%	-2	-0.26%	0	0.00%
7. HCBS Providers	3	-0.12%	-1	-0.12%	0	0.00%
8. Informed Choice	3	-0.08%	-1	-0.11%	0	0.03%
9. Requested Updates	2	-0.26%	-2	-0.26%	0	0.01%
10. Alternative Settings	2	-0.25%	-2	-0.25%	0	0.00%
11. Medicaid and Waiver Dates	1	-0.12%	-3	-0.18%	0	0.05%
12. Treatment Goals	2	-0.16%	-2	-0.21%	0	0.04%

Table D-10. MY 2020 PCSP Validation Findings Section 1: Empower

Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section I: Review of the PCSP Process						
1. Individual Lead	2	0.00	1	0.00	1	0.00
2. Participants	2	0.00	1	0.00	1	0.00

Table D-10. MY 2020 PCSP Validation Findings Section 1: Empower						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
3. Informed Choices	2	0.00	1	0.00	1	0.00
4. Timely PCSP	1	0.00	2	0.00	1	0.00
5. Cultural Considerations	2	0.00	1	0.00	1	0.00
6. Conflict of Interest	2	0.00	1	0.00	1	0.00
7. HCBS Providers	1	0.00	2	0.00	1	0.00
8. Informed Choice	1	0.00	0	0.00	1	0.00
9. Requested Updates	1	0.00	2	0.00	1	0.00
10. Alternative Settings	1	0.00	1	0.00	0	0.00
11. Medicaid and Waiver Dates	2	0.00	1	0.00	1	0.00
12. Treatment Goals	2	0.00	1	0.00	1	0.00

Table D-11. MY 2020 PCSP Validation Findings Section 1: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section I: Review of the PCSP Process						
1. Individual Lead	5	-0.37%	-4	-0.37%	0	0.00%
2. Participants	5	-0.36%	-4	-0.36%	0	0.00%
3. Informed Choices	5	-0.36%	-4	-0.36%	0	0.00%
4. Timely PCSP	3	-0.46%	-6	-0.46%	0	0.00%
5. Cultural Considerations	2	-0.38%	-4	-0.38%	0	0.00%
6. Conflict of Interest	1	-0.37%	-4	-0.37%	0	0.00%
7. HCBS Providers	2	-0.28%	-3	-0.29%	0	0.01%
8. Informed Choice	2	-0.16%	-2	-0.17%	0	0.00%

Table D-11. MY 2020 PCSP Validation Findings Section 1: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
9. Requested Updates	2	-0.25%	-3	-0.25%	0	0.00%
10. Alternative Settings	1	-0.28%	-3	-0.28%	0	0.00%
11. Medicaid and Waiver Dates	5	-0.37%	-4	-0.37%	0	0.00%
12. Treatment Goals	5	-0.36%	-4	-0.36%	0	0.00%

Tables D-12 through **D-14** present the findings from Qsource calculations for Section 2.

Table D-12. MY 2020 PCSP Validation Findings Section 2: ARTC						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section II: PCSP Written Plan						
1. Residence Choice	3	-0.12%	1	0.13%	0	-0.01%
2. Strengths and Preferences	2	-0.25%	2	0.26%	0	-0.01%
3. Functional Needs Assessment	3	-0.11%	1	0.11%	0	0.00%
4. Goals	2	-0.22%	2	0.22%	0	0.00%
5. Natural Supports	2	-0.19%	2	0.24%	0	-0.04%
6. Risk Factors	2	-0.16%	2	0.19%	0	-0.03%
7. Understandable PCSP	3	-0.14%	1	0.13%	0	0.00%
8. Monitoring	3	-0.12%	1	0.13%	0	0.00%
9. Finalized PCSP	2	-0.19%	2	0.19%	0	0.00%
10. Distribution	2	-0.22%	2	0.23%	0	0.00%
11. Self-Direct	1	-0.17%	0	-0.02%	3	0.20%
12. Unnecessary Services	3	-0.12%	1	0.12%	0	-0.01%

Table D-13. MY 2020 PCSP Validation Findings Section 2: Empower						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section II: PCSP Written Plan						
1. Residence Choice	0	-0.25%	2	0.17%	1	0.09%
2. Strengths and Preferences	0	-0.25%	2	0.17%	1	0.08%
3. Functional Needs Assessment	0	-0.16%	1	0.08%	1	0.08%
4. Goals	0	0.00%	-1	-0.08%	1	0.08%
5. Natural Supports	0	-0.07%	0	-0.01%	1	0.08%
6. Risk Factors	0	0.21%	-4	-0.30%	1	0.09%
7. Understandable PCSP	0	-0.25%	2	0.17%	1	0.09%
8. Monitoring	1	-0.17%	1	0.08%	1	0.09%
9. Finalized PCSP	0	0.13%	-3	-0.21%	1	0.08%
10. Distribution	0	0.29%	-6	-0.38%	1	0.08%
11. Self-Direct	0	0.67%	2	0.19%	-15	-0.86%
12. Unnecessary Services	0	-0.25%	2	0.16%	1	0.08%

Table D-14. MY 2020 PCSP Validation Findings Section 2: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section II: PCSP Written Plan						
1. Residence Choice	2	-0.17%	2	0.17%	0	0.00%
2. Strengths and Preferences	2	-0.18%	2	0.18%	0	0.00%
3. Functional Needs	1	-0.28%	3	0.28%	0	0.00%

Table D-14. MY 2020 PCSP Validation Findings Section 2: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Assessment						
4. Goals	1	-0.25%	3	0.25%	0	0.00%
5. Natural Supports	1	-0.24%	3	0.27%	0	-0.02%
6. Risk Factors	2	-0.12%	2	0.12%	0	0.00%
7. Understandable PCSP	2	-0.19%	2	0.19%	0	0.00%
8. Monitoring	2	-0.19%	2	0.19%	0	0.00%
9. Finalized PCSP	0	-0.21%	4	0.21%	0	0.00%
10. Distribution	0	-0.19%	4	0.19%	0	0.00%
11. Self-Direct	0	-0.23%	1	0.08%	3	0.15%
12. Unnecessary Services	2	-0.19%	2	0.19%	0	0.00%

Tables D-15 through **D-17** present the findings from Qsource calculations for Section 3.

Table D-15. MY 2020 PCSP Validation Findings Section 3: ARTC						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section III: Behavior Support Plan						
1. Collection and Review of Data	1	-0.24%	0.00%	-0.02%	1	-0.24%
2. Time Limits	1	-0.25%	0.00%	-0.01%	1	-0.25%
3. Informed Consent	1	-0.22%	0.00%	-0.06%	1	-0.22%
4. No Harm	1	-0.26%	0.00%	-0.01%	1	-0.26%

Table D-16. MY 2020 PCSP Validation Findings Section 3: Empower						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section III: Behavior Support Plan						
1. Collection and Review of Data	0	0.41%	2	0.18%	-10	-0.59%
2. Time Limits	0	0.41%	2	0.18%	-10	-0.59%
3. Informed Consent	0	0.45%	-1	0.05%	-10	-0.50%
4. No Harm	0	0.42%	2	0.18%	-10	-0.59%

Table D-17. MY 2020 PCSP Validation Findings Section 3: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section III: Behavior Support Plan						
1. Collection and Review of Data	0	-0.26%	0.06%	400	0.20%	0.06%
2. Time Limits	0	-0.26%	0.16%	399	0.10%	0.16%
3. Informed Consent	0	-0.21%	0.10%	385	0.11%	0.10%
4. No Harm	1	-0.19%	0.08%	391	0.11%	0.08%

Tables D-18 through **D-20** present the findings from Qsource calculations for Section 4.

Table D-18. MY 2020 PCSP Validation Findings Section 4: ARTC						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section IV: PCSP Timelines						
1. PCSP Review	3	-0.09%	1	0.08%	0	0.00%
2. Support	0	-0.20%	1	0.03%	3	0.17%
3. Interim Service Plan (ISP)	0	-0.20%	1	0.03%	3	0.17%

Table D-18. MY 2020 PCSP Validation Findings Section 4: ARTC						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
4. PCSP Timeline	0	-0.19%	1	0.02%	3	0.16%
5. PCSP Updates	3	-0.10%	1	0.12%	0	-0.02%

Table D-19. MY 2020 PCSP Validation Findings Section 4: Empower						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section IV: PCSP Timelines						
1. PCSP Review	0	0.07%	-2	-0.15%	1	0.08%
2. Support	0	0.70%	-3	0.04%	-18	-0.75%
3. Interim Service Plan (ISP)	0	0.67%	-2	0.12%	-18	-0.78%
4. PCSP Timeline	0	0.68%	-4	0.04%	-18	-0.71%
5. PCSP Updates	0	-0.16%	2	0.17%	0	0.00%

Table D-20. MY 2020 PCSP Validation Findings Section 4: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section IV: PCSP Timelines						
1. PCSP Review	2	-0.21%	2	0.11%	1	0.10%
2. Support	0	-0.16%	3	0.18%	2	-0.03%
3. Interim Service Plan (ISP)	0	-0.16%	3	0.19%	2	-0.03%
4. PCSP Timeline	0	-0.14%	3	0.16%	2	-0.03%
5. PCSP Updates	1	-0.37%	3	0.28%	1	0.09%

Tables D-21 through D-23 present the findings from Qsource calculations for Section 5.

Table D-21. MY 2020 PCSP Validation Findings Section 5: ARTC

Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section V: PASSE Agreement Requirements						
1 a. Health Diagnoses	2	-0.39%	3	0.39%	0	0.00%
1 b. Health Information: History	2	-0.36%	3	0.37%	0	0.00%
1 c. Health Information: Providers	2	-0.38%	3	0.38%	0	0.00%
1 d. Health Information: Legal Authority	2	-0.35%	2	0.23%	1	0.12%
1 e. Health Information: Advance Directive/Living Will	1	-0.14%	2	0.18%	2	-0.04%
2. Necessary Services	2	-0.36%	3	0.36%	0	0.00%
3. Providers	2	-0.38%	3	0.38%	0	0.00%
4. Crisis Plan	1	-0.35%	4	0.35%	0	0.00%

Table D-22. MY 2020 PCSP Validation Findings Section 5: Empower

Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section V: PASSE Agreement Requirements						
1 a. Health Diagnoses	0	-0.08%	0	0.00%	1	0.08%
1 b. Health Information: History	0	0.07%	0	0.00%	-44	-0.08%
1 c. Health Information: Providers	0	-0.17%	1	0.08%	14	0.08%
1 d. Health Information: Legal Authority	1	0.01%	-1	-0.09%	468	0.08%

Table D-22. MY 2020 PCSP Validation Findings Section 5: Empower						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
1 e. Health Information: Advance Directive/Living Will	0	0.45%	-4	-0.19%	-491	-0.26%
2. Necessary Services	0	-0.08%	1	0.08%	0	0.00%
3. Providers	0	-0.17%	2	0.17%	0	0.00%
4. Crisis Plan	0	0.20%	-3	-0.20%	0	0.00%

Table D-23. MY 2020 PCSP Validation Findings Section 5: Summit						
Item	"Yes" Difference	"Yes" % Difference	"No" Difference	"No" % Difference	"NA" Difference	"NA" % Difference
Section V: PASSE Agreement Requirements						
1 a. Health Diagnoses	2	-0.37%	4	0.27%	1	0.10%
1 b. Health Information: History	2	-0.45%	4	0.35%	1	0.10%
1 c. Health Information: Providers	1	-0.58%	5	0.47%	1	0.10%
1 d. Health Information: Legal Authority	3	-0.27%	3	0.19%	1	0.09%
1 e. Health Information: Advance Directive/Living Will	1	-0.18%	3	0.08%	3	0.11%
2. Necessary Services	1	-0.45%	5	0.45%	0	0.00%
3. Providers	1	-0.47%	5	0.47%	0	0.00%
4. Crisis Plan	0	-0.37%	6	0.37%	0	0.00%

APPENDIX E | Protocol 5: EDV Findings

Completeness rates for each encounter were calculated as the number of data fields with data present, and validity rates were calculated as the number of valid data points as a percentage of those with data present. These completeness and validity rates for encounter lines are detailed in **Tables E-1 – E-9**. Completeness and validity rates less than 95.0% appear in **red**.

ARTC

Table E-1. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by ARTC to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
Distinct Encounter Lines N=181,258						
SENDER_ID_CODE	181,258	100%	100%	181,258	100%	100%
RECIPIENT_ID	181,258	100%	100%	181,258	100%	100%
CLAIM_NUMB	181,258	100%	100%	181,258	100%	100%
DATE_BEGIN_SERVICE_DETAIL	181,258	100%	100%	181,258	100%	100%
DATE_END_SERVICE_DETAIL	181,258	100%	100%	181,258	100%	100%
DIAG_CODE	181,258	100%	100%	181,258	100%	100%
PROC_CODE	97,247	**	**	97,247	100%	100%
REVENUE_CODE	181,258	100%	100%	181,258	100%	100%
NUMB_DAYS_COVERED	181,258	100%	100%	181,258	100%	100%
CATGY_OF_SERVICE	181,258	100%	100%	181,258	100%	100%
TOTAL		**100%**	**98.0%**		**100%**	**100%**
Distinct Encounters N=77,465						
DATE_BILLED	77,465	100%	100%	77,465	100%	100%
DATE_CLAIM_STATUS	77,465	100%	100%	77,465	100%	100%
DATE_PAID	77,465	100%	100%	77,465	100%	100%

Table E-1. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by ARTC to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
DATE_BEGIN_SERVICE_HEADER	77,465	100%	100%	77,465	100%	100%
DATE_END_SERVICE_HEADER	77,465	100%	100%	77,465	100%	100%
ATTENDING_PROVIDER_NPI††	77,415	100%†	100%†	77,415	100%	100%
BILLING_PROVIDER_TYPE	77,368	99.9%	100%†	77,368	100%	100%
BILLING_PROVIDER_NPI	77,368	99.9%	100%†	77,368	100%	100%
BILLING_PROVIDER_ID	77,368	99.9%	100%†	77,368	100%	100%
BILLING_PROVIDER_SPECIALTY	77,368	99.9%	100%†	77,368	100%	100%
DATE_ADMISSION	77,465	100%	100%	77,465	100%	100%
FACILITY_ID	77,368	99.9%	100%†	77,368	100%	100%
TOTAL		**99.9%**	**100%†**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%
*** Situational. Required on inpatient claims when a procedure was performed, thus, no results*
†† Replaced performing provider with attending provider for institutional encounters only

For this measurement year, Qsource analyzed the attending provider field instead of the performing provider field. Optum Analytics advised Qsource this was a more appropriate measure of accuracy and validity for institutional encounters. Qsource adjusted the baseline results accordingly for accurate comparison.

Table E-2. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by ARTC to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
Distinct Encounter Lines N=1,175,688						
SENDER_ID_CODE	1,175,688	100%	100%	1,175,688	100%	100%
RECIPIENT_ID	1,175,688	100%	100%	1,175,688	100%	100%
CLAIM_NUMB	1,175,688	100%	100%	1,175,688	100%	100%

Table E-2. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by ARTC to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
DATE_BEGIN_SERVICE_DETAIL	1,175,688	100%	100%	1,175,688	100%	100%
DATE_END_SERVICE_DETAIL	1,175,688	100%	100%	1,175,688	100%	100%
DIAG_CODE	1,175,593	100%†	100%†	1,175,593	100%	100%
PROC_CODE	1,175,670	100%†	100%†	1,175,670	100%	100%
CATGY_OF_SERVICE	1,175,688	100%	100%	1,175,688	100%	100%
PLACE_OF_SERVICE	1,175,688	100%	100%	1,175,687	100%†	100%†
TOTAL		**100%†**	**100%†**		**100%†**	**100%†**
Distinct Encounters N=940,413						
DATE_BILLED	940,413	100%	100%	940,413	100%	100%
DATE_CLAIM_STATUS	940,413	100%	100%	940,413	100%	100%
DATE_PAID	940,413	100%	100%	940,413	100%	100%
DATE_BEGIN_SERVICE_HEADER	940,413	100%	100%	940,413	100%	100%
DATE_END_SERVICE_HEADER	940,413	100%	100%	940,413	100%	100%
PERFORMING_PROVIDER_NPI	730,452	77.7%	82.5%	730,452	100%	100%
PERFORMING_PROVIDER_ID	920,784	97.9%	99.4%	920,784	100%	100%
PERFORMING_PROVIDER_SPECIALTY	920,771	97.9%	99.4%	920,771	100%	100%
BILLING_PROVIDER_TYPE	939,307	99.9%	100%†	939,307	100%	100%
BILLING_PROVIDER_NPI	759,627	80.8%	85.6%	759,627	100%	100%
BILLING_PROVIDER_ID	939,307	99.9%	100%†	939,307	100%	100%
BILLING_PROVIDER_SPECIALTY	939,307	99.9%	100%†	939,307	100%	100%
TOTAL		**96.2%**	**92.7%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%

Table E-3. Completeness and Validity Rates—Pharmacy Encounter Lines and Encounters Submitted by ARTC to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=316,782						
SENDER_ID_CODE	316,782	100%	100%	316,782	100%	100%
RECIPIENT_ID	316,782	100%	100%	316,782	100%	100%
CLAIM_NUMB	316,782	100%	100%	316,782	100%	100%
CATGY_OF_SERVICE	316,782	100%	100%	316,782	100%	100%
NDC_CODE	316,782	100%	100%	316,782	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%†**
Distinct Encounters N=316,011						
DATE_BILLED	316,011	100%	100%	316,011	100%	100%
DATE_PAID	316,011	100%	100%	316,011	100%	100%
DATE_BEGIN_SERVICE_HEADER	316,011	100%	100%	316,011	100%	100%
DATE_END_SERVICE_HEADER	316,011	100%	100%	316,011	100%	100%
DAYS_SUPPLY	316,011	100%	100%	316,011	100%	100%
BILLING_PROVIDER_TYPE	316,011	100%	100%	316,011	100%	100%
BILLING_PROVIDER_NPI	316,011	100%	100%	316,011	100%	100%
BILLING_PROVIDER_ID	316,011	100%	100%	316,011	100%	100%
BILLING_PROVIDER_SPECIALTY	316,011	100%	100%	316,011	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*

Empower

Table E-4. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by Empower to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
Distinct Encounter Lines N=222,244						
SENDER_ID_CODE	222,244	100%	100%	222,244	100%	100%
RECIPIENT_ID	221,747	99.8%	100%	221,747	100%	100%
CLAIM_NUMB	222,244	100%	100%	222,244	100%	100%
DATE_BEGIN_SERVICE_DETAIL	222,244	100%	100%	222,244	100%	100%
DATE_END_SERVICE_DETAIL	222,244	100%	100%	222,244	100%	100%
DIAG_CODE	222,244	100%	100%	222,244	100%	100%
PROC_CODE	141,453	**	**	141,453	100%	100%
REVENUE_CODE	222,244	100%	100%	222,244	100%	100%
NUMB_DAYS_COVERED	222,244	100%	100%	222,244	100%	100%
CATGY_OF_SERVICE	222,244	100%	100%	222,244	100%	100%
TOTAL		**100%†**	**100%**		**100%**	**100%**
Distinct Encounters N=88,512						
DATE_BILLED	88,512	100%	100%	88,512	100%	100%
DATE_CLAIM_STATUS	88,512	100%	100%	88,512	100%	100%
DATE_PAID	88,512	100%	100%	88,512	100%	100%
DATE_BEGIN_SERVICE_HEADER	88,512	100%	100%	88,512	100%	100%
DATE_END_SERVICE_HEADER	88,512	100%	100%	88,512	100%	100%
ATTENDING_PROVIDER_NPI††	85,513	96.6%	94.6%	85,513	100%	100%
BILLING_PROVIDER_TYPE	88,312	99.8%	100%†	88,312	100%	100%
BILLING_PROVIDER_NPI	88,312	99.8%	100%†	88,312	100%	100%
BILLING_PROVIDER_ID	88,312	99.8%	100%†	88,312	100%	100%

Table E-4. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by Empower to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
BILLING_PROVIDER_SPECIALTY	88,312	99.8%	100%†	88,312	100%	100%
DATE_ADMISSION	88,512	100%	100%	88,512	100%	100%
FACILITY_ID	88,355	99.8%	100%	88,355	100%	100%
TOTAL		**99.6%**	**99.5%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%
*** Situational. Required on inpatient claims when a procedure was performed, thus, no results*
†† Replaced performing provider with attending provider for institutional encounters only

For this measurement year, Qsource analyzed the attending provider field instead of the performing provider field. Optum Analytics advised Qsource this was a more appropriate measure of accuracy and validity for institutional encounters. Qsource adjusted the baseline results accordingly for accurate comparison.

Table E-5. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by Empower to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=2,082,688						
SENDER_ID_CODE	2,082,688	100%	100%	2,082,688	100%	100%
RECIPIENT_ID	2,081,063	99.9%	100%†	2,081,063	100%	100%
CLAIM_NUMB	2,082,688	100%	100%	2,082,688	100%	100%
DATE_BEGIN_SERVICE_DETAIL	2,082,688	100%	100%	2,082,688	100%	100%
DATE_END_SERVICE_DETAIL	2,082,688	100%	100%	2,082,688	100%	100%
DIAG_CODE	2,082,551	100%†	100%†	2,082,551	100%	100%
PROC_CODE	2,082,586	100%†	100%†	2,082,586	100%	100%
CATGY_OF_SERVICE	2,082,688	100%	100%	2,082,688	100%	100%
PLACE_OF_SERVICE	2,082,688	100%	100%	2,082,688	100%	100%

Table E-5. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by Empower to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
TOTAL		**100%†**	**100%†**		**100%**	**100%**
Distinct Encounters N=1,644,658						
DATE_BILLED	1,644,658	100%	100%	1,644,658	100%	100%
DATE_CLAIM_STATUS	1,644,658	100%	100%	1,644,658	100%	100%
DATE_PAID	1,644,658	100%	100%	1,644,658	100%	100%
DATE_BEGIN_SERVICE_HEADER	1,644,658	100%	100%	1,644,658	100%	100%
DATE_END_SERVICE_HEADER	1,644,658	100%	100%	1,644,658	100%	100%
PERFORMING_PROVIDER_NPI	1,226,606	74.6%	69.7%	1,226,606	100%	100%
PERFORMING_PROVIDER_ID	1,538,794	93.6%	82.0%	1,538,794	100%	100%
PERFORMING_PROVIDER_SPECIALTY	1,538,794	93.6%	82.0%	1,538,794	100%	100%
BILLING_PROVIDER_TYPE	1,629,745	99.1%	99.7%	1,629,745	100%	100%
BILLING_PROVIDER_NPI	1,347,703	81.9%	89.9%	1,347,703	100%	100%
BILLING_PROVIDER_ID	1,629,745	99.1%	99.7%	1,629,745	100%	100%
BILLING_PROVIDER_SPECIALTY	1,629,745	99.1%	99.7%	1,629,745	100%	100%
TOTAL		**95.1%**	**93.6%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%

Table E-6. Completeness and Validity Rates—Pharmacy Encounter Lines and Encounters Submitted by Empower to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=465,804						
SENDER_ID_CODE	465,804	100%	100%	465,804	100%	100%
RECIPIENT_ID	465,804	100%	100%	465,804	100%	100%
CLAIM_NUMB	465,804	100%	100%	465,804	100%	100%
CATGY_OF_SERVICE	465,804	100%	100%	465,804	100%	100%
NDC_CODE	465,804	100%	100%	465,804	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%†**
Distinct Encounters N=464,667						
DATE_BILLED	464,667	100%	100%	464,667	100%	100%
DATE_PAID	464,667	100%	100%	464,667	100%	100%
DATE_BEGIN_SERVICE_HEADER	464,667	100%	100%	464,667	100%	100%
DATE_END_SERVICE_HEADER	464,667	100%	100%	464,667	100%	100%
DAYS_SUPPLY	464,667	100%	100%	464,667	100%	100%
BILLING_PROVIDER_TYPE	464,667	100%	100%	464,667	100%	100%
BILLING_PROVIDER_NPI	464,667	100%	100%	464,667	100%	100%
BILLING_PROVIDER_ID	464,667	100%	100%	464,667	100%	100%
BILLING_PROVIDER_SPECIALTY	464,667	100%	100%	464,667	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*

Summit

Table E-7. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by Summit to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
Distinct Encounter Lines N=223,954						
SENDER_ID_CODE	223,954	100%	100%	223,954	100%	100%
RECIPIENT_ID	223,954	100%	100%	223,954	100%	100%
CLAIM_NUMB	223,954	100%	100%	223,954	100%	100%
DATE_BEGIN_SERVICE_DETAIL	223,954	100%	100%	223,954	100%	100%
DATE_END_SERVICE_DETAIL	223,954	100%	100%	223,954	100%	100%
DIAG_CODE	223,954	100%	100%	223,954	100%	100%
PROC_CODE	146,123	**	**	146,123	100%	100%
REVENUE_CODE	223,954	100%	100%	223,954	100%	100%
NUMB_DAYS_COVERED	223,954	100%	100%	223,954	100%	100%
CATGY_OF_SERVICE	223,954	100%	100%	223,954	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%**
Distinct Encounters N=69,447						
DATE_BILLED	69,447	100%	100%	69,447	100%	100%
DATE_CLAIM_STATUS	69,447	100%	100%	69,447	100%	100%
DATE_PAID	69,447	100%	100%	69,447	100%	100%
DATE_BEGIN_SERVICE_HEADER	69,447	100%	100%	69,447	100%	100%
DATE_END_SERVICE_HEADER	69,447	100%	100%	69,447	100%	100%
ATTENDING_PROVIDER_NPI††	69,315	99.8%	99.9%	69,315	100%	100%
BILLING_PROVIDER_TYPE	69,430	100%†	100%	69,430	100%	100%
BILLING_PROVIDER_NPI	69,430	100%†	100%	69,430	100%	100%
BILLING_PROVIDER_ID	69,430	100%†	100%	69,430	100%	100%

Table E-7. Completeness and Validity Rates—Institutional Encounter Lines and Encounters Submitted by Summit to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
BILLING_PROVIDER_SPECIALTY	69,430	100%†	100%	69,430	100%	100%
DATE_ADMISSION	69,447	100%	100%	69,447	100%	100%
FACILITY_ID	69,430	100%†	100%	69,430	100%	100%
TOTAL		**100%†**	**100%†**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%
*** Situational. Required on inpatient claims when a procedure was performed, thus, no results*
†† Replaced performing provider with attending provider for institutional encounters only

For this measurement year, Qsource analyzed the attending provider field instead of the performing provider field. Optum Analytics advised Qsource this was a more appropriate measure of accuracy and validity for institutional encounters.

Table E-8. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by Summit to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=2,353,766						
SENDER_ID_CODE	2,353,766	100%	100%	2,353,766	100%	100%
RECIPIENT_ID	2,353,766	100%	100%	2,353,766	100%	100%
CLAIM_NUMB	2,353,766	100%	100%	2,353,766	100%	100%
DATE_BEGIN_SERVICE_DETAIL	2,353,766	100%	100%	2,353,766	100%	100%
DATE_END_SERVICE_DETAIL	2,353,766	100%	100%	2,353,766	100%	100%
DIAG_CODE	2,353,543	100%†	100%†	2,353,543	100%	100%
PROC_CODE	2,353,643	100%†	100%	2,353,643	100%	100%
CATGY_OF_SERVICE	2,353,766	100%	100%	2,353,766	100%	100%
PLACE_OF_SERVICE	2,353,766	100%	100%	2,353,766	100%	100%
TOTAL		**100%†**	**100%†**		**100%**	**100%**

Table E-8. Completeness and Validity Rates—Professional Encounter Lines and Encounters Submitted by Summit to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounters N=1,702,586						
DATE_BILLED	1,702,586	100%	100%	1,702,586	100%	100%
DATE_CLAIM_STATUS	1,702,586	100%	100%	1,702,586	100%	100%
DATE_PAID	1,702,586	100%	100%	1,702,586	100%	100%
DATE_BEGIN_SERVICE_HEADER	1,702,586	100%	100%	1,702,586	100%	100%
DATE_END_SERVICE_HEADER	1,702,586	100%	100%	1,702,586	100%	100%
PERFORMING_PROVIDER_NPI	1,237,060	72.7%	73.2%	1,237,060	100%	100%
PERFORMING_PROVIDER_ID	1,643,539	96.5%	92.5%	1,643,539	100%	100%
PERFORMING_PROVIDER_SPECIALTY	1,643,539	96.5%	92.5%	1,643,539	100%	100%
BILLING_PROVIDER_TYPE	1,702,126	100%†	100%	1,702,126	100%	100%
BILLING_PROVIDER_NPI	1,315,433	77.3%	80.8%	1,315,433	100%	100%
BILLING_PROVIDER_ID	1,702,126	100%†	99.9%	1,702,126	100%	100%
BILLING_PROVIDER_SPECIALTY	1,702,126	100%†	99.9%	1,702,126	100%	100%
TOTAL		**95.2%**	**94.9%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*
† This rate was rounded up to 100%

Table E-9. Completeness and Validity Rates—Pharmacy Encounter Lines and Encounters Submitted by Summit to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=315,354						
SENDER_ID_CODE	315,354	100%	100%	315,354	100%	100%
RECIPIENT_ID	315,354	100%	100%	315,354	100%	100%
CLAIM_NUMB	315,354	100%	100%	315,354	100%	100%
CATGY_OF_SERVICE	315,354	100%	100%	315,354	100%	100%
NDC_CODE	315,354	100%	100%	315,354	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%**
Distinct Encounters N=314,779						
DATE_BILLED	314,779	100%	100%	314,779	100%	100%
DATE_PAID	314,779	100%	100%	314,779	100%	100%
DATE_BEGIN_SERVICE_HEADER	314,779	100%	100%	314,779	100%	100%
DATE_END_SERVICE_HEADER	314,779	100%	100%	314,779	100%	100%
DAYS_SUPPLY	314,779	100%	100%	314,779	100%	100%
BILLING_PROVIDER_TYPE	314,779	100%	100%	314,779	100%	100%
BILLING_PROVIDER_NPI	314,779	100%	100%	314,779	100%	100%
BILLING_PROVIDER_ID	314,779	100%	100%	314,779	100%	100%
BILLING_PROVIDER_SPECIALTY	314,779	100%	100%	314,779	100%	100%
TOTAL		**100%**	**100%**		**100%**	**100%**

** Validity Rates were those deemed accurate of records determined complete*

Delta Dental

Table E-10. Completeness and Validity Rates—Encounter Lines and Encounters Submitted by Delta Dental to DHS

Field	Present	Completeness Rate (2020)	Baseline Completeness Rate (2019)	Accurate	Validity Rate* (2020)	Baseline Validity Rate (2019)
Distinct Encounter Lines N=1,307,780						
SENDER_ID_CODE	1,307,780	100%	100%	1,307,780	100%	100%
RECIPIENT_ID	1,307,774	100%†	99.99%	1,307,774	100%	100%
CLAIM_NUMB	1,307,780	100%	100%	1,307,780	100%	100%
DATE_BEGIN_SERVICE_DETAIL	1,307,780	100%	100%	1,307,780	100%	100%
DATE_END_SERVICE_DETAIL	1,307,780	100%	100%	1,307,780	100%	100%
PROC_CODE	1,307,780	100%	100%	1,307,780	100%	100%
PLACE_OF_SERVICE	1,307,780	100%	100%	1,307,780	100%	100%
TOTAL		**100%†**	**100%†**		**100%**	**100%**
Distinct Encounters N=369,557						
DATE_BILLED	369,557	100%	100%	369,557	100%	100%
DATE_PAID	369,557	100%	100%	369,557	100%	100%
DATE_BEGIN_SERVICE_HEADER	369,557	100%	100%	369,557	100%	100%
DATE_END_SERVICE_HEADER	369,557	100%	100%	369,557	100%	100%
PERFORMING_PROVIDER_NPI	368,429	99.7%	99.9%	368,429	100%	100%
PERFORMING_PROVIDER_ID	368,429	99.7%	99.9%	368,429	100%	100%
PERFORMING_PROVIDER_SPECIALTY	368,429	99.7%	99.9%	368,429	100%	100%
BILLING_PROVIDER_TYPE	360,059	97.4%	92.5%	360,059	100%	100%

Table E-10. Completeness and Validity Rates—Encounter Lines and Encounters Submitted by Delta Dental to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
BILLING_PROVIDER_NPI	360,059	97.4%	92.5%	360,059	100%	100%
BILLING_PROVIDER_ID	360,059	97.4%	92.5%	360,059	100%	100%
BILLING_PROVIDER_SPECIALTY	360,059	97.4%	92.5%	360,059	100%	100%
TOTAL		**99.0%**	**97.2%**		**100%**	**100%**

** Valid Rates were those deemed accurate of records determined complete.*
†Rounded to 100%

MCNA

Table 22. Completeness and Validity Rates—Encounter Lines and Encounters Submitted by MCNA to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
Distinct Encounter Lines N=1,072,567						
SENDER_ID_CODE	1,072,567	100%	100%	1,072,567	100%	100%
RECIPIENT_ID	1,072,567	100%	100%†	1,072,567	100%	100%
CLAIM_NUMB	1,072,567	100%	100%	1,072,567	100%	100%
DATE_BEGIN_SERVICE_DETAIL	1,072,567	100%	100%	1,072,567	100%	100%
DATE_END_SERVICE_DETAIL	1,072,567	100%	100%	1,072,567	100%	100%
PROC_CODE	1,072,567	100%	100%	1,072,567	100%	100%
PLACE_OF_SERVICE	1,072,567	100%	100%	1,072,567	100%	100%
TOTAL		**100%**	**100%†**		**100%**	**100%**
Distinct Encounters N=252,302						
DATE_BILLED	252,302	100%	100%	252,302	100%	100%

Table 22. Completeness and Validity Rates—Encounter Lines and Encounters Submitted by MCNA to DHS						
Field	**Present**	**Completeness Rate (2020)**	**Baseline Completeness Rate (2019)**	**Accurate**	**Validity Rate* (2020)**	**Baseline Validity Rate (2019)**
DATE_PAID	252,302	100%	100%	252,302	100%	100%
DATE_BEGIN_SERVICE_HEADER	252,302	100%	100%	252,302	100%	100%
DATE_END_SERVICE_HEADER	252,302	100%	100%	252,302	100%	100%
PERFORMING_PROVIDER_NPI	252,302	100%	99.9%	252,302	100%	100%
PERFORMING_PROVIDER_ID	252,302	100%	99.9%	252,302	100%	100%
PERFORMING_PROVIDER_SPECIALTY	252,302	100%	99.9%	252,302	100%	100%
BILLING_PROVIDER_TYPE	252,300	100%†	99.95%	252,300	100%	100%
BILLING_PROVIDER_NPI	252,300	100%†	99.95%	252,300	100%	100%
BILLING_PROVIDER_ID	252,300	100%†	99.95%	252,300	100%	100%
BILLING_PROVIDER_SPECIALTY	252,300	100%†	99.95%	252,300	100%	100%
TOTAL		**100%†**	**99.98%**		**100%**	**100%**

** Valid Rates were those deemed accurate of records determined complete.*
†Rounded to 100%

APPENDIX F | Critical Incident Analysis Findings

The completeness and validity rates for encounter lines in the current measurement year are detailed in **Table F-1**. Completeness and validity rates less than 95% appear in **red**.

Table F-1. MY 2019 Critical Incident Analysis: Completeness and Validity Rates

Field	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	ARTC		Empower		Summit	
Injured Person's First Name	100%	100%	100%	100%	100%	100%
Injured Person's Last Name	100%	100%	100%	99.8%	100%	100%
Date Reported	94.8%	98.4%	89.7%	96.9%	95.0%	96.9%
Timely/Untimely	93.2%	100%	88.7%	100%	90.7%	100%
PASSE	93.8%	93.2%	90.6%	96.3%	93.0%	98.7%
Incident Date	100%	100%	100%	100%	100%	100%
Age	81.7%	100%	77.9%	100%	85.1%	100%
Date of Birth	90.7%	99.6%	86.0%	99.4%	90.9%	99.3%
Gender	95.5%	100%	92.8%	100%	94.9%	100%
Race	93.8%	100%	89.7%	100%	92.3%	100%
Incident Type	100%	100%	100%	100%	100%	100%
Medical Attention Required	64.5%	100%	51.7%	100%	68.5%	100%
Designation of Incident	87.2%	100%	84.1%	100%	82.1%	100%
Notifications	65.8%	100%	61.1%	100%	60.5%	100%
Findings/Outcome/Disposition	24.7%	100%	21.8%	100%	16.0%	100%
PASSE Provider	99.0%	100%	99.4%	100%	99.6%	100%

** Validity Rates are those deemed accurate of records determined complete.*

For comparison, the completeness and validity rates for encounter lines in the previous measurement year are detailed in **Table F-2**. Completeness and validity rates less than 95% appear in **red**.

Table F-2. MY 2020 Critical Incident Analysis: Completeness and Validity Rates

Field	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	ARTC		Empower		Summit	
First Name	100%	100%	100%	100%	100%	100%
Last Name	100%	100%	100%	100%	100%	100%
Date Reported	73.5%	98.7%	67.5%	98.1%	76.2%	96.7%
Timely/Untimely	69.9%	100%	61.2%	100%	68.6%	100%
PASSE	72.3%	97.0%	72.2%	97.3%	74.5%	98.1%
Incident Date Time	100%	100%	100%	100%	100%	100%
Age	55.1%	100%	63.3%	100%	66.2%	100%
Date of Birth	75.0%	99.4%	74.1%	99.3%	80%	99.3%
Gender	76.2%	100%	75.9%	100%	80.7%	100%
Race	74.5%	100%	74.8%	100%	79.8%	100%
Incident Type	100%	100%	100%	100%	100%	100%
Medical Attention Required	52.2%	100%	36.7%	100%	53.2%	100%
Designation of Incident	69.9%	100%	70.4%	100%	74.0%	100%
Notifications	56.8%	100%	54.7%	100%	53.6%	100%
Findings/Outcome/Disposition	37.1%	100%	29.3%	100%	28.0%	100%
PASSE Provider	99.8%	100%	99.7%	100%	99.9%	100%

** Validity Rates are those deemed accurate of records determined complete.*

Tables F-3 through F-5 present the reported incidents by age group and type for each PASSE. The tables include the previous measurement year's results for comparison.

Table F-3. Type of Incidents by Age Group: ARTC

Incident Type	Age Group					
	Adult (2020)	Adult (2019)	Child (2020)	Child (2019)	Unknown (2020)	Unknown (2019)
Arrest	1.3%	*	2.2%	*	0.0%	*
Death	1.3%	1.0%	2.2%	3.6%	0.0%	1.0%
Disturbance	6.0%	13.9%	4.4%	14.3%	9.5%	10.3%
ER Visit	12.0%	*	7.7%	*	2.4%	*
Elopement	2.6%	*	1.1%	*	0.0%	*
Hospitalization	12.0%	*	9.9%	*	4.8%	*
Injury	10.5%	10.8%	12.1%	10.7%	9.5%	18.6%
Interruption of Services	2.9%	*	4.4%	*	0.0%	*
Maltreatment	4.5%	6.6%	18.7%	10.7%	9.5%	7.2%
Medication Error	6.0%	*	1.1%	*	0.0%	*
Missing Client	0.3%	*	1.1%	*	0.0%	*
Other	18.6%	61.3%	16.5%	57.1%	50.0%	58.8%
Physician Visit	13.1%	*	9.9%	*	2.4%	*
Property Destruction	1.8%	*	0.0%	*	2.4%	*
Suicidal Behaviors	6.3%	6.3%	8.8%	3.6%	7.1%	4.1%
Theft	0.8%	*	0.0%	*	2.4%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table F-4. Type of Incidents by Age Group: Empower						
Incident Type	Age Group					
	Adult (2020)	Adult (2019)	Child (2020)	Child (2019)	Unknown (2020)	Unknown (2019)
Arrest	1.6%	*	1.1%	*	2.9%	*
Death	1.9%	1.2%	2.1%	4.3%	1.4%	0.0%
Disturbance	8.7%	7.7%	19.1%	13.0%	8.6%	12.5%
ER Visit	12.2%	*	4.3%	*	0.0%	*
Elopement	1.3%	*	1.1%	*	0.0%	*
Hospitalization	10.3%	*	7.4%	*	5.7%	*
Injury	5.6%	9.6%	8.5%	5.8%	4.3%	10.4%
Interruption of Services	4.0%	*	3.2%	*	0.0%	*
Maltreatment	3.7%	5.7%	17.0%	8.7%	1.4%	4.9%
Medication Error	11.4%	*	3.2%	*	0.0%	*
Missing Client	1.3%	*	2.1%	*	0.0%	*
Other	23.0%	71.4%	11.7%	53.6%	64.3%	68.1%
Physical Restraint	0.5%	*	0.0%	*	0.0%	*
Physician Visit	8.5%	*	3.2%	*	1.4%	*
Property Destruction	0.5%	*	1.1%	*	0.0%	*
Rape	0.3%	*	1.1%	*	1.4%	*
Suicidal Behaviors	4.8%	4.4%	13.8%	14.5%	8.6%	4.2%
Theft	0.5%	*	0.0%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table F-5. Type of Incidents by Age Group: Summit

Incident Type	Age Group					
	Adult (2020)	Adult (2019)	Child (2020)	Child (2019)	Unknown (2020)	Unknown (2019)
Arrest	1.1%	*	0.0%	*	1.5%	*
Death	4.0%	1.9%	6.3%	0.0%	1.5%	1.4%
Disturbance	3.8%	4.6%	16.7%	0.0%	3.1%	2.7%
ER Visit	15.8%	*	2.1%	*	10.8%	*
Elopement	0.2%	*	8.3%	*	0.0%	*
Hospitalization	14.1%	*	10.4%	*	7.7%	*
Injury	8.2%	13.1%	8.3%	21.2%	7.7%	11.6%
Interruption of Services	2.1%	*	4.2%	*	0.0%	*
Maltreatment	4.4%	6.4%	12.5%	9.1%	4.6%	8.2%
Medication Error	4.8%	*	0.0%	*	0.0%	*
Missing Client	1.0%	*	4.2%	*	0.0%	*
Other	22.2%	69.4%	16.7%	60.6%	55.4%	72.8%
Physician Visit	14.7%	*	8.3%	*	0.0%	*
Property Destruction	0.8%	*	0.0%	*	3.1%	*
Rape	0.3%	*	0.0%	*	0.0%	*
Suicidal Behaviors	2.2%	4.6%	0.0%	9.1%	4.6%	3.4%
Theft	0.3%	*	2.1%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Tables F-6 through F-8 present the reported incidents by gender and type for each PASSE. The tables include the previous measurement year's results for comparison.

Table F-6. Type of Incidents by Gender: ARTC

Incident Type	Gender					
	Female (2020)	Female (2019)	Male (2020)	Male (2019)	Unknown (2020)	Unknown (2019)
Arrest	0.9%	*	1.8%	*	0.0%	*
Death	0.9%	0.7%	1.8%	1.7%	0.0%	1.0%
Disturbance	5.9%	16.1%	5.5%	11.9%	12.0%	11.2%
ER Visit	10.0%	*	11.8%	*	0.0%	*
Elopement	2.7%	*	1.8%	*	0.0%	*
Hospitalization	14.6%	*	8.5%	*	8.0%	*
Injury	11.9%	14.6%	10.0%	7.9%	8.0%	18.4%
Interruption of Services	1.8%	*	4.1%	*	0.0%	*
Maltreatment	6.8%	4.4%	7.7%	8.5%	8.0%	8.2%
Medication Error	4.1%	*	5.5%	*	0.0%	*
Missing Client	0.0%	*	0.7%	*	0.0%	*
Other	16.0%	54.7%	21.8%	66.7%	52.0%	57.1%
Physician Visit	14.6%	*	10.3%	*	0.0%	*
Property Destruction	0.5%	*	2.2%	*	4.0%	*
Suicidal Behaviors	8.7%	9.5%	5.5%	3.4%	4.0%	4.1%
Theft	0.5%	*	0.7%	*	4.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table F-7. Type of Incidents by Gender: Empower						
Incident Type	Gender					
	Female (2020)	Female (2019)	Male (2020)	Male (2019)	Unknown (2020)	Unknown (2019)
Arrest	1.1%	*	2.2%	*	0.0%	*
Death	2.2%	2.4%	1.9%	1.3%	0.0%	0.0%
Disturbance	7.1%	6.5%	13.4%	9.7%	4.3%	12.1%
ER Visit	8.2%	*	11.2%	*	0.0%	*
Elopement	0.5%	*	1.6%	*	0.0%	*
Hospitalization	11.5%	*	8.6%	*	4.3%	*
Injury	7.1%	9.5%	5.8%	8.7%	2.1%	10.7%
Interruption of Services	1.1%	*	5.1%	*	0.0%	*
Maltreatment	7.7%	4.1%	4.8%	7.3%	4.3%	4.7%
Medication Error	3.8%	*	12.5%	*	0.0%	*
Missing Client	2.2%	*	1.0%	*	0.0%	*
Other	25.8%	71.0%	19.5%	68.7%	74.5%	65.8%
Physical Restraint	0.0%	*	0.6%	*	0.0%	*
Physician Visit	9.3%	*	6.1%	*	0.0%	*
Property Destruction	0.5%	*	0.6%	*	0.0%	*
Rape	1.1%	*	0.3%	*	0.0%	*
Suicidal Behaviors	9.9%	6.5%	4.5%	4.3%	10.6%	6.7%
Theft	0.5%	*	0.3%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table F-8. Type of Incidents by Gender: Summit

Incident Type	Gender					
	Female (2020)	Female (2019)	Male (2020)	Male (2019)	Unknown (2020)	Unknown (2019)
Arrest	0.3%	*	1.5%	*	2.3%	*
Death	2.9%	1.3%	4.6%	2.1%	4.7%	1.4%
Disturbance	1.9%	1.8%	6.6%	6.0%	4.7%	2.7%
ER Visit	15.2%	*	14.5%	*	9.3%	*
Elopement	1.0%	*	0.5%	*	0.0%	*
Hospitalization	12.3%	*	14.5%	*	9.3%	*
Injury	9.7%	13.6%	7.1%	13.8%	7.0%	10.8%
Interruption of Services	1.9%	*	2.3%	*	0.0%	*
Maltreatment	5.2%	5.7%	5.4%	7.0%	0.0%	8.1%
Medication Error	4.9%	*	3.8%	*	0.0%	*
Missing Client	1.3%	*	1.0%	*	0.0%	*
Other	24.3%	71.9%	21.7%	66.8%	55.8%	73.6%
Physician Visit	15.9%	*	12.2%	*	0.0%	*
Property Destruction	0.3%	*	1.3%	*	2.3%	*
Rape	0.6%	*	0.0%	*	0.0%	*
Suicidal Behaviors	2.3%	5.7%	2.0%	4.4%	4.7%	3.4%
Theft	0.0%	*	0.8%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Tables F-9 through F-11 present the reported incidents by race and type for each PASSE. The tables include the previous measurement year's results for comparison.

Table F-9. Type of Incidents by Race: ARTC

Incident Type	Race							
	African American (2020)	African American (2019)	Caucasian (2020)	Caucasian (2019)	Other Race (2020)	Other Race (2019)	Unknown Race (2020)	Unknown Race (2019)
Arrest	0.0%	*	1.7%	*	0.0%	*	0.0%	*
Death	2.3%	5.6%	1.5%	1.1%	0.0%	0.0%	0.0%	1.0%
Disturbance	4.5%	5.6%	6.3%	14.4%	0.0%	20.0%	6.8%	10.0%
ER Visit	6.8%	*	11.7%	*	11.8%	*	2.3%	*
Elopement	0.0%	*	2.7%	*	0.0%	*	0.0%	*
Hospitalization	13.6%	*	12.0%	*	0.0%	*	4.5%	*
Injury	4.5%	5.6%	11.2%	10.6%	17.6%	60.0%	9.1%	17.0%
Interruption of Services	4.5%	*	2.4%	*	11.8%	*	2.3%	*
Maltreatment	6.8%	0.0%	6.3%	7.4%	23.5%	0.0%	11.4%	8.0%
Medication Error	9.1%	*	4.9%	*	0.0%	*	0.0%	*
Missing Client	0.0%	*	0.5%	*	0.0%	*	0.0%	*
Other	31.8%	83.3%	16.3%	60.6%	29.4%	20.0%	47.7%	58.0%
Physician Visit	13.6%	*	12.7%	*	0.0%	*	4.5%	*
Property Destruction	0.0%	*	1.7%	*	0.0%	*	2.3%	*
Suicidal Behaviors	2.3%	0.0%	7.3%	6.0%	5.9%	0.0%	6.8%	6.0%
Theft	0.0%	*	0.7%	*	0.0%	*	2.3%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

Table F-10. Type of Incidents by Race: Empower

Incident Type	Race							
	African American (2020)	African American (2019)	Caucasian (2020)	Caucasian (2019)	Other Race (2020)	Other Race (2019)	Unknown Race (2020)	Unknown Race (2019)
Arrest	1.0%	*	2.0%	*	0.0%	*	1.3%	*
Death	1.9%	1.3%	2.0%	1.6%	0.0%	0.0%	1.3%	0.6%
Disturbance	15.5%	7.7%	9.5%	8.8%	16.7%	9.1%	7.7%	11.5%
ER Visit	10.7%	*	10.9%	*	8.3%	*	0.0%	*
Elopement	1.9%	*	1.1%	*	0.0%	*	0.0%	*
Hospitalization	7.8%	*	10.0%	*	16.7%	*	6.4%	*
Injury	2.9%	3.8%	7.2%	9.9%	0.0%	18.2%	5.1%	10.3%
Interruption of Services	2.9%	*	4.0%	*	8.3%	*	0.0%	*
Maltreatment	1.9%	3.8%	7.4%	6.2%	0.0%	27.3%	3.8%	4.5%
Medication Error	23.3%	*	6.3%	*	0.0%	*	0.0%	*
Missing Client	1.0%	*	1.4%	*	0.0%	*	1.3%	*
Other	14.6%	75.6%	21.8%	68.6%	41.7%	45.5%	60.3%	66.7%
Physical Restraint	0.0%	*	0.6%	*	0.0%	*	0.0%	*
Physician Visit	7.8%	*	7.4%	*	8.3%	*	1.3%	*
Property Destruction	1.0%	*	0.6%	*	0.0%	*	0.0%	*
Rape	1.0%	*	0.3%	*	0.0%	*	1.3%	*
Suicidal Behaviors	4.9%	7.7%	6.9%	4.8%	0.0%	0.0%	10.3%	6.4%
Theft	0.0%	*	0.6%	*	0.0%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

Table F-11. Type of Incidents by Race: Summit

Incident Type	Race							
	African American (2020)	African American (2019)	Caucasian (2020)	Caucasian (2019)	Other (2020)	Other (2019)	Unknown (2020)	Unknown (2019)
Arrest	2.4%	*	0.6%	*	0.0%	*	2.4%	*
Death	3.2%	2.8%	4.6%	1.6%	0.0%	0.0%	1.2%	1.3%
Disturbance	1.6%	6.5%	5.1%	3.9%	10.0%	9.1%	4.8%	2.6%
ER Visit	11.2%	*	15.6%	*	10.0%	*	13.1%	*
Elopement	1.6%	*	0.6%	*	0.0%	*	0.0%	*
Hospitalization	12.8%	*	14.1%	*	20.0%	*	8.3%	*
Injury	8.8%	10.3%	8.2%	14.5%	10.0%	18.2%	7.1%	10.4%
Interruption of Services	1.6%	*	2.3%	*	10.0%	*	0.0%	*
Maltreatment	2.4%	10.3%	5.7%	4.9%	10.0%	27.3%	3.6%	9.1%
Medication Error	4.8%	*	4.6%	*	0.0%	*	0.0%	*
Missing Client	1.6%	*	1.1%	*	0.0%	*	0.0%	*
Other	28.8%	62.6%	19.2%	71.0%	20.0%	45.5%	53.6%	72.1%
Physician Visit	15.2%	*	14.5%	*	10.0%	*	1.2%	*
Property Destruction	1.6%	*	0.8%	*	0.0%	*	1.2%	*
Rape	0.0%	*	0.4%	*	0.0%	*	0.0%	*
Suicidal Behaviors	2.4%	7.5%	2.1%	4.1%	0.0%	0.0%	3.6%	4.5%
Theft	0.0%	*	0.6%	*	0.0%	*	0.0%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

Tables F-12 through F-14 present the reported incidents by medical attention and type for each PASSE. The tables include the previous measurement year's results for comparison.

Table F-12. Type of Incidents by Medical Attention: ARTC

Incident Type	Medical Attention					
	Yes (2020)	Yes (2019)	No (2020)	No (2019)	Unknown (2020)	Unknown (2019)
Arrest	0.0%	*	1.8%	*	2.7%	*
Death	0.9%	1.5%	0.9%	1.3%	2.2%	1.0%
Disturbance	3.7%	8.8%	2.6%	20.3%	10.9%	13.2%
ER Visit	21.1%	*	0.0%	*	4.4%	*
Elopement	0.5%	*	6.1%	*	1.6%	*
Hospitalization	22.0%	*	1.8%	*	3.8%	*
Injury	9.6%	9.6%	7.9%	12.7%	13.7%	14.7%
Interruption of Services	0.0%	*	4.4%	*	5.5%	*
Maltreatment	1.8%	0.0%	12.3%	10.1%	10.9%	10.7%
Medication Error	0.5%	*	5.3%	*	9.3%	*
Missing Client	0.0%	*	0.9%	*	0.5%	*
Other	11.5%	72.1%	36.0%	54.4%	22.4%	54.8%
Physician Visit	16.1%	*	14.9%	*	4.4%	*
Property Destruction	0.0%	*	1.8%	*	3.3%	*
Suicidal Behaviors	12.4%	8.1%	2.6%	1.3%	2.7%	5.6%
Theft	0.0%	*	0.9%	*	1.6%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

Table F-13. Type of Incidents by Medical Attention: Empower

Incident Type	Medical Attention					
	Yes (2020)	Yes (2019)	No (2020)	No (2019)	Unknown (2020)	Unknown (2019)
Arrest	0.6%	*	2.9%	*	1.9%	*
Death	2.8%	2.3%	1.0%	0.0%	1.5%	1.0%
Disturbance	1.7%	6.2%	9.6%	10.0%	16.8%	10.7%
ER Visit	25.6%	*	2.9%	*	0.8%	*
Elopement	0.6%	*	1.0%	*	1.5%	*
Hospitalization	23.3%	*	0.0%	*	3.4%	*
Injury	6.3%	9.6%	3.8%	4.0%	6.5%	10.0%
Interruption of Services	0.0%	*	8.7%	*	3.4%	*
Maltreatment	0.6%	3.4%	10.6%	6.0%	7.3%	6.9%
Medication Error	0.0%	*	4.8%	*	15.6%	*
Missing Client	1.7%	*	2.9%	*	0.4%	*
Other	15.3%	70.1%	32.7%	78.0%	31.3%	66.8%
Physical Restraint	0.6%	*	0.0%	*	0.4%	*
Physician Visit	9.1%	*	8.7%	*	4.2%	*
Property Destruction	0.0%	*	1.9%	*	0.4%	*
Rape	0.6%	*	0.0%	*	0.8%	*
Suicidal Behaviors	11.4%	8.5%	8.7%	2.0%	3.1%	4.6%
Theft	0.0%	*	0.0%	*	0.8%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

Table F-14. Type of Incidents by Medical Attention: Summit						
Incident Type	Medical Attention					
	Yes (2020)	Yes (2019)	No (2020)	No (2019)	Unknown (2020)	Unknown (2019)
Arrest	0.3%	*	1.3%	*	2.1%	*
Death	4.5%	1.8%	2.6%	2.3%	3.8%	1.4%
Disturbance	2.2%	2.2%	9.1%	6.1%	5.1%	4.8%
ER Visit	21.6%	*	3.2%	*	11.1%	*
Elopement	0.3%	*	2.6%	*	0.0%	*
Hospitalization	22.8%	*	2.6%	*	6.0%	*
Injury	9.6%	18.6%	5.8%	8.4%	7.7%	10.7%
Interruption of Services	0.0%	*	3.2%	*	4.3%	*
Maltreatment	0.6%	0.4%	11.0%	11.5%	7.7%	10.1%
Medication Error	0.6%	*	7.1%	*	7.3%	*
Missing Client	0.0%	*	1.3%	*	2.6%	*
Other	19.4%	68.6%	27.9%	70.2%	30.8%	70.2%
Physician Visit	15.4%	*	18.8%	*	5.6%	*
Property Destruction	0.0%	*	0.6%	*	2.6%	*
Rape	0.3%	*	0.6%	*	0.0%	*
Suicidal Behaviors	2.5%	8.4%	0.6%	1.5%	3.0%	2.8%
Theft	0.0%	*	1.3%	*	0.4%	*
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

**Not reported*

APPENDIX G | Utilization Analysis Findings

Tables G-1 through **G-5** present the results for over- and underutilization of services for the PASSEs.

Table G-1. MY 2020 Utilization Analysis: PASSE Overutilization for Developmentally Disabled (DD)

Services/Units	Number of Enrollees Receiving Services	Rate for All DD Enrollees (units paid)
ARTC		
Inpatient Hospital and Psychiatric Stays	9	0.4%
Emergency Services	558	23.6%
Empower		
Inpatient Hospital and Psychiatric Stays	61	2.1%
Emergency Services	717	24.4%
Summit		
Inpatient Hospital and Psychiatric Stays	33	0.8%
Emergency Services	877	20.4%

Table G-2. MY 2020 Utilization Analysis: PASSE Underutilization				
Services/Units	Number of DD Enrollees Receiving Services	Rate for All DD Enrollees (units paid)	Number of Enrollees Receiving Services	Rate for All Enrollees (units paid)
	Developmentally Disabled		All Enrollees	
ARTC				
Occupational Therapy				
0	2,062	87.3%	14,800	97.6%
1–30	142	6.0%	185	1.2%
≥ 31	159	6.7%	183	1.2%
Physical Therapy				
0	1,952	82.6%	14,597	96.2%
1–30	149	6.3%	255	1.7%
≥ 31	262	11.1%	316	2.1%
Speech-Language Pathology				
0	1,726	73.0%	14,429	95.1%
1–30	234	9.9%	287	1.9%
≥ 31	403	17.1%	452	3.0%
Augmentative Communication Device	1	0.04%	1	0.01%
Durable Medical Equipment (DME)	2	0.08%	2	0.01%
Empower				
Occupational Therapy				
0	2,467	84.0%	24,091	97.7%
1–30	229	7.8%	298	1.2%
≥ 31	242	8.2%	272	1.1%
Physical Therapy				
0	2,398	81.6%	23,920	97.0%

Table G-2. MY 2020 Utilization Analysis: PASSE Underutilization				
Services/Units	Number of DD Enrollees Receiving Services	Rate for All DD Enrollees (units paid)	Number of Enrollees Receiving Services	Rate for All Enrollees (units paid)
	Developmentally Disabled		All Enrollees	
1–30	158	5.4%	288	1.2%
≥ 31	382	13.0%	453	1.8%
Speech-Language Pathology				
0	2,141	72.9%	23,722	96.2%
1–30	290	9.9%	365	1.5%
≥ 31	507	17.3%	574	2.3%
Augmentative Communication Device	2	0.1%	2	0.01%
Durable Medical Equipment (DME)	5	0.2%	5	0.02%
Summit				
Occupational Therapy				
0	3,897	90.5%	18,805	97.5%
1–30	188	4.4%	235	1.2%
≥ 31	223	5.2%	248	1.3%
Physical Therapy				
0	3,744	86.9%	18,562	96.2%
1–30	165	3.8%	270	1.4%
≥ 31	399	9.3%	456	2.4%
Speech-Language Pathology				
0	3,573	82.9%	18,436	95.6%
1–30	279	6.5%	344	1.8%
≥ 31	456	10.6%	508	2.6%

Table G-2. MY 2020 Utilization Analysis: PASSE Underutilization				
Services/Units	Number of DD Enrollees Receiving Services	Rate for All DD Enrollees (units paid)	Number of Enrollees Receiving Services	Rate for All Enrollees (units paid)
	Developmentally Disabled		All Enrollees	
Augmentative Communication Device	0	0.0%	0	0.0%
Durable Medical Equipment (DME)	4	0.1%	4	0.02%

Table G-3. MY 2020 Utilization Analysis: Behavioral Health Utilization: ARTC		
Service Received	Number of Enrollees Receiving Services	Rate
Child under Age 21		
0	3,954	33.7%
1–4	1,428	12.2%
≥5	6,347	54.1%
Adult		
0	1,602	46.6%
1–4	380	11.0%
≥5	1,457	42.4%

Table G-4. MY 2020 Utilization Analysis: Behavioral Health Utilization: Empower		
Service Received	Number of Enrollees Receiving Services	Rate
Child under Age 21		
0	6,030	31.4%
1–4	1,194	6.2%
≥5	11,986	62.4%

Table G-4. MY 2020 Utilization Analysis: Behavioral Health Utilization: Empower		
Service Received	**Number of Enrollees Receiving Services**	**Rate**
Adult		
0	2,334	42.8%
1–4	387	7.1%
≥5	2,730	50.1%

Table G-5. MY 2020 Utilization Analysis: Behavioral Health Utilization: Summit		
Service Received	**Number of Enrollees Receiving Services**	**Rate**
Child under Age 21		
0	3,786	28.7%
1–4	1,110	8.4%
≥5	8,281	62.8%
Adult		
0	2,936	48.0%
1–4	480	7.9%
≥5	2,695	44.1%

Tables G-6 – G-7 present the results for over- and underutilization of services for the DMOs.

Table G-6. MY 2020 Utilization Analysis: DMO Overutilization	
Services	**Number of Claims Receiving Services**
Delta Dental	
Crown – Restorations and other restorative services	13,223
Extraction	3,948
Anesthesia 1 – Quantity of 3 or more	0
Anesthesia 2 – Quantity of 2 or more	2

Table G-6. MY 2020 Utilization Analysis: DMO Overutilization	
Services	**Number of Claims Receiving Services**
MCNA	
Crown – Restorations and other restorative services	11,625
Extraction	3,613
Anesthesia 1 – Quantity of 3 or more	2
Anesthesia 2 – Quantity of 2 or more	3

Table G-7. MY 2020 Utilization Analysis: DMO Underutilization	
Services	**Number of Claims Receiving Services**
Delta Dental	
Non-Surgical Periodontal Service	434
MCNA	
Non-Surgical Periodontal Service	346