Qlarant

Maryland
DEPARTMENT OF HEALTH

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

Annual Technical Report

Calendar Year 2019

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Maryland Department of Health

2019 Annual Technical Report

Executive Summary

Introduction

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible participants by contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice's guiding principle is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost effective.

MDH's Medical Benefits Management Administration (MBMA) is responsible for oversight of the HealthChoice program. MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing HealthChoice. For this purpose, MDH contracts with Qlarant Quality Solutions, Inc. (Qlarant) to serve as the EQRO.

The 2019 Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities rendered during measurement years 2018 and 2019. The ATR describes external quality review (EQR) methodologies for completing activities; provides managed care organization (MCO) performance measure results; summarizes compliance results; and includes an overview of the quality, timeliness, and accessibility of health care services furnished by the MCOs of the State of Maryland to participants of the Maryland Medicaid Managed Care Program, known as HealthChoice.

As of December 31, 2019, the HealthChoice program enrolled 1,187,270 participants. MDH contracted with nine MCOs during this evaluation period. The MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)*
- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid–Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)

*ABH joined HealthChoice in October 2017.

All quality assurance (QA) activities assess the quality, timeliness, and accessibility of services furnished by the HealthChoice MCOs. Throughout the ATR, individual and collective MCO strengths and barriers are identified. Additionally, recommendations for improvement are made, both on an individual MCO basis and program-wide; and if acted upon, may positively impact participant outcomes.

Key Findings

Systems Performance Review

Compliance thresholds are 100% for the 11 standards identified within the Systems Performance Review (SPR). For calendar year (CY) 2018, average Maryland MCO compliance scores were 100% for three standards: Systematic Process of Quality Assessment, Continuity of Care, and Outreach. Additionally, for three additional standards—Accountability to Governing Body, Credentialing and Recredentialing, and Health Education—all MCOs were exempt from review as they scored 100% in past reviews, except ABH, as this was the plan's first scored SPR. For these three standards, ABH scored 93%, 99%, and 100%, respectively.

Average MCO compliance scores for the five remaining standards were as follows:

- 88% for Oversight of Delegated Entities
- 91% for Enrollee Rights
- 86% for Access and Availability
- 93% for Utilization Review
- 94% for Fraud, Waste, and Abuse

The overall composite score for all standards and MCOs was 97%. Corrective action plans (CAPs) were put in place to address areas of non-compliance for all but one MCO (JMS), which if correctly implemented, should increase compliance rates.

E.S. Table 1. Total Corrective Action Plans per MCO

CAPs Required	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
	1	5	0	5	4	2	3	1	4

Value-Based Purchasing

The Value-Based Purchasing (VBP) activity uses financial incentives and disincentives to promote performance improvement. In CY 2018, MDH selected the following 13 measures:

- Adolescent Well-Care Visits
- Adult Body Mass Index (BMI) Assessment
- Ambulatory Care Visits for Supplemental Security Income (SSI) Adults
- Ambulatory Care Visits for SSI Children
- Asthma Medication Ratio
- Breast Cancer Screening
- Childhood Immunization Status – Combination 3
- Comprehensive Diabetes Care – HbA1c Testing
- Controlling High Blood Pressure
- Immunizations for Adolescents – Combination 1

- Lead Screenings for Children – Ages 12 to 23 Months
- Postpartum Care
- Well-Child Visits for Children – Ages 3 to 6

For each measure, MDH calculates an incentive and disincentive target. VBP is budget neutral, meaning that disincentives collected are used to pay incentives earned. For CY 2018, eight MCOs participated in VBP (excluding ABH). Three MCOs (JMS, KPMAS, and UMHP) earned net incentives, while the remaining five MCOs (ACC, MPC, MSFC, PPMCO, and UHC) incurred net disincentives. More details, including the incentive and disincentive methodology and targets, are included in the ATR.

Performance Improvement Project Review

Eight MCOs (excluding ABH) conducted two performance improvement projects (PIPs). The Asthma Medication Ratio PIP assessed quality of care, while the Lead Screening PIP assessed quality, timeliness, and accessibility of care. Each MCO set its own improvement target for each PIP. For the Asthma Medication Ratio PIP, three MCOs (ACC, JMS, and PPMCO) demonstrated improvement in performance over remeasurement year one, while five MCOs (KPMAS, MPC, MSFC, UHC, and UMHP) experienced a decline in performance. When compared to HEDIS®[1] 2018 (CY 2017) benchmarks, JMS and KPMAS performed above the Medicaid 90th percentile, ACC performed above the 50th percentile, and the remaining MCOs (MPC, MSFC, PPMCO, UHC, and UMHP) performed below the 50th percentile.

The Lead Screening PIP, which is evaluated against both the HEDIS measure as well as a Maryland encounter data measure, demonstrated that all eight MCOs improved over baseline rates. When compared to HEDIS 2018 benchmarks, JMS performed above the Medicaid 90th percentile; ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP performed close to or above the 75th percentile; and UHC performed above the 50th percentile. General recommendations made to improve MCO PIP performance include conducting in-depth barrier analysis and implementing targeted interventions.

Encounter Data Validation

The Encounter Data Validation (EDV) activity assessed quality of care and monitors program integrity. MDH uses information from encounter data to determine the acuity of the HealthChoice population, which then impacts the calculation of MCO capitation payments. Five activities are completed for all nine MCOs, with this being the first year for ABH:

- Review of State requirements for collection and submission of encounter data
- Review of health plan's capability to produce accurate and complete encounter data
- Analysis of health plan's electronic encounter data for accuracy and completeness (completed by the Hilltop Institute)
- Review of medical records for additional confirmation of findings
- Analysis and submission of findings

Overall validation findings indicate that the data are complete and accurate. In general, the MCOs have similar distributions of rejections, types of encounters, types of visits, and outliers, except where specifically noted in the results located in the EDV section of the ATR. The volume of accepted

[1] HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

encounters was generally consistent with MCO enrollment. The time-dimension analysis indicated some variation between MCOs regarding the timeliness of encounter submissions by MCOs to MDH; however, the vast majority of encounters submitted by all MCOs occur within the 8-month maximum time allotted by MDH for processing. Minimum compliance indicators were set at 90% for the medical record review EDV activity. Only one MCO (UMHP) required a CAP.

Recommendations to improve the quality of encounter submissions and increase MDH's ability to assess the efficiency and effectiveness of the Medicaid program include continuing to work with each MCO to address discrepancies. In addition, MDH staff should work with MCOs to improve the timeliness of encounter submissions, especially for MCOs with high rates of submissions occurring more than 6 months after the end date of service.

Early and Periodic Screening, Diagnosis, and Treatment Medical Record Review

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical record review assesses quality, timeliness, and accessibility of care. Over 2,400 medical records were reviewed for this activity. Compliance thresholds for each indicator were set at 80%. CY 2018 review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas:

- Health and Developmental History
- Comprehensive Physical Examination
- Laboratory Tests/At-Risk Screenings
- Immunizations
- Health Education/Anticipatory Guidance

One MCO (ACC) required a CAP for the Laboratory Tests/At-Risk Screenings component; however, MCO aggregate scores demonstrate all nine MCOs exceeded the minimum compliance requirements, all averaging at or above 90%. When compared to previous years, HealthChoice aggregate results demonstrated continuous improvement, increasing from 90% in CY 2016 to 91% in CY 2017 to 94% in CY 2018.

Focused Review of Grievances, Appeals, and Denials

The focused review of grievances, appeals, and denials activity accessed quality and timeliness of all nine MCOs. The activity reviewed grievances, appeals, and denials reviewed from the final two quarters in CY 2018 and the first two quarters in CY 2019.

Focused Review of Grievances
The focused review of grievances assessed if grievances were appropriately classified, the issue is fully described, grievances were timely and appropriately resolved, and if appropriate resolution letters were sent. Five MCOs (ABH, ACC, JMS, UHC, and UMHP) met all requirements. KPMAS, MPC, MSFC, and PPMCO received one or more partially met findings.

Focused Review of Appeals
The focused review of appeals assessed many factors, including whether appeals were processed based upon level of urgency, if appeal decisions were appropriately documented and made by health care professionals with appropriate expertise, if written and verbal notifications were provided timely, and if

decisions were made available to enrollees in easy to understand language. Results showed all nine MCOs processed appeals based upon the level of urgency, documented the appeal decision in the case record, and utilized health care professionals with appropriate clinical expertise in making appeal determinations. Three MCOs (JMS, MSFC, and UHC) met all applicable requirements for the appeals review. The remaining six MCOs (ABH, ACC, KPMAS, MPC, PPMCO, UMHP) had one or more areas of non-compliance.

E.S. Table 2. CY 2018 MCO Appeal Record Review Results

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Processed Based Upon Level of Urgency	M	M	M	M	M	M	M	M	M
Compliance with Verbal Notification of Denial of an Expedited Request	UM	M	NA	M	NA	NA	NA	M	NA
Compliance with Written Notification of Denial of an Expedited Request	M	M	NA	UM	NA	NA	NA	M	NA
Compliance with 72-hour Time Frame for Expedited Appeal Resolution	PM	M	NA	M	NA	M	NA	M	M
Compliance with Verbal Notification of Expedited Appeal Decision	UM	UM	NA	M	NA	M	NA	M	M
Compliance with 24-hour Time Frame for Written Notification of Expedited Appeal Decision	PM	M	NA	M	NA	M	NA	M	M
Compliance with Written Notification Time Frame for Non-Emergency Appeal	M	M	M	M	M	M	PM	M	M
Appeal Decision Documented	M	M	M	M	M	M	M	M	M
Decision Made by Health Care Professional with Appropriate Expertise	M	M	M	M	M	M	M	M	M
Decision Available to Enrollee in Easy to Understand	M	M	M	M	PM	M	M	M	PM

M=Met; PM=Partially Met; UM=Unmet; NA=Not Applicable

Focused Review of Denials

The focused review of denials assessed appropriateness of adverse determinations, compliance with pre-service determination time frames, compliance with adverse determination notification time frames, and required letter components. All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO-specific clinical policies. Partially met findings were identified for various MCOs for the remaining requirements. Overall, the MCOs demonstrated relatively strong and consistent results in meeting regulations relating to grievances, appeals, and denials.

E.S. Table 3. Results of CY 2018 Denial Record Review

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Appropriateness of Adverse Determinations	M	M	M	M	M	M	M	M	M
Compliance with Pre-Service Determination Time Frames	M	M	PM	M	PM	M	PM	M	M
Compliance with Adverse Determination Notification Time Frames	M	M	M	M	PM	M	M	M	M
Required Letter Components	PM	PM	M	PM	PM	PM	PM	PM	PM

M=Met; PM=Partially Met; UM=Unmet; NA=Not Applicable

Recommendations for MCO opportunities for improvement include the MCOs fully implementing managed care model notices using the MDH provided template. Additional recommendations include MDH providing member grievance guidance to the MCOs when those grievances are received from the State and revising the quarterly pre-service denial reporting template for clarity and consistency.

Network Adequacy Validation

The Network Adequacy Validation (NAV) activity assessed quality, timeliness, and accessibility for CY 2019. Compliance thresholds were set at 80% for this activity. Areas of the NAV activity that increased in performance over CY 2018 results are as follows: successful primary care physician (PCP) contact, correctness of PCP telephone number and address, accepting the listed MCO insurance, accepting new patients, urgent care appointments, listed age ranges of patients served, listed languages spoken by PCP, and listed practice accommodations for patients with disabilities.

The following table summarizes aggregate areas of improvement compared to the CY 2018 review.

E.S. Table 4. NAV CY 2018 and CY 2019 Comparison in Improved Areas

Review Area	CY 2018	CY 2019
Successful PCP Contacts	46%	56%
PCP Accepts Listed MCO	98%	100%
PCP Accepts New Patients	85%	88%
PCP Urgent Care Appointment Compliance	90%	93%
MCO Directory Matched Address Given by PCP	92%	93%
MCO Directory Listed Age Ranges of Patients Served	66%	86%
MCO Directory Listed Languages Spoken by PCP	61%	90%
MCO Directory Identifies Practice Accommodations for Patients with Disabilities	53%	64%

Although performance in several areas increased, eight MCOs (ABH, ACC, JMS, KPMAS, MPC, PPMCO, UHC, and UMHP) required CAPs for the area that compared telephone responses to online provider directories regarding PCP details. Additionally, one MCO (UHC) required a CAP to improve compliance with routine care appointment time frames.

HEDIS Measure Validation

MDH contracted with MetaStar, Inc. to conduct HEDIS Compliance Audits of all HealthChoice MCOs. HEDIS measures are designed to assess quality, timeliness, and accessibility of care. For Medicaid services rendered in CY 2018, MDH required the MCOs to report 45 HEDIS measures (85 total, including sub-measures) within four domain categories: Effectiveness of Care, Access/Availability of Care, Utilization and Risk Adjusted Utilization, and Health Plan Descriptive Information.

Three-year trending showed ACC and JMS improved in 38 measures, KPMAS improved in 44 measures, MPC improved in 26 measures, PPMCO improved in 39 measures, UHC improved in 33 measures, and UMHP improved in 64 measures. ABH was excluded from this trending analysis. Full HEDIS results and Health Plan Descriptive Information are located in Appendices A2 and A3, respectively.

CAHPS Survey

MDH contracted with the Center for the Study of Services (CSS), Inc. to administer and report the results of the CAHPS®[2] 5.0H Member Experience Survey for services provided in CY 2018. The overall goal of the survey was to provide actionable performance feedback to aid health plans in improving overall member experience in the areas of quality, timeliness, and accessibility of care. Ratings and composite measures in the CAHPS 5.0H Adult and Child Medicaid Survey included :

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision–Making

[2] CAHPS® – Consumer Assessment of Healthcare Providers and Systems. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U. S. Department of Health and Human Services.

Five additional composite measures were calculated for the Children with Chronic Conditions (CCC) population:

- Access to Prescription Medicine
- Access to Specialized Services
- Getting Needed Information
- Personal Doctor Who Knows Child
- Coordination of Care for CCC

Adult summary rates from CY 2016 to 2018 showed improvement in the following composite measures: Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. Slight declines in performance were noted in the Customer Service and Shared Decision-Making composite measures.

Child summary rates from CY 2016 to 2018 , including the additional CCC composite measures, did not show any year-over-year improvement. All CCC composite measures slightly decreased from CY 2017 to CY 2018.

Conclusion

MDH sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality improvement. The 2019 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Additionally, the HealthChoice MCOs have further demonstrated their commitment to quality by obtaining NCQA accreditation. NCQA awards accreditation to health plans with strong consumer protections and a commitment to quality by completing a comprehensive evaluation that bases its results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). Recent accreditation reviews resulted in two of the HealthChoice MCOs (JMS and KPMAS) receiving NCQA's highest accreditation rating of excellent, and three of the MCOs (ACC, MSFC, and PPMCO) receiving the second highest rating of commendable. JMS and KPMAS are the only two health plans in the nation with the top rating of 5.0.

Throughout the ATR, recommendations are made on the MCO and program-wide level to promote continuous improvement. If implemented, the Maryland HealthChoice Program will continue providing high quality, accessible, and timely services to its participants.

Maryland Department of Health

2019 Annual Technical Report

Introduction

Background

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible participants by contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997 under the authority of an 1115 waiver of the Social Security Act. HealthChoice's guiding principle is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost effective.

MDH's Medical Benefits Management Administration (MBMA) is responsible for oversight of the HealthChoice program. MBMA ensures that the MCOs are in compliance with the initiatives established in 42 CFR 438, Subpart D. The Division of HealthChoice Quality Assurance (DHQA) within MBMA is primarily responsible for monitoring the quality activities involving external quality review and Centers for Medicare and Medicaid Services (CMS) quality improvement requirements for the HealthChoice program. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care oversight process.

MDH is required to annually evaluate the quality of care provided by contracting MCOs in accordance with Federal law[3]. MDH contracts with Qlarant Quality Solutions, Inc., an External Quality Review Organization (EQRO), to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program.

Qlarant is a non–profit organization that was established in 1973 as a Professional Standards Review Organization and is now designated by CMS as a Quality Improvement Organization (QIO)–like entity. Qlarant performs external quality reviews and other services for Maryland and other Medicaid agencies across the United States. As the EQRO, Qlarant maintains a cooperative and collaborative approach in providing high quality, timely, and cost–effective services to MDH.

As of December 31, 2019, the HealthChoice program enrolled 1,187,270 participants. MDH contracted with nine MCOs during this evaluation period. The MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)*
- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid–Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)

*ABH joined HealthChoice in October 2017.

[3] Federal law - Section 1932(c)(2)(A)(i) of the Social Security Act

Pursuant to 42 CFR 438.364, the 2019 Annual Technical Report describes the findings from Qlarant's External Quality Review activities for years 2017–2019 which took place in CY 2019. The report includes each review activity conducted by Qlarant or MDH's subcontractors, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCOs.

MBMA Quality Strategy

The overall goals of MDH's Quality Strategy are to:

- Ensure compliance with changes in Federal and State laws and regulations affecting the Medicaid program;
- Improve quality and health care performance continually using evidence–based methodologies for evaluation;
- Compare Maryland's results to national and state performance benchmarks to identify areas of success and improvement;
- Reduce administrative burden on MCOs and the program overall; and,
- Assist MDH with setting priorities and responding to identified areas of concern within the HealthChoice participant population.

MDH works collaboratively with MCOs and stakeholders to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of health care services for HealthChoice participants.

Qlarant allocated standards and/or measures to domains indicative of quality, access, and timeliness of care and services. The quality improvement activities are:

- Systems Performance Review
- Value-Based Purchasing
- Performance Improvement Projects
- Encounter Data Validation
- EPSDT Medical Record Review
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Consumer Report Card
- Focused Review of MCO Grievances, Appeals, and Denials
- Network Adequacy

EQRO Program Assessment Activities

Federal regulations require that the EQRO perform three activities using methods consistent with CMS protocols:

- Review of MCOs' operations to assess compliance with State and Federal standards for quality program operations;
- Validation of State-required performance measures; and
- Validation of State-required performance improvement projects (PIPs) underway during the prior 12 months.

Federal regulations also permit MDH to contract with an EQRO to validate encounter data submitted by the MCOs. Qlarant performed this activity on behalf of MDH in collaboration with The Hilltop Institute at University of Maryland Baltimore County (Hilltop).

Qlarant conducted each of the above activities in a manner consistent with the CMS protocols during CY 2019.

Additionally, Qlarant completed the following five review activities:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews;
- Development and production of an annual Consumer Report Card to assist participants in selecting an MCO;
- Market research study to determine any needed enhancements to the Consumer Report Card;
- Quarterly focused reviews of MCO grievances, appeals, and denials; and
- Validation of MCO Network Adequacy.

Separate report sections address each review activity and describe the methodology and data sources used to draw conclusions for the particular area of focus. The final report section summarizes findings and recommendations to MBMA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice participants.

General Overview of Findings

Assessment of Quality, Access, and Timeliness

For the purposes of evaluating the MCOs using the quality assurance activities, Qlarant has adopted the following definitions for quality, access, and timeliness:

- **Quality**, as it pertains to external quality review, means "the degree to which an MCO or PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through:
    1) Its structural and operational characteristics.
    2) The provision of services that are consistent with current professional, evidence-based knowledge.
    3) Interventions for performance improvement."

(CMS, *Final Rule: Medicaid Managed Care; 42 CFR Part 438, et. al. Subpart E– Quality Measurement and Improvement; External Quality Review* [May 2016]).

- **Access** (or accessibility), as defined by NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001)*.

Table 1 outlines the review activities conducted annually and identifies the areas where they assess quality, access, and/or timeliness.

Table 1. Review Activities that Assess Quality (Q), Access (A), and Timeliness (T)

Systems Performance Review	Q	A	T
Standard 1 – Systematic Process of Quality Assessment and Improvement	√		
Standard 2 – Accountability to the Governing Body	√		
Standard 3 – Oversight of Delegated Entities	√		
Standard 4 – Credentialing and Recredentialing	√	√	√
Standard 5 – Enrollee Rights	√	√	√
Standard 6 – Availability and Accessibility		√	√
Standard 7 – Utilization Review	√	√	√
Standard 8 – Continuity of Care	√	√	√
Standard 9 – Health Education Plan	√	√	
Standard 10 – Outreach Plan	√	√	
Standard 11 – Fraud and Abuse	√		√
Value-Based Purchasing	**Q**	**A**	**T**
Adolescent Well–Care	√	√	√
Adult BMI Assessment	√		
Ambulatory Care Services for SSI Adults Ages 21–64 Years	√	√	
Ambulatory Care Services for SSI Children Ages 0–20 Years	√	√	
Asthma Medication Ratio	√	√	√
Breast Cancer Screening	√	√	√
Childhood Immunization Status (Combo 3)	√	√	√
Comprehensive Diabetes Care – HbA1c Testing	√	√	√
Controlling High Blood Pressure	√		√
Immunizations for Adolescents	√		√
Lead Screenings for Children Ages 12–23 Months	√		√

Value-Based Purchasing	Q	A	T
Postpartum Care	√	√	√
Well–Child Visits for Children Ages 3–6 Years	√	√	√
Performance Improvement Projects	**Q**	**A**	**T**
Asthma Medication Ratio PIP	√		
Lead Screening PIP	√	√	√
Encounter Data Validation	**Q**	**A**	**T**
Inpatient, Outpatient, Office Visit Medical Record Review	√		
EPSDT Medical Record Review	**Q**	**A**	**T**
Health and Developmental History	√		√
Comprehensive Physical Examination	√		√
Laboratory Tests/At–Risk Screenings		√	√
Immunizations	√		√
Health Education and Anticipatory Guidance	√		√
Focused Review of Grievances, Appeals, & Denials	**Q**	**A**	**T**
Grievances	√		√
Appeals	√		√
Denials	√		√
Network Adequacy	**Q**	**A**	**T**
Correctness of Provider Directories	√		
Compliance with Routine Care Appointment Requirements		√	√
Compliance with Urgent Care Appointment Requirements		√	√
HEDIS	**Q**	**A**	**T**
Weight Assessment and Counseling for Nutrition and Physical activity for Children/Adolescent	√	√	√
Childhood Immunization Status	√		√
Immunizations for Adolescents	√		√
Appropriate Treatment for Children with Upper Respiratory Infection	√		
Appropriate Testing for Children with Pharyngitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Chlamydia Screening in Women	√		√
Comprehensive Diabetes Care	√		√
Plan All-Cause Readmission	√	√	√
Use of Imaging Studies for Low Back Pain	√		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	√		
Adult BMI Assessment	√		√
Controlling High Blood Pressure	√		√
Annual Monitoring for Patients on Persistent Medications	√		√
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	√		
Medication Management for People with Asthma	√		
Adults' Access to Preventive/Ambulatory Health Services	√	√	√
Children and Adolescents' Access to Primary Care Practitioners	√	√	√
Prenatal and Postpartum Care	√	√	√

HEDIS	Q	A	T
Ambulatory Care		√	
Well–Child Visits in the First 15 Months of Life	√	√	√
Well–Child Visits in the 3rd, 4th, 5th and 6th Years of Life	√	√	√
Adolescent Well–Care Visits	√	√	√
Risk of Continued Opioid Use – *New*	√		
Statin Therapy for Patients with Diabetes	√		
Statin Therapy for Patients with Cardiovascular Disease	√		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	√		√
Pharmacotherapy Management of COPD Exacerbation	√		√
Asthma Medication Ratio	√		
Persistence of Beta–Blocker Treatment After a Heart Attack	√		√
Lead Screening in Children	√	√	
Non–Recommended Cervical Cancer Screening in Adolescent Females	√	√	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	√	√	
Diabetes Monitoring for People with Diabetes and Schizophrenia	√	√	
Frequency of Selected Procedures		√	
Inpatient Utilization – General Hospital/Acute Care	√	√	
Antibiotic Utilization	√	√	
Use of Opioids at High Dosage	√		
Use of Opioids from Multiple Providers	√		
Board Certification	√		
Enrollment by Product Line		√	
Enrollment by State		√	
Language Diversity of Membership		√	
Race/Ethnicity Diversity of Membership		√	
Total Membership		√	
CAHPS	**Q**	**A**	**T**
Getting Needed Care		√	
Getting Care Quickly			√
How Well Doctors Communicate	√		
Customer Service	√	√	
Shared Decision Making	√		
Access to Prescription Medicine*		√	
Access to Specialized Services*		√	
Personal Doctor Who Knows Your Child*	√		
Getting Needed Information*	√		
Coordination of Care for Children with Chronic Conditions*	√		

*Additional Composite Measures for Children with Chronic Conditions

Systems Performance Review

Introduction

COMAR 10.67.04 requires that all HealthChoice MCOs comply with the Systems Performance Review (SPR) standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for Calendar Year (CY) 2018. All nine MCOs were evaluated for this review period.

Purpose and Process

The purpose of the SPR is to provide an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

The CY 2018 SPR was conducted as a comprehensive onsite review at the MCO offices. This was the first onsite review subsequent to MDH's decision to transition to a triennial review process. Both CY 2016 and CY 2017 reviews were conducted as Interim Desktop Reviews focusing on standards that were not fully met in previous reviews, scored as baseline in previous reviews, or new. The CY 2018 onsite SPR applied the systems performance standards defined for CY 2018 in the Code of Maryland Regulations (COMAR) 10.67.04.03B(1). Additionally, a sample of grievance, appeal, and adverse determination records were reviewed to assess compliance with applicable standards.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; COMAR; the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and MDH policies. The Medical Benefits Management Administration (MBMA) leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO SPR standards and guidelines used in CY 2018.

The review team that performed the annual SPRs consisted of health care professionals: a nurse practitioner and two masters prepared reviewers. The team has combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice. Feedback was provided to DHQA and each MCO with the goal of improving care provided to HealthChoice enrollees.

Methodology

For CY 2018, COMAR 10.67.04 required that all HealthChoice MCOs comply with the SPR standards established by MDH and all applicable federal and state laws and regulations.

In September 2018, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2018 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2018/2019 Review Timeline

- External Quality Review Contact Persons
- Presite Visit Overview and Survey
- Presite SPR Document List
- CY 2018 Systems Performance Review Standards and Guidelines, including specific changes

The following performance standards were included in the CY 2018 SPR:

- Standard 1: Systematic Process of Quality Assessment
- Standard 2: Accountability to the Governing Body*
- Standard 3: Oversight of Delegated Entities
- Standard 4: Credentialing and Recredentialing*
- Standard 5: Enrollee Rights
- Standard 6: Availability and Accessibility
- Standard 7: Utilization Review
- Standard 8: Coordination of Care
- Standard 9: Health Education*
- Standard 10: Outreach
- Standard 11: Fraud and Abuse

*Note: These standards were exempt from review for MCOs that achieved 100% in past reviews (except for new elements and/or components).

Prior to the onsite review, the MCOs were required to submit a completed presite survey form and provide documentation for various processes such as quality, utilization management, delegation, credentialing, enrollee rights, coordination of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Qlarant.

During the onsite reviews conducted in January through March 2019, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Qlarant evaluates each standard by assessing compliance with all related elements and components, which are then individually scored. Each standard breaks down into elements, and some elements break down further into individual components. Each element and component corresponds with a specific regulatory or policy requirement MCOs must meet.

The level of compliance for each element and component was scored with a review determination of “Met”, “Partially Met”, or “Unmet” as shown in Table 2:

Table 2. Score Level for Element and Component

Assessment	Scoring
Met	100%
Partially Met	50%
Unmet	0%

Each element or component of a standard was weighted equally. A corrective action plan (CAP) was required for each performance standard that did not meet the minimum required compliance score, as defined for the CY 2018 review. If an MCO chose to have standards in their policies and procedures that were higher than what was required by MDH, the MCO was held accountable to the standards which were outlined in their policies and procedures during the SPR. MDH also had the discretion to change a review finding to "Unmet" if the element or component had been found "Partially Met" for more than one consecutive year.

Each MCO was expected to meet the minimum compliance rate of 100% for all standards except for ABH. The minimum compliance rate was set at 80% for ABH for its first scored SPR. The CY 2017 SPR was a baseline review for ABH as the MCO joined HealthChoice in October 2017.

Preliminary results of the SPR were compiled and submitted to MDH for review. Upon MDH's approval, the MCOs received a report containing individual review findings. The MCOs were required to submit a CAP for any element/component that did not meet the minimum compliance rate. After receiving the preliminary reports, the MCOs were given 45 calendar days to respond to Qlarant with required CAPs. The MCOs could have also responded to any other issues contained in the report at its discretion within this same time frame, requested a consultation with MDH and Qlarant to clarify issues, and/or asked for assistance in preparing a CAP.

Findings

If the MCOs did not meet the minimum compliance rate, a CAP was required. One MCO (JMS) received compliance scores of 100% in all standards reviewed. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for CY 2018. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Table 3 provides a comparison of SPR results across MCOs and the MD MCO Compliance Score for CY 2018.

Table 3. CY 2018 MCO SPR Results

Standard	MD MCO Compliance Score	ABH+	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Systematic Process of Quality Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2. Accountability to Governing Body	93%	93%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
3. Oversight of Delegated Entities	88%	50%	58%	100%	63%	100%	100%	100%	100%	100%
4. Credentialing and Recredentialin	99%	99%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
5. Enrollee Rights	91%	94%	91%	100%	69%	89%	97%	88%	100%	88%
6. Availability and Accessibility	86%	95%	85%	100%	85%	80%	90%	85%	100%	55%
7. Utilization Review	93%	93%	90%	100%	83%	95%	100%	88%	95%	91%
8. Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
9. Health Education	100%	100%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
10. Outreach	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
11. Fraud, Waste, and Abuse	94%	90%	90%	100%	79%	96%	100%	100%	100%	88%♦
Composite Score	**97%**	**95%**	**95%**	**100%**	**90%**	**96%**	**99%**	**96%**	**99%**	**94%**

+ABH's minimum compliance threshold was set at 80%, as this was the MCO's first scored SPR.

♦Quarterly updates required on CAP per MDH Performance Monitoring Policy.

Red highlighted scores denote compliance below the 100% minimum threshold requirement. Green highlighted scores denote compliance at the 100% threshold requirement. Exempt means the area was not required to be reviewed.

For each standard assessed in the CY 2018 SPR, the following section describes the requirements reviewed, the overall MCO results and findings, and the follow up, if required.

Standard 1: Systematic Process of Quality Assessment and Improvement

Requirements. The Quality Assurance Program (QAP) objectively and systematically monitors/evaluates the quality of care (QOC) and services to participants. Through QOC studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor QOC against clinical practice guidelines which are based on reasonable evidence-based practices. The QAP must have written guidelines for its QOC studies and related activities that require the analysis of clinical and

related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

Results and Findings. All MCOs were fully compliant in the area of Systematic Process of Quality Assessment and Improvement. All MCOs' QAPs were found to be comprehensive in scope and to appropriately monitor and evaluate the quality of care and service to members using meaningful and relevant performance measures. Clinical care standards and/or practice guidelines are in place which the MCOs monitor performance against annually, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Additionally, there was evidence of development, implementation, and monitoring of corrective actions.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 2: Accountability to Governing Body

Requirements. The governing body of the MCO is the Board of Directors or, where the Board's participation with the quality improvement issues is not direct, a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care. There must be documentation that the governing body has oversight of the QAP. The governing body must approve the overall QAP and an annual QAP. The governing body formally designates an accountable entity or entities within the organization to provide oversight of quality assurance, or has formally decided to provide oversight as a committee. The governing body must routinely receive written reports on the QAP that describe actions taken, progress in meeting quality objectives, and improvements made. The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO. The governing body is active in credentialing, recredentialing, and utilization review activities.

Results and Findings. All MCOs were exempt from the review of Accountability to the Governing Body except for ABH, as this was the MCO's first onsite SPR. ABH received a compliance score of 93% in this area of review for CY 2018, which was above the minimum compliance score set at 80% for the MCOs first SPR. Overall, ABH was found to have appropriate oversight by their governing board. Evidence was provided of the oversight provided by the governing body, along with ongoing feedback and direction of quality improvement activities and operational activities of the MCO.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 3: Oversight of Delegated Entities

Requirements. The MCO remains accountable for all functions, even if certain functions are delegated to other entities. There must be a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided. The MCO must also provide evidence of continuous and ongoing evaluation of delegated activities.

Results and Findings. Three MCOs (ABH, ACC, and KPMAS) had opportunities for improvement in this standard. Table 4 identifies MCOs that required CAPs in the following element/components to become compliant for the CY 2019 SPR.

Table 4. Oversight of Delegated Entities CAPs

Element/Component	ABH	ACC	KPMAS
Element 3.2: Written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.		PM	
Component 3.3 a: Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc.	PM		UM
Component 3.3 c: Review and approval of claims payment activities at least semi-annually, where applicable.	PM		PM
Component 3.3 d: Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.	UM	UM	
Component 3.3 e: Review and approval of over and under utilization reports, at least semi-annually, where applicable.	UM	UM	

PM=Partially Met; UM=Unmet

Follow-Up:

- ABH, ACC and KPMAS were required to submit CAPs for the above elements/components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2019 SPR.

Standard 4: Credentialing and Recredentialing

Requirements. The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services. The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. Credentialing Plans must designate the peer review body that has the authority to make

recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority.

MCOs must provide documentation of review and approval of new providers and sites and termination or suspend individual providers as applicable. The MCO may delegate credentialing/recredentialing activities with a written description of the delegated activities, a description of the delegate's accountability for designated activities, and evidence that the delegate accomplished the credentialing activities. The credentialing process must be ongoing and current. There must be evidence that the MCO requests information from recognized monitoring organizations about the practitioner. The credentialing application must include information regarding the use of illegal drugs, a history of loss of license and loss or limitation of privileges or disciplinary activity, and an attestation to the correctness and completeness of the application. There must be evidence of an initial visit to each potential primary care physician's (PCP's) office with documentation of a review of the site and medical record keeping practices to ensure compliance with the Americans with Disabilities Act and the MCO's standards. MCOs must provide evidence that recredentialing is performed at least every three years and includes a review of enrollee complaints, results of quality reviews, hospital privileges, current licensure, and office site compliance with Americans with Disabilities Act of 1990 (ADA) standards, if applicable.

Policies and procedures should be directed at ensuring that participant choice is enhanced by providers participating in multiple MCOs; ensuring that providers are retained within the Medicaid network.

MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP.

MCO must be compliant with the COMAR 10.67.04.17B(4) requirements for notifying and reporting provider terminations.

Results and Findings. ABH had opportunities for improvement in this standard. Table 5 identifies the required CAP in the following element/components to facilitate ABH compliance in the CY 2019 SPR.

Table 5. Credentialing and Recredentialing CAP

Element/Component	ABH
Element 4.8: There is evidence that recredentialing is performed at least every three years.	PM
Component 4.8 e: Meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.	PM

PM=Partially Met

Follow-Up:

- ABH was required to submit a CAP for the above element/component. Qlarant reviewed and approved the submission.
- The approved CAP will be reviewed in CY 2019 SPR.

Standard 5: Enrollee Rights

Requirements. MCOs must demonstrate a commitment to treating participants in a manner that acknowledges their rights and responsibilities. The MCO must have a system linked to the QAP for resolving participants' grievances. This system must meet all requirements in COMAR 10.67.09.02 and 10.67.09.04. Enrollee information must be written to be readable and easily understood. This information must be available in the prevalent non-English languages identified by MDH. The MCO must act to ensure that the confidentiality of specified patient information and records are protected. The MCO must have written policies regarding the appropriate treatment of minors. The MCO must, as a result of the enrollee satisfaction surveys, identify and investigate sources of enrollee dissatisfaction, implement steps to follow-up on the findings, inform practitioners and providers of assessment results, and reevaluate the effectiveness of the implementation steps at least quarterly. The MCO must have systems in place to assure that new participants receive required information within established time frames.

Results and Findings. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in this standard. Table 6 identifies MCO required CAPs in the following elements/components to become compliant for the CY 2019 SPR. The MCO met the standard unless otherwise noted.

Table 6. Enrollee Rights CAPs

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
Component 5.1a: There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.						UM
Component 5.1c: The system ensures that the resolution of a grievance is documented according to policy and procedure.		UM			PM	
Component 5.1d: The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.		UM				
Component 5.1f: There is complete documentation of the substance of the grievances and steps taken.		PM	UM			
Component 5.1g: The MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.		PM	PM		PM	
Component 5.1h: The MCO has a process in place for notifying the member in writing of the grievance determination, even if the notification was previously provided verbally.	PM	UM	PM	PM	UM	

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
Component 5.3d: Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner.						PM
Element 5.4: The MCO has written policies regarding the appropriate treatment of minors.			PM			
Component 5.5a: As a result of the enrollee satisfaction surveys, the MCO identifies and investigates sources of dissatisfaction.		UM				
Component 5.5b: As a result of the enrollee satisfaction surveys, the MCO implements steps to follow up on the findings.		UM				
Component 5.5c: The MCO informs practitioners and providers of assessment results.	UM	UM				UM
Component 5.5d: The MCO reevaluates the interventions put in place to follow up on satisfaction surveys at least quarterly.		UM			PM	
Component 5.6a: Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee.	PM			PM	PM	
Component 5.7a: The MCO's CAB membership must reflect the special needs population requirements.						PM
Component 5.8a: Materials distributed by the MCO to the enrollee will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland.		UM				
Component 5.8c: Notices and Taglines must be posted in significant communications and publications.					UM	
Component 5.9c: The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.						UM

PM=Partially Met; UM=Unmet

Follow-up:

- Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) were required to submit CAPs for the above noted elements/components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed when the SPR for CY 2019 is conducted.

Standard 6: Availability and Accessibility

Requirements. The MCO must have established measurable standards for access and availability. The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. The MCO must have a list of providers that are currently accepting new participants. The MCO must implement policies and procedures to assure that there is a system in place for notifying participants of due dates for wellness services.

Results and Findings. Six MCO (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in this standard. Table 7 identifies MCO required CAPs in the following elements/components to become compliant for the CY 2019 SPR. The MCO met the standard unless otherwise noted.

Table 7. Availability and Accessibility CAPs

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
Component 6.1b: The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.		UM	UM			PM
Component 6.1c: The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.	PM				PM	
Component 6.1d: The MCO has documented review of the Enrollee Services Call Center performance.					PM	
Component 6.2b: At the time of enrollment, enrollees are provided with information about the MCO's providers that includes requirements set forth in COMAR 10.67.05						UM
Component 6.2c: The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.			UM			PM
Component 6.2d: The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.		PM				PM

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
Component 6.3a: The MCO must have policies and procedures in place for notifying enrollees of due dates for wellness services, IHAs, and preventive services.						UM
Component 6.3c: Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	UM			UM	PM	UM

PM=Partially Met; UM=Unmet

Follow-Up:

- ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed when the SPR for CY 2019 is conducted.

Standard 7: Utilization Review

Requirements. The MCO must have a comprehensive Utilization Management Program, monitored by the governing body, and designed to evaluate systematically the use of services through the collection and analysis of data in order to achieve overall improvement. The Utilization Management Program must specify criteria for Utilization Review/Management decisions. The written Utilization Management Plan must have mechanisms in place to detect over utilization and underutilization of services. For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization, concurrent review, and appeal decisions are made and supervised by appropriate qualified medical professionals; efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate; the reasons for decisions are clearly documented and available to the enrollee; there are well publicized and readily available appeal mechanisms for both providers and participants; preauthorization and concurrent review decisions are made in a timely manner as specified by the State; appeal decisions are made in a timely manner as required by the exigencies of the situation; and the MCO maintains policies and procedures pertaining to provider appeals as outlined in COMAR 10.67.09.03. Adverse determination letters must include a description of how to file an appeal and all other required components. The MCO must also have policies, procedures, and reporting mechanisms in place to evaluate the effects of the Utilization Management Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

Results and Findings. Six MCOs (ACC, KPMAS, MPC, PPMCO, UHC, and UMHP) have opportunities for improvement in this standard. Table 8 identifies MCO required CAPs in the following elements/components to become compliant for the CY 2019 SPR. The MCO met the standard unless otherwise noted.

Table 8. Utilization Review CAPs

Element/Component	ACC	KPMAS	MPC	PPMCO	UHC	UMHP
Component 7.2d: There must be evidence that UR criteria are reviewed and updated according to MCO policies and procedures.	UM				UM	
Component 7.3b: UR reports must provide the ability to identify problems and take the appropriate corrective action.				PM		
Component 7.3c: Corrective measures implemented must be monitored.				UM		
Element 7.6: The MCO must meet adverse determination notification timeframes in response to preauthorization requests as specified by the State.	PM	PM		UM		
Component 7.7e: Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.		PM				UM
Component 7.9a: The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.		PM				
Component 7.9b: The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.		UM				
Component 7.9c: The MCO acts upon identified issues as a result of the review of the data.		UM				
Component 7.11a: The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.	PM		UM			PM

PM=Partially Met; UM=Unmet

Follow-Up:

- ACC, KPMAS, MPC, PPMCO, UHC, and UMHP were required to submit CAPs for the above element/components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed when the SPR for CY 2019 is conducted.

Standard 8: Continuity of Care

Requirements. The MCO must put a basic system in place that promotes continuity of care and case management. Participants with special needs and/or those with complex health care needs must have access to case management according to established criteria and must receive the appropriate services. The MCO must have policies and procedures in place to coordinate care with other appropriate agencies or institutions (e.g., school health programs). The MCO must monitor continuity of care across all services and treatment modalities. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals). The MCO must ensure appropriate initiation of care based on the results of the Health Risk Assessment (HRA) data supplied to the MCO. This must include a process for gathering HRA data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.

Results and Findings. All MCOs were fully compliant in this standard. Overall, the findings, conclusions, actions taken, and results of actions taken as a result of the MCO's quality assurance activities are documented and reported to appropriate individuals within the MCO's structure and through the established quality assurance channels. All MCOs have allocated resources, such as automated tracking methodologies, that facilitate communication between members, PCPs, other health care professionals, and the MCO's care coordinators.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 9: Health Education

Requirements. The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population. The Health Education Plan must incorporate activities that address needs identified through the analysis of enrollee data and have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. The Health Education Plan must provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. The Health Education Plan must contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals. The MCO must have mechanisms in place to identify participants in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning. The MCO must make the education program available to the enrollee population and demonstrate that participants have attended.

Results and Findings. All MCOs were exempt from review of the Health Education standard except for ABH as this was the MCOs first SPR. ABH received full compliance (100%) in CY 2018. The MCO's Health Education Plans were found to be comprehensive and include policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education. The MCO met the standard unless otherwise noted.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 10: Outreach Plan

Requirements. The MCO must have developed a comprehensive written Outreach Plan to assist participants in overcoming barriers in accessing health care services. The Outreach Plan must adequately describe the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the Outreach Plan, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.

Results and Findings. All MCOs were fully compliant for the Outreach Plan standards. Overall, the Outreach Plans were found to have adequately described the populations served, an assessment of common health problems, and barriers to outreach within the MCO's membership. The MCOs also described the organizational capacity to provide both broad-based and enrollee specific outreach in the plan. The unique features of the MCO's enrollee education initiatives, community partnerships, and the roles of the provider network and local health departments were also included in the Outreach Plan. Appropriate supporting evidence of the outreach activities was also provided.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 11: Fraud, Waste, and Abuse

Requirements. The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.

Results and Findings. Four MCOs (ACC, KPMAS, MPC and UMHP) have opportunities for improvement in this standard. Table 9 identifies MCO required CAPs in the following elements/components to become compliant for the CY 2019 SPR. The MCO met the standard unless otherwise noted.

Table 9. Fraud, Waste, and Abuse CAPs

Element/Component	ACC	KPMAS	MPC	UMHP
Component 11.1 f: A documented process to ensure that services billed to the MCO were actually received by the enrollee. Due to continued opportunities from the CY 2017 SPR, UMHP requires quarterly monitoring of the CAP for			UM	UM

Element/Component	ACC	KPMAS	MPC	UMHP
11.1f according to MDH's Performance Monitoring Policy.				
Component 11.2e: A documented process for enforcement of standards through clear communication of well publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse.		UM		
Component 11.4a: Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.	PM	UM		PM
Component 11.4b: Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP.		UM		PM
Component 11.4c: Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.	UM	UM		PM
Component 11.4d: Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	UM	UM		
Component 11.5d: An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM.				PM

PM=Partially Met; UM=Unmet

Follow-Up:

- ACC, KPMAS, MPC, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- UMHP is required to provide quarterly updates on the CAP in CY 2018 in adherence with MDH's Quality Monitoring Policy.
- The approved CAPs will be reviewed when the SPR for CY 2019 is conducted.

Corrective Action Plans

The CAP process requires that each MCO submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the SPR results. CAPs are reviewed by Qlarant and determined to be adequate only if they address the following required elements and components:

- Action item(s) to address each required element or component
- Methodology for evaluating the effectiveness of actions taken
- Time frame for each action item, including plans for evaluation
- Responsible party for each action item

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for the CY 2018 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2019 will determine whether the CAPs from the CY 2018 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

Table 10 provides the required CAPs for each of the MCOs as a result of the CY 2018 review.

Table 10. CY 2018 MCO CAP Requirements

Standard	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
3. Oversight of Delegated Entities	3.3a 3.3c 3.3d 3.3e	3.2 3.3d 3.3e		3.3a 3.3c					
5. Enrollee Rights		5.1h 5.5c 5.6a		5.1c 5.1d 5.1f 5.1g 5.1h 5.5a 5.5b 5.5c 5.5d 5.8a	5.1f 5.1g 5.1h 5.4	5.1h 5.6a	5.1c 5.1g 5.1h 5.5d 5.6a 5.8c		5.1a 5.3d 5.5c 5.7a 5.9c
6. Availability and Access		6.1c 6.3c		6.1b 6.2d	6.1b 6.2c	6.3c	6.1c 6.1d 6.3c		6.1b 6.2b 6.2c 6.2d 6.3a 6.3c

Standard	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7. Utilization Review		7.2d 7.6 7.11a		7.6 7.7e 7.9a 7.9b 7.9c	7.11a		7.3b 7.3c 7.6	7.2d	7.7e 7.11a
11. Fraud, Waste, and Abuse		11.4a 11.4c 11.4d		11.2e 11.4a 11.4b 11.4c 11.4d	11.1f				11.1f* 11.4a 11.4b 11.4c 11.5d
CAPs Required	**1**	**5**	**0**	**5**	**4**	**2**	**3**	**1**	**4**

*Quarterly updates required on CAP per MDH MCO Performance Monitoring Policy

Corrective Action Plan Review

MDH implemented its Performance Monitoring Policy in 2015, whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by the EQRO. As a result, four MCOs (KPMAS, MSFC, PPMCO, and UHC) were required to submit quarterly updates of their CAPs to Qlarant in the areas of review identified in Table 11.

Table 11. CY 2017 MCO Quarterly CAPs

MCO	Element/Component
KPMAS	Component 6.1 d: The MCO has documented review of the Enrollee Services Call Center performance.
MSFC	Component 3.3 c: Review and approval of claims payment activities at least semi-annually, where applicable.
PPMCO	Component 3.3 b: Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. Component 7.4 e: Preauthorization and concurrent review decisions are made in a timely manner as specified by the State. Component 7.4 f: Appeal decisions are made in a timely manner as required by the exigencies of the situation.
UHC	Component 7.4 e: Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

Progress was reported on each of the above CAPs quarterly to Qlarant and MDH. One MCO's (UHC) CAP was recommended to be closed early (in May of 2018). Following the CY 2018 SPR, it was found that all MCOs could close the quarterly CAPs. However, one MCO (UMHP) was required to begin submitting quarterly CAP updates on a different area of review (Standard 11: Fraud and Abuse).

Conclusion

JMS continued to receive a perfect score in the CY 2018 SPR for the 9th year. For its first review since joining HealthChoice, ABH's results were high at 95%, well above the 80% benchmark for new MCOs. Composite score results demonstrate improvement for one MCO (UHC) and decline for six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP), ranging from one to five percentage points.

According to MDH's Performance Monitoring Policy, whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant, one MCO (UMHP) is required to submit quarterly updates of their CAP. As part of the triennial review process, the CY 2019 review will be conducted as an Interim Desktop Review focusing on standards that were not fully met in CY 2018, scored as baseline in previous reviews, or new.

Overall, HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees.

Value-Based Purchasing

Introduction

The Maryland Department of Health (MDH) worked with the Center for Health Care Strategies in 1999 to develop a Value-Based Purchasing (VBP) initiative for HealthChoice, Maryland's Medicaid managed care program. VBP improves quality by awarding business and incentives to contractors based on their performance along a range of dimensions. The goal of Maryland's purchasing strategy is to achieve better enrollee health through improved managed care organization (MCO) performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care and increased access. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice.

MDH contracted with Qlarant and MetaStar, Inc. (MetaStar), a NCQA–Licensed HEDIS Compliance Audit Organization, to validate calendar year (CY) 2018 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data and determines the extent to which specific performance measure calculations followed established specifications. A validation (or audit) determination is assigned to each measure, indicating whether the result is fully compliant, substantially compliant, or not valid. MetaStar performed the validation of the HEDIS–based VBP measurement data for all of the HealthChoice MCOs using the NCQA's HEDIS Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures. Qlarant validated the measures developed by MDH and calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Performance Measure Selection Process

MDH identifies priority health outcome areas in selecting the performance measures. Measures may be added or removed, based upon evolving MDH priorities and participant health care needs.

MDH selects measures that are:

1. Relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, adults with disabilities, and adults with chronic conditions;
2. Prevention–oriented and associated with improved outcomes;
3. Measurable with available data;
4. Comparable to national performance measures for benchmarking;
5. Consistent with how CMS is developing a national set of performance measures for Medicaid; and
6. Possible for MCOs to affect change.

Value-Based Purchasing Validation

Several measures (Table 12) are included in the CY 2018 VBP program. They are chosen from NCQA's HEDIS data set and developed from encounter data supplied by the HealthChoice MCOs. Validation is subsequently provided by MetaStar and Qlarant. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 12. CY 2018 VBP Measures

Performance Measure	Domain	Measure	Reporting Entity
Adolescent Well-Care Visits: Adolescents ages 12-21 (enrolled 320 or more days) receiving at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Use of Services	HEDIS	MCO
Adult BMI Assessment: Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	Effectiveness of Care	HEDIS	MCO
Ambulatory Care Visits for SSI Adults - Ages 21 to 64 Years: SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Access to Care	Encounter Data	MDH
Ambulatory Care Visits for SSI Children - Ages 0 to 20 Years: SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Access to Care	Encounter Data	MDH
Asthma Medication Ratio: Enrollees ages 5-85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Effectiveness of Care	HEDIS	MCO
Breast Cancer Screening: Women 50–74 years of age who had a mammogram to screen for breast cancer	Effectiveness of Care	HEDIS	MCO
Childhood Immunization Status - Combination 3: Children who turned 2 years of age during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DTaP, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's 2nd birthday	Effectiveness of Care	HEDIS	MCO

Performance Measure	Domain	Measure	Reporting Entity
Comprehensive Diabetes Care – HbA1c Testing: Enrollees 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test	Effectiveness of Care	HEDIS	MCO
Controlling High Blood Pressure: Enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year	Effectiveness of Care	HEDIS	MCO
Immunizations for Adolescents - Combination 1: Adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine and either one Tdap or Td vaccine by their 13th birthday	Effectiveness of Care	HEDIS	MCO
Lead Screenings for Children - Ages 12 to 23 Months: Children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year	Effectiveness of Care	Encounter, Lead Registry, & Fee For Service Data	MDH
Postpartum Care: Deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Access to Care	HEDIS	MCO
Well-Child Visits for Children - Ages 3 to 6 Years: Children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the measurement year, consistent with American Academy of Pediatrics & EPSDT recommended number of visits	Use of Services	HEDIS	MCO

HEDIS Measure Validation

HealthChoice MCOs are required to produce and report audited HEDIS data under Code of Maryland Regulations (COMAR) 10.67.04.03B(2). In order to avoid duplicating efforts and placing undue administrative burden on the HealthChoice MCOs, MDH used ten of the HEDIS audit measure determinations as VBP measure determinations.

Ten of the CY 2018 VBP measures are HEDIS measures and are validated under the HEDIS Compliance Audit:

- Adolescent Well-Care Visits
- Adult Body Mass Index (BMI) Assessment
- Asthma Medication Ratio

- Breast Cancer Screening
- Childhood Immunization Status - Combination 3
- Comprehensive Diabetes Care – HbA1c Testing
- Controlling High Blood Pressure
- Immunizations for Adolescents - Combination 1
- Postpartum Care
- Well-Child Visits for Children - Ages 3 to 6

The goal of the HEDIS audit is to ensure accurate, reliable, and publicly reportable data. The HEDIS Compliance Audit is conducted in three phases: offsite, onsite, and post onsite (reporting). The offsite audit phase includes a review of each MCO's HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap is used to supply information about an MCO's data systems and HEDIS data reporting structure and processes. Other activities of the offsite audit process include the selection of HEDIS measures to audit in detail (results are then extrapolated to the rest of the HEDIS measures), investigation of measure rotation strategies, and validation of the medical record review process by the certified audit firm.

Prior to the onsite phase, MetaStar holds annual auditor conference calls with all MCOs to address any NCQA changes or updates to the audit guidelines and provide technical assistance.

During the onsite phase, auditors investigate issues identified in the Roadmap and observe the systems used to collect and produce HEDIS data. The audit team interviews MCO staff; reviews MCO information system structure, protocols, and processes; and reviews MCO measure-specific data collection processes with the MCO staff.

The post onsite and reporting phase of the HEDIS Compliance Audit includes the issuance of a follow-up letter to the MCO that lists any items the auditors still require to complete the audit; a list of corrective actions for problems found in the Roadmap or onsite, as well as the necessary completion dates; and preliminary audit findings specifically indicating the measures at risk for a *Not Reportable* designation. When the MCO has provided all requested documents and performed the recommended corrective actions, the auditor completes a final audit report and assigns audit designations indicating the suitability of measures for public reporting. The four possible audit designations are explained in Table 13. The final activity of the post onsite phase of the audit consists of the MCO submitting data to NCQA, using NCQA's Interactive Data Submission System.

Table 13. HEDIS Compliance Audit Designations

Audit Findings	Description	Rate/Results
Reportable rate or numeric result for HEDIS measures.	Reportable Measure	0-XXX
The MCO followed the specifications but the denominator was too small to report a valid rate.	Denominator <30.	NA
The MCO did not offer the health benefits required by the measure (e.g., specialty mental health).	No Benefit	NB
The MCO calculated the measure but the rate was materially biased, or the MCO was not required to report the measure.	Not Reportable	NR

NA=Not Applicable, NB=No Benefit, NR=Not Reportable

Maryland Encounter Data Measure Validation

Three CY 2018 Maryland encounter data measures were calculated by Hilltop. Hilltop used encounter data submitted by the MCOs, Maryland Department of the Environment's Lead Registry data, and Fee-for-Service data. The measures include:

- Ambulatory Care Visits for SSI Adults
- Ambulatory Care Visits for SSI Children
- Lead Screenings for Children - Ages 12 to 23 Months

Qlarant validated the above measures including the specifications for each measure, source code to determine algorithmic compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the encounter data process.

Table 14 indicates the possible validation determinations of the measures to characterize the findings. To validate the rates calculated, two analysts reviewed and approved the measure creation process and source code.

Table 14. Possible Validation Determinations for EQRO-Validated Measures

Validation Determination	Definition
Fully Compliant	Measure was fully compliant with State specifications and reportable.
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid	Measure deviated from state specifications such that the reported rate was significantly biased. This designation is also assigned to measures where no rate was reported, although reporting of the rate was required.
Not Applicable	Measure was not reported because the entity did not have any Medicaid enrollees that qualified for the denominator.

Validation Results

Validation of the VBP measures results in a determination of the effect of bias on the resulting statistic. Validation determinations by MetaStar are reported using the audit designations and rationales outlined by NCQA as part of the HEDIS Compliance Audit.

All of the HEDIS VBP measures audited by MetaStar were determined to be reportable for all MCOs.

Table 15 shows the results of the encounter data measure validation activities. Hilltop was responsible for producing the encounter data measure results at the MCO level. The EQRO validated the measure specifications, source code, and preliminary and final results. During the validation process undertaken by Qlarant, no issues were identified that could have introduced bias to the resulting statistics.

Table 15. EQRO VBP Measure Validation Determinations

Measure	Validation Determinations
Ambulatory Care Visits for SSI Adults	Fully Compliant
Ambulatory Care Visits for SSI Children	Fully Compliant
Lead Screenings for Children - Ages 12 to 23 Months	Fully Compliant

Incentive/Disincentive Target Setting Methodology

The following target setting methodology has been developed for the CY 2018 VBP measures:

- Targets for incentive, disincentive, and neutral ranges are based on the enrollment-weighted performance average of all MCOs from two years prior (the base year). The enrollment weight assigned to each MCO is the 12-month average enrollment of the base year.
- The midpoint of the incentive and disincentive targets for each measure is the sum of the weighted average of MCO performance on each measure in the base year and 15% of the difference between that number and 100%.
- The incentive target is calculated by determining the sum of the midpoint and 10% of the difference between the midpoint and 100%.
- The disincentive target is equal to the midpoint minus 10% of the difference between the midpoint and 100%.
- If the difference between the incentive target and disincentive target is less than 4 percentage points, then the incentive and disincentive targets will be the midpoint +/-2 percentage points.

Financial Incentive/Disincentive Methodology

As described in COMAR 10.67.04.03, MDH uses financial incentives and disincentives to promote performance improvement. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance is at or below the disincentive target. All measures are evaluated separately and are of equal weight in the methodology.

For any measure that the MCO does not meet the minimum target, a disincentive of 1/13 of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of 1/13 of 1 percent of the total capitation amount paid to the MCO during the measurement year. The amounts are calculated for each measure and the total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year, plus any additional funds allocated by MDH for a quality initiative.

Table 16 displays the incentive and disincentive targets for each measure, MCO performance, and MCO net incentives and disincentives earned.

Performance Measure Results

Table 16. MCO CY 2018 VBP Performance Summary

Performance Measure	CY 2018 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adolescent Well-Care Visits	Incentive: ≥ 74% Neutral: 69%–73% Disincentive: ≤ 68%	74% (I)	77% (I)	65% (D)	57% (D)	54% (D)	57% (D)	65% (D)	62% (D)
Adult BMI Assessment	Incentive: ≥ 94% Neutral: 91%–93% Disincentive: ≤ 90%	94% (I)	99% (I)	98% (I)	89% (D)	100% (I)	94% (I)	85% (D)	94% (I)
Ambulatory Care Visits for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	82% (D)	91% (I)	69% (D)	84% (N)	82% (D)	86% (N)	80% (D)	88% (I)
Ambulatory Care Visits for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	85% (N)	90% (I)	76% (D)	82% (D)	79% (D)	85% (N)	80% (D)	86% (I)
Asthma Medication Ratio	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	66% (D)	73% (I)	74% (I)	58% (D)	62% (D)	60% (D)	62% (D)	57% (D)
Breast Cancer Screening	Incentive: ≥ 75% Neutral: 71%–74% Disincentive: ≤ 70%	69% (D)	76% (I)	80% (I)	56% (D)	69% (D)	70% (D)	59% (D)	76% (I)
Childhood Immunization Status - Combination 3	Incentive: ≥ 85% Neutral: 82%–84% Disincentive: ≤ 81%	80% (D)	81% (D)	80% (D)	70% (D)	79% (D)	75% (D)	73% (D)	83% (N)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 92% Neutral: 89%–91% Disincentive: ≤ 88%	86% (D)	95% (I)	93% (I)	81% (D)	90% (N)	87% (D)	84% (D)	89% (N)

Performance Measure	CY 2018 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Controlling High Blood Pressure	Incentive: ≥ 71% Neutral: 65%–70% Disincentive: ≤ 64%	59% (D)	73% (I)	80% (I)	46% (D)	60% (D)	50% (D)	57% (D)	66% (N)
Immunizations for Adolescents - Combination 1	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%	90% (N)	92% (I)	83% (D)	88% (N)	90% (N)	92% (I)	91% (I)	90% (N)
Lead Screenings for Children Ages - 12 to 23 Months	Incentive: ≥ 70% Neutral: 64%–69% Disincentive: ≤ 63%	66% (N)	75% (I)	71% (I)	56% (D)	57% (D)	67% (N)	58% (D)	64% (N)
Postpartum Care	Incentive: ≥ 78% Neutral: 75%–77% Disincentive: ≤ 74%	78% (I)	90% (I)	84% (I)	67% (D)	78% (I)	71% (D)	66% (D)	79% (I)
Well-Child Visits for Children - Ages 3 to 6	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	88% (I)	91% (I)	85% (N)	72% (D)	77% (D)	80% (D)	84% (N)	82% (D)
Total # of Incentives/Neutral/Disincentives		4/3/6	12/0/1	7/1/5	0/2/11	2/2/9	2/3/8	1/1/11	5/5/3
Measure Value		$856,207.97	$153,617.15	$208,498.76	$888,429.46	$362,395.86	$1,143,657.84	$543.867.02	$185,531.94
Net Incentive/Disincentive Amounts		($1,712,415.94)	$1,689,788.65	$416,997.52	($9,772,724.06)	($2,536,771.02)	($6,861,947.04)	($5,438,670.20)	$371,063.88

Incentive amounts are identified in green.
Disincentive amounts are identified in red.

Performance Improvement Projects

Introduction

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio PIP, and the Lead Screening PIP replaced the Controlling High Blood Pressure PIP in 2018. This report summarizes the findings from the validation of both PIPs. All MCOs conducted PIPs in 2019 except ABH, since the MCO joined the HealthChoice program in October 2017.

Purpose and Objectives

Each MCO was required to conduct PIPs that were designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care or non-clinical care areas that were expected to have a favorable effect on health outcomes. The PIPs included measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. In addition to improving the quality, access, or timeliness of service delivery, the process of completing a PIP functions as a learning opportunity for the MCO. The processes and skills required in PIPs, such as indicator development, root cause analysis, and intervention development, are transferable to other projects that can lead to improvement in other health areas.

Topics Selected

The Asthma Medication Ratio PIP was initiated in February 2017 using HEDIS 2017 rates as the baseline measurement for MCOs. The Lead Screening PIP was initiated in March 2018 using HEDIS 2018 and CY 2017 Maryland encounter data measure rates as the baseline measurements for MCOs.

Asthma Medication Ratio PIP

The asthma medication ratio measure seeks to increase the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Asthma is a chronic lung disease that affects Marylanders regardless of age, sex, race, or ethnicity. Although the exact cause of asthma is unknown and it cannot be cured, it can be controlled with self-management, education, appropriate medical care, and avoiding exposure to environmental triggers. In Maryland, asthma results in millions of dollars in health care costs — costs that are largely preventable through an evidence-based, public health approach to asthma control.

Lead Screening PIP

The lead screening measure seeks to increase the percentage of children 2 years of age who had one or more capillary or venous blood level tests for lead poisoning by their second birthday. The Maryland encounter data measure seeks to increase the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year. Childhood lead poisoning is a completely preventable disease. Exposure to lead is the most significant and widespread

environmental hazard for children in Maryland. Children are at the greatest risk while their neurological systems are developing, from birth to age 6. Exposure to lead can cause long-term neurological damage that may be associated with learning difficulties, behavioral problems, and decreased intelligence. According to the Maryland Department of the Environment's Annual Surveillance Report, statewide data indicates only 20.6% of the 535,094 children between ages zero to 72 months were tested for lead in 2015. This PIP aims to support lead testing and ensure that providers and MCOs are aware of the funds that are available for both environmental lead investigations and lead abatement.

Beginning with the Lead Screening PIP, all new PIPs will use the new Rapid Cycle PIP Process in order to provide MCOs with a quality improvement method that identifies, implements, and measures changes over short periods. This PIP process aligns with the CMS EQR PIP Validation Protocol and utilized the following development and implementation requirements:

1. **Develop an appropriate project rationale** based on supporting MCO data.
2. **Develop clear and measurable study questions**.
3. **Identify performance measures** that address the project rationale and reflect the study questions. Our performance measurement and performance improvement team work collaboratively to ensure MCOs have the right performance measures and data collection methodologies in place that will facilitate accurate and valid performance measure reporting.
4. **Identify barriers** including member, provider, and MCO barriers.
5. **Develop improvement strategies** or interventions.
6. **Measure, assess, and analyze the impact of the interventions**. MCOs must measure performance frequently (such as on a monthly or quarterly basis). Using performance measure results, it is critical to study the impact of interventions to determine which interventions may be effective and which interventions may need to be modified, replaced, or eliminated.

Validation Process

The guidelines utilized for PIP review activities were CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects.* The tool assists in evaluating whether the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Each MCO was required to provide the study framework and project description for each PIP. This information was reviewed to ensure that each MCO was using relevant and valid study techniques. Annual PIP submissions were required in September. The annual submissions included results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the defined data analysis plan, and information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO decided to modify other portions of the project, updates to the submissions were permitted in consultation with Qlarant and MDH.

Reviewers evaluated each project submitted using a standard validation tool that employed the CMS validation methodology, which included assessing each project in the following ten critical areas. The 10-step validation is summarized in Table 17.

Table 17. 10–Step Validation Methodology to PIP Validation

Validation Steps	Qlarant's Validation Process
Step 1. The **study topic** selected must be appropriate and relevant to the MCO's population.	Review the study topic/project rationale and look for demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO–specific data should support the study topic.
Step 2. The **study question(s)** must be clear, simple, and answerable.	Identify a study question that addresses the topic and relates to the indicators.
Step 3. The **study indicator(s)** must be meaningful, clearly defined, and measurable.	Examine each project indicator to ensure appropriateness to the activity. Numerators/denominators and project goals should be clearly defined.
Step 4. The **study population** must reflect all individuals to whom the study questions and indicators are relevant.	Examine the study population (targeted population) relevancy, which is provided in the project rationale and indicator statements.
Step 5. The **sampling method** must be valid and protect against bias.	Assess the techniques used to provide valid and reliable information.
Step 6. The **data collection procedures** must use a systematic method of collecting valid and reliable data representing the entire study population.	Review the project data sources and collection methodologies, which should capture the entire study population.
Step 7. The **improvement strategies**, or interventions, must be reasonable and address barriers on a system level.	Assess each intervention to ensure project barriers are addressed. Interventions are expected to be multi–faceted and induce permanent change. Interventions should demonstrate consideration of cultural and linguistic differences within the targeted population.
Step 8. The **study findings**, or results, must be accurately and clearly stated. A comprehensive quantitative and qualitative analysis must be provided.	Examine the project results, including the data analysis. Review the quantitative and qualitative analysis for each project indicator.
Step 9. Project results must be assessed as **real improvement**.	Assess performance improvement to ensure the same methodology is repeated. Improvement should be linked to interventions, as opposed to an unrelated occurrence. Review statistical testing results, if available.
Step 10. Sustained improvement must be demonstrated through repeated measurements.	Review the results after the second re–measurement to determine consistent and sustained improvement when compared to baseline.

As Qlarant staff conducted the review, each of the components within a step was rated as "Yes", "No", or "N/A" (Not Applicable). Components were then aggregated to create a determination of "Met", "Partially Met", "Unmet", or "Not Applicable" for each of the 10 steps. The rating scale is then converted into confidence levels developed by Qlarant to assess the validation and reliability of the PIP study design for each MCO, which will be provided in the conclusion of this section (Tables 21 and 22). Table 18 describes the criteria for reaching a determination in the scoring methodology.

Table 18. Rating Scale for PIP Validation

Determination	Criteria
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Results

This section presents an overview of the findings from the validation activities completed for each PIP submitted by the MCOs. Each MCO's PIP was reviewed against all components contained within the 10 steps. Recommendations for each step that did not receive a rating of "Met" follow each MCO's results in this report.

Asthma Medication Ratio PIPs

All Asthma Medication Ratio PIPs focused on increasing the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year, according to HEDIS technical specifications.

Table 19 represents the CY 2019 Validation Results for all Asthma Medication Ratio PIPs (ABH excluded).

Table 19. Asthma Medication PIP Validation Results for CY 2019

Step/Description	CY 2019 Asthma Medication Ratio PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	M	M	M	M	M	M	M	M
2. Review the Study Question(s)	M	M	M	M	M	M	M	M
3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M	M
4. Review the Identified Study Population	M	M	M	M	M	M	M	M
5. Review Sampling Methods	NA	NA	NA	NA	NA	NA	NA	NA
6. Review Data Collection Procedures	M	M	M	M	M	M	M	M
7. Assess Improvement Strategies	PM	M	PM	PM	PM	PM	PM	PM
8. Review Data Analysis & Interpretation of Study Results	PM	M	PM	PM	PM	PM	PM	PM
9. Assess Whether Improvement is Real Improvement	M	PM	PM	PM	PM	PM	PM	PM

Step/Description	CY 2019 Asthma Medication Ratio PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
10. Assess Sustained Improvement	UM	M	UM	UM	UM	UM	UM	UM

M=Met; PM=Partially Met; UM=Unmet; NA=Not Applicable
Note: ABH did not participate in Performance Improvement Projects as they were new to the HealthChoice Program.

All MCOs received a rating of "NA" for Step 5 (Review Sampling Methods) because the entire study population was included.

Seven MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, UHC, UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). Five MCOs (ACC, MPC, MSFC, PPMCO, and UMHP) did not implement any targeted interventions to address cultural differences. Four MCOs (KPMAS, MPC, MSFC, and UHC) implemented interventions that were either too passive, too generic, and/or not timely enough to have a measurable impact on the rate. One MCO (UHC) did not develop any new interventions since January 2017.

All MCOs except JMS received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results) because they did not include all required components of the defined data analysis plan in their data analysis. Additionally, ACC and UMHP did not present all numerical results and findings accurately.

All MCOs except ACC received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement) because there was either no documented quantitative improvement in the rate compared to the previous measurement year for five MCOs (KPMAS, MPC, MSFC, UHC, UMHP) or there was no evidence that the improvement in the rate was statistically significant (JMS and PPMCO).

All MCOs except JMS received a rating of "Unmet" for Step 10 (Assess Sustained Improvement) because sustained improvement was not demonstrated through repeated measurements.

Asthma Medication Ratio PIP Identified Barriers. Annually, the HealthChoice MCOs perform a barrier analysis to identify root causes, barriers to optimal performance, and potential opportunities for improvement. The annual analysis identifies barriers to care for members, providers, and the MCOs. Common barriers across all MCOs for the Asthma Medication Ratio PIP are described below.

Member Barriers:

- Knowledge deficits
- Lack of medication compliance
- Lack of follow-up with primary care provider (PCP) or asthma specialist after emergency department (ED) visit
- Cultural practices, beliefs, values
- Presence of allergens in the home
- Lack of transportation for office appointments and prescription needs
- Cost associated with multiple medications

Provider Barriers:

- Lack of awareness of patient ED visits for asthma
- Lack of staff to provide member education and outreach
- Knowledge deficit of MCO resources/initiatives to assist with member compliance
- Knowledge deficits relating to appropriate asthma treatment
- Knowledge deficits relating to member adherence

MCO Barriers:

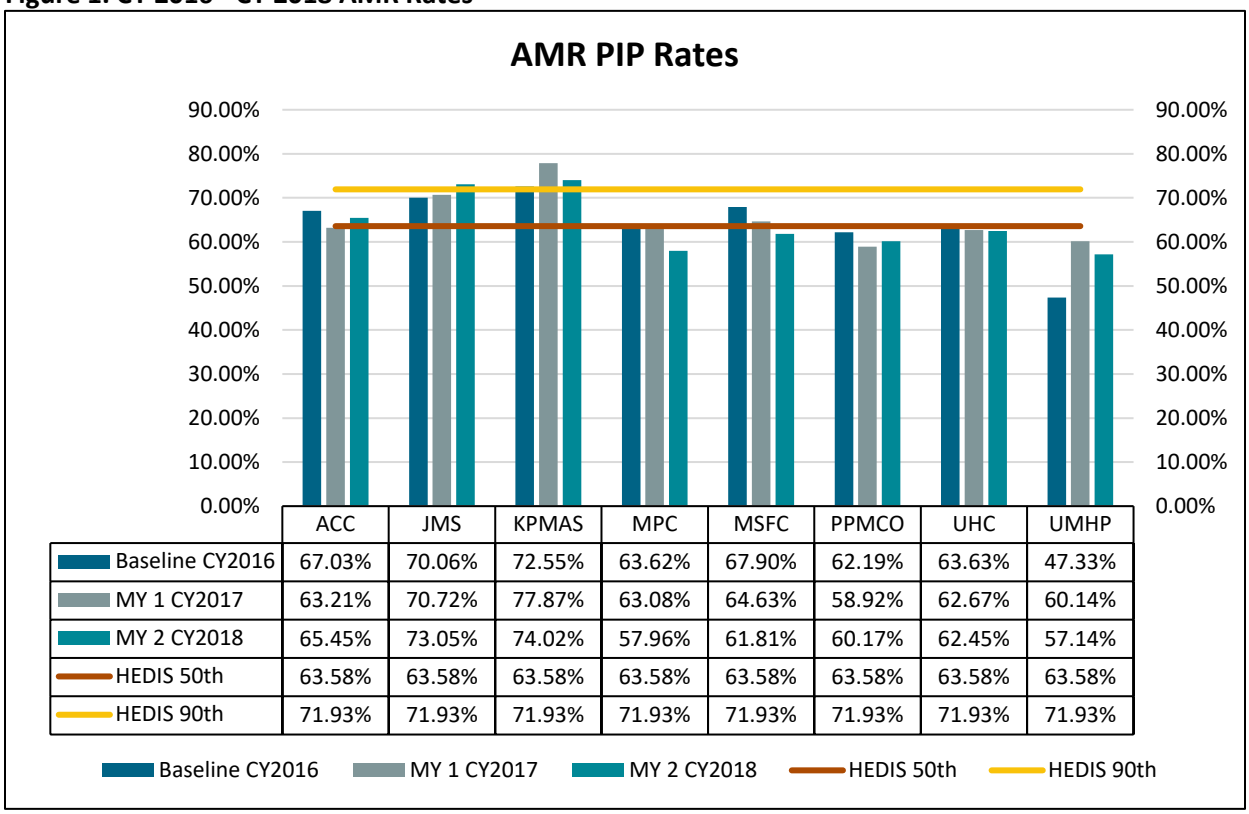
- Inaccurate member demographic information negatively impacting member outreach
- Increased denials of medications at point of service due to frequent formulary changes
- Inaccuracy of pharmacy data provided

Asthma Medication Ratio Interventions Implemented. Below are examples of interventions implemented by the HealthChoice MCOs for the Asthma Medication Ratio PIPs:

- Member education and outreach, including targeting members who meet specific criteria
- Use of CRISP (Chesapeake Regional Information System for our Patients) data by MCOs and providers to identify and target members with ED usage
- Disease/case management
- Health coaches
- Provider education
- Provider care opportunity reports
- Electronic medical record supplemental data from high volume provider sites
- Transportation for office appointments and prescription needs; pharmacy delivery of prescriptions
- Transitional care coordination to facilitate PCP follow-up after emergency department visit
- Required review of member demographics upon each member contact
- Asthma Adherence Monitoring Program through retail pharmacists
- Onsite appointment scheduling
- Chart review/patient assessment/recommended interventions by allergist of pediatric patients discharged from ED or hospital for asthma
- Creation of an electronic medical record tool to require decision-making/chart review before refilling rescue medications
- Referrals to Green and Healthy Homes for home assessment of asthma triggers
- Collaboration with school-based health centers
- Meetings with commonly used pharmacies to discuss auto refills of albuterol
- Feedback to customer service representatives on success rate of outreach calls to members to pick up their asthma controller medications from the pharmacy

Asthma Medication Ratio Indicator Results. CY 2018 is the second remeasurement year of data collection for the Asthma Medication Ratio PIP. Figure 1 represents the Asthma Medication Ratio PIP indicator rates for all MCOs.

Figure 1. CY 2016 - CY 2018 AMR Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY2016	67.03%	70.06%	72.55%	63.62%	67.90%	62.19%	63.63%	47.33%
MY 1 CY2017	63.21%	70.72%	77.87%	63.08%	64.63%	58.92%	62.67%	60.14%
MY 2 CY2018	65.45%	73.05%	74.02%	57.96%	61.81%	60.17%	62.45%	57.14%
HEDIS 50th	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%
HEDIS 90th	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%

Note: Measurement Year (MY)

There is wide variation among the MCOs in their performance relative to the HEDIS 2018 (MY 2017) Medicaid 90th Percentile benchmark. JMS and KPMAS are performing above the 90th percentile. ACC is performing above the 50th percentile. MPC, MSFC, PPMCO, UHC, and UMHP are performing below the 50th percentile.

Three MCOs demonstrated improvement in performance over their remeasurement 1 rate:

- ACC's rate increased by 2.24 percentage points, which was statistically significant
- JMS' rate increased by 2.99 percentage points
- PPMCO's rate increased by 1.25 percentage points

The remaining five MCOs experienced a decline in performance over their remeasurement rate:

- KPMAS' rate declined by 3.85 percentage points
- MPC's rate declined by 5.66 percentage points, which was statistically significant
- MSFC's rate declined by 2.82 percentage points
- UHC's rate declined by 0.22 percentage points
- UMHP's rate decreased by 3 percentage points

Lead Screening PIPs

All Lead Screening PIPs focused on increasing the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday and the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year.

Table 20 represents the CY 2019 Validation Results for all Lead Screening PIPs (ABH excluded).

Table 20. Lead Screening PIP Validation Results for CY 2019

Step/Description	CY 2019 Lead Screening PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	M	M	M	M	M	M	M	M
2. Review the Study Question(s)	M	M	M	M	M	M	M	M
3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M	M
4. Review the Identified Study Population	M	M	M	M	M	M	M	M
5. Review Sampling Methods	NA	NA	M	M	M	NA	NA	M
6. Review Data Collection Procedures	M	M	M	M	M	M	M	M
7. Assess Improvement Strategies	PM	M	PM	PM	M	PM	M	M
8. Review Data Analysis & Interpretation of Study Results	PM	M	PM	PM	PM	M	PM	PM
9. Assess Whether Improvement Is Real Improvement	PM	PM	M	PM	PM	PM	PM	M
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

M=Met; PM=Partially Met; UM=Unmet; NA=Not Applicable
Note: ABH did not participate in Performance Improvement Projects as they were new to the HealthChoice Program.

Four MCOs (ACC, KPMAS, MPC, and PPMCO) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). MPC and PPMCO did not implement sufficient interventions to achieve the long-term goal of a 10 percentage point increase over the baseline rate. Interventions were either not robust enough, insufficient in number, and/or not implemented timely. All four MCOs did not demonstrate implementation of targeted interventions in the measurement year in response to any identified linguistic and cultural barriers.

Six MCOs (ACC, KPMAS, MPC, MSFC, UHC, and UMHP) received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results). None of these MCOs provided a quantitative and/or qualitative analysis that was fully consistent with its defined analysis plan. Additionally, ACC and UHC presented one or more inaccurate numerical results.

Six MCOs (ACC, JMS, MPC, MSFC, PPMCO, and UHC) received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement). ACC, JMS, MPC, MSFC, and UHC demonstrated improvement in only the HEDIS indicator, and only ACC and UHC demonstrated that the improvement was statistically significant. PPMCO demonstrated improvement in both indicators; however, improvement in only one (VBP) was determined to be statistically significant.

All MCOs received a rating of "NA" for Step 10 (Assess Sustained Improvement) as two remeasurements must occur before sustained improvement can be assessed. Step 10 will be assessed in the CY 2020 PIP Validation.

Lead Screening PIP Identified Barriers. Below are common barriers identified among the HealthChoice MCOs for the Lead Screening PIP.

Member Barriers:

- Knowledge deficit
- Lack of transportation for routine care and lead testing
- Financial challenges impeding efforts to maintain a safe, clean, livable environment
- Housing that is not lead-free
- Difficulty communicating with providers as a result of language and/or reading preferences/abilities
- Non-adherence with preventive care visits

Provider Barriers:

- Knowledge deficit regarding different HEDIS and MDH requirements
- Providers do not trust Medtox results due to false positives
- Competing priorities during member office visits
- Lack of point of care testing resources
- Lack of resources for patient follow-up
- Inability to coordinate care with the targeted population

MCO Barriers:

- Home visit providers are not available in 12 counties
- Lack of data sharing across MCOs
- Insufficient or inaccurate member contact and demographic data
- Inability to proactively identify lead care gaps
- Limited understanding of cultural and linguistic barriers
- Lack of resources to outreach members with gaps in care, such as lead testing

Lead Screening PIP Interventions Implemented. Below are examples of interventions implemented by the HealthChoice MCOs for Lead Screening PIPs:

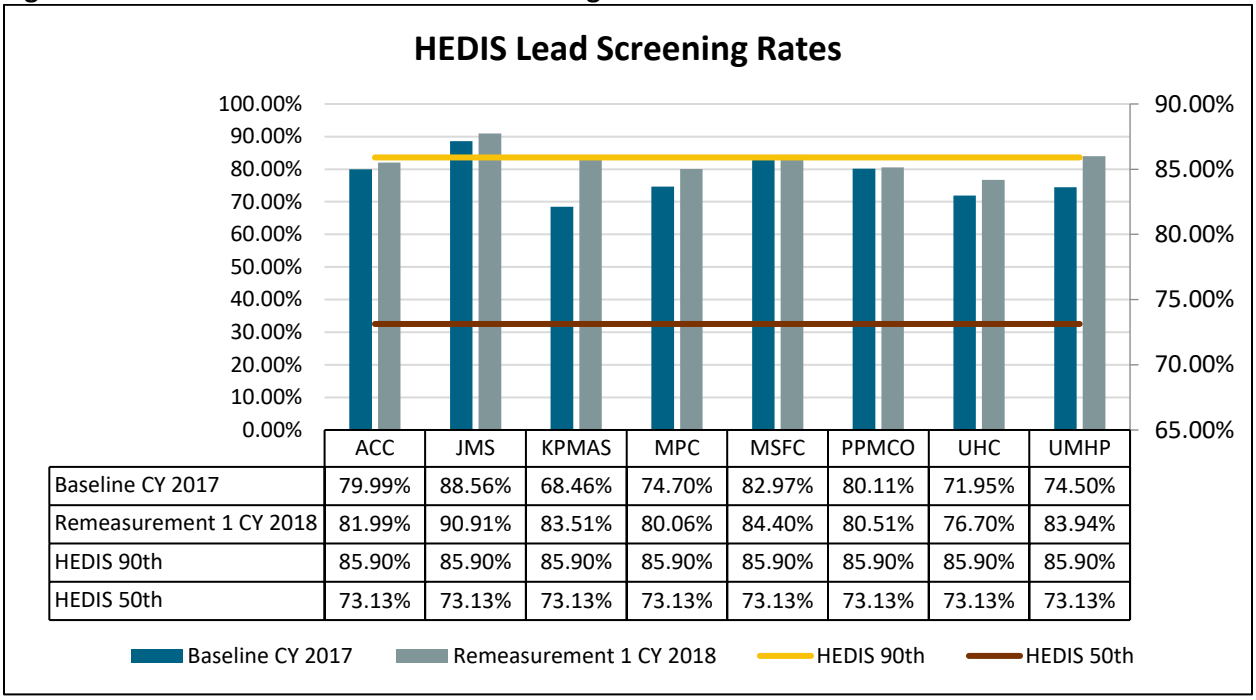
- Member education
- Clinic Days at provider sites with phlebotomy services
- Member outreach and assistance with appointment scheduling
- In-home lead testing
- Community health worker home visits
- Referrals to Baltimore City Childhood Lead Poisoning Prevention Program for home assessments and education
- Referrals to county health departments for environmental and medical home visits, telephonic case management, and education
- Community events, which include education and onsite blood level testing
- Member incentives
- Provider education
- Case Management
- Bulk lab lead orders
- State lead testing registry review and reconciliation
- Transportation assistance to labs for testing
- Provider incentive program
- EMR data share
- Provider feedback on lead screening performance

Lead Screening Indicator Results

CY 2018 is the first remeasurement year of data collection for the Lead Screening PIP.

Figure 2 represents the HEDIS indicator rates for the eight MCOs participating in this PIP.

Figure 2. CY 2017 - CY 2018 HEDIS Lead Screening Indicator Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY 2017	79.99%	88.56%	68.46%	74.70%	82.97%	80.11%	71.95%	74.50%
Remeasurement 1 CY 2018	81.99%	90.91%	83.51%	80.06%	84.40%	80.51%	76.70%	83.94%
HEDIS 90th	85.90%	85.90%	85.90%	85.90%	85.90%	85.90%	85.90%	85.90%
HEDIS 50th	73.13%	73.13%	73.13%	73.13%	73.13%	73.13%	73.13%	73.13%

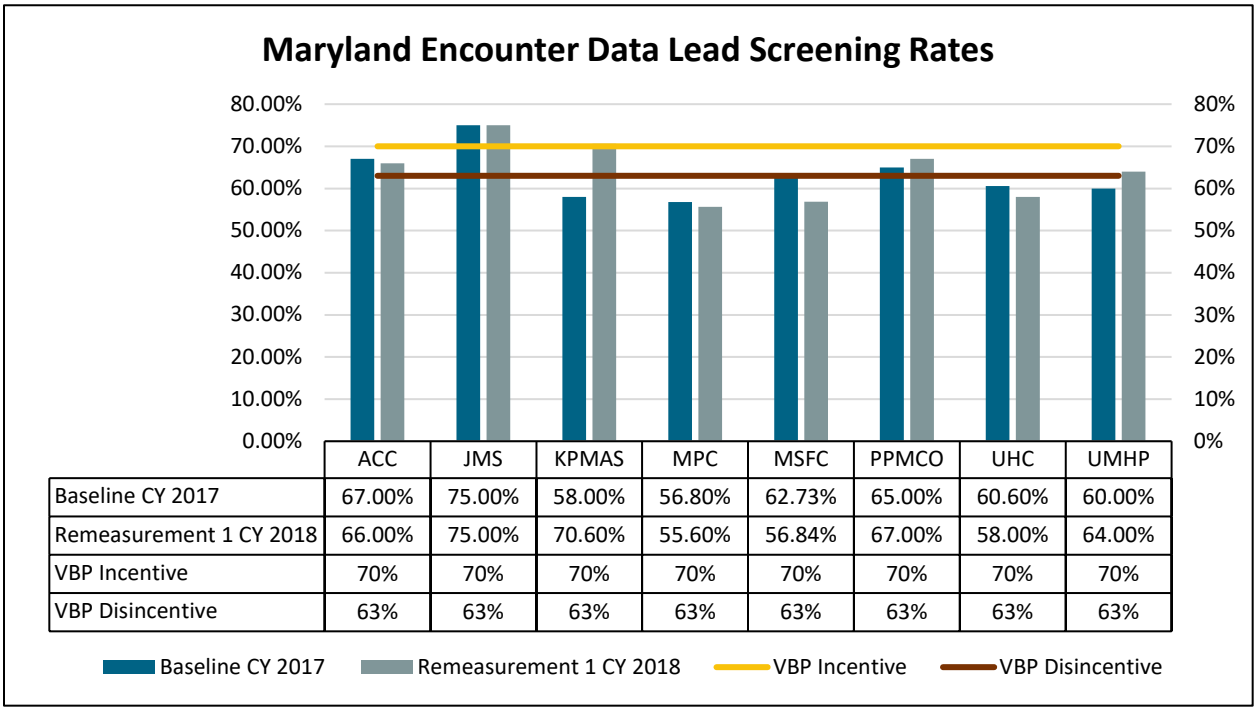
Among the majority of MCOs there is fairly narrow variation in the remeasurement 1 rates relative to the 2018 HEDIS Medicaid 90th Percentile benchmark. JMS exceeds the 90th percentile benchmark for the Lead Screening rate. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) are performing close to or above the 75th percentile for this measure. UHC is performing mid-range between the 50th and 75th percentiles.

All eight MCOs demonstrated improvement in performance over their HEDIS baseline rate:

- ACC's rate increased by 2 percentage points, which was statistically significant
- JMS' rate increased by 2.35 percentage points
- KPMAS' rate increased by 15.05 percentage points, which was statistically significant
- MPC's rate increased by 5.36 percentage points
- MSFC's rate increased by 1.43 percentage points
- PPMCO's rate increased by 0.40 percentage points
- UHC's rate increased by 4.75 percentage points, which was statistically significant
- UMHP's rate increased by 9.44 percentage points, which was statistically significant

Figure 3 represents the Maryland encounter data indicator rates.

Figure 3. CY 2018 Maryland Encounter Data Lead Screening Indicator Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY 2017	67.00%	75.00%	58.00%	56.80%	62.73%	65.00%	60.60%	60.00%
Remeasurement 1 CY 2018	66.00%	75.00%	70.60%	55.60%	56.84%	67.00%	58.00%	64.00%
VBP Incentive	70%	70%	70%	70%	70%	70%	70%	70%
VBP Disincentive	63%	63%	63%	63%	63%	63%	63%	63%

JMS and KPMAS are the only MCOs with Maryland encounter data rates for lead screening that are in the incentive benchmark range of ≥ 70% for Maryland's Value-Based

Purchasing Initiative. Three MCOs (ACC, PPMCO, and UMHP) have rates within the VBP neutral benchmarks (64%-69%). The remaining three MCOs (MPC, MSFC, and UHC) have rates within the VBP disincentive benchmark (≤ 63%).

Three MCOs demonstrated improvement in performance over their baseline rate:

- KPMAS' rate increased by 12.6 percentage points, which was statistically significant
- PPMCO's rate increased by 2.0 percentage points, which was statistically significant
- UMHP's rate increased by 4.0 percentage points, which was statistically significant

Four MCOs experienced a decline in performance over their baseline rate:

- ACC's rate declined by 1.0 percentage points
- MPC's rate declined by 1.2 percentage points
- MSFC's rate declined by 5.89 percentage points, which was statistically significant
- UHC's rate declined by 2.6 percentage points, which was statistically significant

JMS' rate remained unchanged from their baseline rate.

Recommendations

Qlarant recommends that the HealthChoice MCOs concentrate efforts on the areas described below. Many MCOs' PIPs did not reflect the changes that were required or recommended following the last PIP validation as was noted in last year's annual report.

- **Complete annual in-depth barrier analysis** to identify root causes of suboptimal performance and to effectively drive improvement when resources are limited. MCOs continue to conduct high-level barrier analyses, resulting in little or no improvement in indicator rates.
- **Develop robust, system–level interventions** in response to identified barriers. Examples of interventions include educational efforts, changes in policy, targeting of additional resources, or other organization–wide initiatives. Face–to–face contact is usually most effective. To improve outcomes, interventions should be systematic (affecting a wide range of members, providers and the MCO), timely, and effective. Since members generally view their PCP as their trusted advisor, PCP interventions may be the most effective in influencing health-related behavior change in members.
- **Implement timely interventions** within the measurement year to have a meaningful impact on the measure rate.
- **Ensure that interventions address differences among population subgroups**, such as differences in health care attitudes and beliefs among various racial/ethnic groups within the MCO's membership. Although Qlarant provided training to all MCOs on the process for identifying disparities based on analysis of MCO-specific data in May 2018, the majority of MCOs continue to demonstrate a lack of in-depth analysis to identify root causes for informing targeted interventions. It should be noted, however, that a common barrier to understanding racial and cultural differences is the lack of critical demographic data for a large percentage of the MCOs' membership.
- **Assess interventions for their effectiveness**, and initiate adjustments where outcomes are unsatisfactory. Consideration should be given to small tests of change to assess intervention effectiveness before implementing across the board. MCOs generally focus at the activity level rather than at the process or outcome level when assessing the impact of interventions. Requiring MCOs to submit a plan for evaluating the effectiveness of each intervention as a component of its development may not only strengthen the evaluation methodology but also the design of the intervention.
- **Ensure that data analysis is consistent with the defined data analysis plan**, both quantitative and qualitative.

It was observed that the MCOs had much more difficulty in increasing the VBP indicator for lead screening than it did for the HEDIS indicator. One of the barriers frequently cited by MCOs as contributing to this lower level of performance is the lack of preliminary lead screening rates and member level detail throughout the measurement year from Hilltop, MDH's subcontractor. MCOs that review prospective HEDIS rates on a monthly basis have demonstrated improved performance as a result of their ability to adjust interventions and/or develop new ones within a short time frame based upon identified needs. This is consistent with the Rapid Cycle PIP methodology being deployed as a best practice. In view of this barrier, it is recommended that MDH consider inviting Hilltop to a meeting with the MCOs to discuss how the MCOs may be provided with the tools they need to run preliminary rates throughout the measurement year for the VBP indicator. This will support the MCOs in continuous quality improvement efforts and enable them to adjust their interventions or develop additional ones as indicated.

It is also recommended that in future annual MCO PIP submissions that tests of statistical significance be conducted not only on changes from the prior to the current remeasurement but also from baseline to the current measurement.

Conclusion

Qlarant assessed the validity and reliability of the PIP study design and results after a detailed review of each MCO's PIPs, audited HEDIS and Maryland encounter data measure findings, and conclusions for the selected indicators. Tables 21 and 22 identify the level of confidence Qlarant assigned to each MCO's Asthma Medication Ratio and Lead Screening PIPs for CY 2018.

Table 21. CY 2019 Asthma Medication Ratio PIP Validation Results - Level of Confidence

Level of Confidence in Reported Results	Asthma Medication Ratio PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence		X						
Confidence	X					X		
Low Confidence			X	X	X		X	X
Results Not Credible								

A low confidence level was assigned to five MCOs (KPMAS, MPC, MSFC, UHC, and UMHP) for the Asthma Medication Ratio PIP, as their interventions were not robust or timely enough or not always linked to an identified barrier; analysis of MCO data, both quantitative and qualitative, was not consistent with its defined data analysis plan; and remeasurement 2 rates declined over the prior remeasurement year. MPC, MSFC, and UMHP had no evidence of targeted interventions in response to linguistic and cultural barriers. UMHP also did not provide accurate numerical PIP results and findings.

ACC's PIP was assigned a level of confidence due to the lack of targeted interventions in response to linguistic and cultural barriers; inconsistent analysis of its data, both quantitative and qualitative, based upon its defined data analysis plan; and inaccurate numerical PIP results and findings. PPMCO's PIP was assigned a level of confidence due to the lack of robust, targeted interventions including initiatives in response to linguistic and cultural barriers; lack of assessment of the impact of its interventions; and improvement not determined to be statistically significant.

JMS' PIP received a high confidence level as implemented interventions align and address the MCOs identified barriers along with appearing sufficient to improve outcomes. Additionally, JMS demonstrated real improvement, although performance was not statistically significant.

Table 22. CY 2019 Lead Screening PIP Validation Results - Level of Confidence

Level of Confidence in Reported Results	Lead Screening PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence		X						X
Confidence	X		X		X	X	X	
Low Confidence				X				

Level of Confidence in Reported Results	Lead Screening PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Results Not Credible								

The Lead Screening PIP submitted by MPC was assigned a level of low confidence because it did not evidence sufficient or timely interventions to improve outcomes in a meaningful way; implement targeted interventions to address cultural and linguistic barriers; analyze its data consistent with its data analysis plan; and demonstrate statistically significant improvement in both indicators.

A level of confidence was assigned to five MCOs (ACC, KPMAS, MSFC, PPMCO, and UHC). ACC's PIP was assigned a level of confidence since a numerical result was reported inaccurately; both its quantitative and qualitative analyses were not consistent with its data analysis plan; it had no evidence of targeted interventions to address linguistic and cultural barriers; and it did not demonstrate statistically significant improvement in both indicators. MSFC's PIP was assigned a level of confidence as its quantitative analysis was inconsistent with its data analysis plan and it did not demonstrate statistically significant improvement in both indicators. PPMCO's PIP was assigned a level of confidence as its interventions were insufficient to achieve its long-term goal; it had no evidence of targeted interventions to address linguistic and cultural barriers; and it did not demonstrate statistically significant improvement in both indicators. UHC's PIP was assigned a level of confidence as both its quantitative and qualitative analysis were inconsistent with its data analysis plan; its numerical results for the VBP indicator were inaccurately reported; and it did not demonstrate statistically significant improvement in both indicators.

JMS' PIP received a high confidence level as numerical PIP results and findings were accurately and clearly presented. Along with a comprehensive data analysis plan which included statistical significance testing, JMS' qualitative analysis included an interpretation of the extent to which its PIP was successful, the impact of interventions, updated barriers, and planned interventions for CY 2019.

Encounter Data Validation

Introduction

Beginning in 1995, CMS began developing a series of tools to help State Medicaid agencies collect, validate, and use encounter data for managed care program oversight. Encounter data can provide valuable information about distinct services provided to enrollees that can be used to assess and review quality, monitor program integrity, and determine capitation rates. Though not required, CMS strongly encourages states to contract with EQROs to conduct encounter data validation (EDV) to ensure the overall validity and reliability of its encounter data.

In compliance with 42 CFR 438.350, MDH contracts with Qlarant to serve as the EQRO for the HealthChoice Program. The EDV review was conducted according to the CMS EDV protocol, *Validation of Encounter Data Reported by the MCO, Protocol 4, Version 2.0, September 2012.* Qlarant conducted EDV for CY 2018, encompassing January 1, 2018 through December 31, 2018, for all nine MCOs.

Purpose

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the State. Encounter data are the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be billable under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format. States often use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates.

Encounter Data Validation Process

The CMS approach to EDV includes the following three core activities:

- Assessment of health plan information system (IS).
- Analysis of health plan electronic encounter data for accuracy and completeness.
- Review of medical records for additional confirmation of findings.

The EDV protocol makes the following assumptions:

- An encounter refers to the electronic record of a service provided to a health plan enrollee by both institutional and non-institutional providers.
- The State specifies the types of encounters (e.g., physician, hospital, dental, vision, laboratory, etc.) for which encounter data are to be provided. In addition, the type of data selected for review (inpatient, outpatient, etc.) is directly proportionate to the total percent of encounter types per calendar year.
- Encounter data is considered “complete” when the data can be used to describe the majority of services that have been provided to Medicaid beneficiaries who are health plan enrollees. HealthChoice required MCOs to submit CY 2018 encounter data by June 2019.

- Encounter data completeness and accuracy requires continued monitoring and improvement. States need to develop encounter data standards and monitor for accuracy and completeness. Ultimately, it is the State that establishes standards for encounter data accuracy and completeness.

Qlarant completed Activities 1,2, 4, and 5, and The Hilltop Institute, University of Maryland Baltimore County (Hilltop) completed Activty 3 of the five sequential EDV activities shown in Table 23:

Table 23. EDV Activities

Activity	Description
Activity 1	Review of State requirements for collection and submission of encounter data
Activity 2	Review of health plan's capability to produce accurate and complete encounter data
Activity 3	Analysis of health plan's electronic encounter data for accuracy and completeness*
Activity 4	Review of medical records for additional confirmation of findings
Activity 5	Analysis and submission of findings

A description of each sequential EDV activity, along with detailed results, follows.

Activity 1: Review of State Requirements

Qlarant reviewed information regarding MDH's requirements for collecting and submitting encounter data. MDH provided Qlarant with:

- MDH's requirements for collection and submission of encounter data by MCOs (specifications in the contracts between the State and the MCO)
- Data submission format requirements for MCO use
- Requirements regarding the types of encounters that must be validated
- MDH's data dictionary
- A description of the information flow from the MCO to the State, including the role of any contractors or data intermediaries
- MDH's standards for encounter data completeness and accuracy
- A list and description of edit checks built into MDH's Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks
- Requirements regarding time frames for data submission
- Prior year's EQR report on validating encounter data
- Any other information relevant to encounter data validation

Results of Activity 1: Review of State Requirements

MDH sets forth the requirements for collection and submission of encounter data by MCOs in Appendix H of the MCO's contract. It includes all of the COMAR provisions applicable to MCOs, including regulations concerning encounter data. The regulations applying to encounters in CY 2018 are noted in Table 24.

Table 24. CY 2018 COMAR Requirements for Encounter Data

COMAR	Requirement
10.67.03.11B	A description of the applicant's operational procedures for generating service-specific encounter data.
10.67.03.11C	Evidence of the applicant's ability to report, on a monthly basis, service-specific encounter data in UB04 or CMS1500 format.
10.67.07.03A(1)	MCOs shall submit to MDH the following: Encounter data in the form and manner described in COMAR 10.67.04.15B, 42 CFR §438.242(c), and 42 CFR §438.818.
10.67.07.03B	MCOs shall report to MDH any identified inaccuracies in the encounter data reported by the MCOs or its subcontractors within 30 days of the date discovered regardless of the effect which the inaccuracy has upon MCOs reimbursement.
10.67.04.15B	Encounter Data • MCOs shall submit encounter data reflecting 100% of provider-enrollee encounters, in CMS1500 or UB04 format or an alternative format previously approved by MDH. • MCOs may use alternative formats including: o ASC X12N 837 and NCPDP formats; and o ASC X12N 835 format, as appropriate. • MCOs shall submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and MDH, including, at a minimum: o Enrollee and provider identifying information; o Service, procedure, and diagnosis codes; o Allowed, paid, enrollee responsibility, and third party liability amounts; and o Service, claims submissions, adjudication, and payment dates. • MCOs shall report encounter data within 60 calendar days after receipt of the claim from the provider. • MCOs shall submit encounter data utilizing a secure on-line data transfer system.

The electronic data interchange (EDI) is the automated system that includes rules dictating the transfer of data from each MCO to MDH. MDH uses the Health Insurance Portability and Accountability Act (HIPAA) EDI transaction sets and standards for data submission of 835 and 837 files. The 837 contains patient claim information, while the 835 contains the payment and/or explanation of benefits for a claim. MDH receives encounter data from the MCOs in a format that is HIPAA 837 compliant—via an EDI system—and then executes validations to generate exception reports that are in both HIPAA 835 compliant file format, as well as an MDH summarized version known to MDH as the "8ER" report.

MDH processes encounters through the Electronic Data Interchange Translator Processing System (EDITPS). Encounters are first edited for completeness and accuracy using the HIPAA EDI implementation guidelines. Successfully processed encounters are mapped for further code validation based on MDH requirements that identify the criteria each encounter must meet in order to be accepted into MMIS.

MDH provided an abridged data dictionary and described the process of encounter data submission from the MCOs to the state. MCOs can submit encounter data through a web portal or through a secure file transfer protocol (SFTP). Each MCO may contract a vendor or use data intermediaries to perform encounter data submission.

Although MDH does not maintain a list and description of the edit checks, the system treats encounters that fail the MMIS edit checks in the following manner:

1. All denied and rejected encounters appear with the MMIS Explanation of Benefit (EOB) code and description in the 8ER file.
2. The 835 file contains all paid and denied encounters. The denied encounters use the HIPAA EDI Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to report back denied reason. Encounters marked as suspended are not included in the 835.
3. In addition, MMIS generates a summary report for each MCO.

MDH sets forth requirements regarding time frames for data submission in COMAR 10.67.04.15B, which states that MCOs must report encounter data within 60 calendar days after receipt of the claim from the provider. For daily data exchanges, the cutoff time is 3 PM for transmission of a single encounter data file for an MCO to receive an 835 the next day.

Activity 2: Review of MCO's Ability to Produce Accurate and Complete Encounter Data

Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Prior to examining the quality of data produced by the MCO's information system, each MCO's information system process and capabilities in capturing complete and accurate encounter data will be assessed through the following steps:

1. Review of the MCO's Information Systems Capabilities Assessment (ISCA).
2. Interview MCO personnel, as needed.

Results of Activity 2: Review of MCO's Ability to Produce Accurate and Complete Encounter Data

Qlarant reviewed each MCO's ISCA to determine where the MCO's information systems may be vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting. MCOs were provided a crosswalk between the Healthcare Effectiveness data and Information Set (HEDIS) Record of Administration, Data Management and Processes (Roadmap) completed as part of the HEDIS Compliance Audit and the ISCA required as part of the EDV. Qlarant's ISCA review covers the following areas:

1. Information Systems: Data Processing and Procedures
    a. Data Base Management System (DBMS) Type
    b. Programming language
    c. Process for updating the program to meet changes in State requirements

2. Claims/Encounter Processing
    a. Overview of the processing of encounter data submissions
    b. Completeness of the data submitted
    c. Policies/procedures for audits and edits
3. Claims/Encounter System Demonstration
    a. Processes for merging and/or transfer of data
    b. Processes for encounter data handling, logging and processes for adjudication
    c. Audits performed to assure the quality and accuracy of the information and timeliness of processing
    d. Maintenance and updating of provider data
4. Enrollment Data
    a. Verification of claims/encounter data
    b. Frequency of information updates
    c. Management of enrollment/disenrollment information

After reviewing the findings from the ISCA, Qlarant conducted follow-up interviews with MCO personnel, as needed, to supplement the information and ensure an understanding of the MCO's information systems and processes. No issues were identified.

Qlarant then completed an assessment of each MCO's ISCA. Overall results indicate that:

- All MCOs appear to have well-managed systems and processes.
- All MCOs use only standard forms and coding schemes.
- All MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service.
- All MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.
- Six MCOs (ABH, ACC, KPMAS, PPMCO, UHC, and UMHP) process claims and encounters with in-house systems, while the remaining three MCOs (JMS, MSFC, and MPC) contract with third party administrators for processing claims and encounters.
- The HealthChoice MCO average auto-adjudication was 83.37%, with MCO-specific rates ranging from 62% to 96%.
- The HealthChoice MCO average rate for processing clean claims in 30 days was 97.30%, with MCO-specific rates ranging from 83.38% to 99.92%.
- On average, the HealthChoice MCOs received 87.78% of professional claims and 91.42% of facility claims electronically.

MCO-specific results pertaining to the ISCA Assessment were provided to MDH and each MCO.

Activity 3: Analysis of MCO's Electronic Encounter Data

MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Therefore, Hilltop completed Activity 3 of the EDV.

Activity 3 contains the following four required analyses steps:

1. Develop a data quality test plan
2. Verify the integrity of the MCOs' encounter data files
3. Generate and review analytic reports
4. Compare findings to state-identified standards

Step 1. Develop a Data Quality Test Plan

The development of a data quality test plan incorporates information gathered in Activity 1 and 2 with an aim towards investigating system edit issues that have been previously overlooked or excused. Hilltop obtained pertinent information from MDH regarding the process and procedure used to receive, evaluate, and report on the validity of MCO encounter data. Hilltop also interviewed MDH staff to document state processes for accepting and validating encounter data to investigate and determine the magnitude and types of missing encounter data and identify potential data quality and MCO submission issues. Topics discussed during this meeting included, but were not limited to the following:

- MCOs submitted encounter data that was transferred to MDH's mainframe for processing and validation checks, and the accepted data was uploaded to MMIS2
- Encounter data fields were validated through the EDI process, such as validation of recipient ID, sex, age, diagnostic codes, and procedure codes
- MDH processes incoming data from the MCOs within 1 to 2 business days when data has been validated by EDI
- Error code reports (835 and 8ER) generated by the validation process were distributed to MCOs
- EDI error report data (the 8ER report) was transmitted to Hilltop for analysis and included the number and types of errors of failed encounter submissions for each MCO

This discussion included the new MMIS2 specification that requires the MCOs to submit encounters with paid-amounts data in a specified form and content standards and criteria, effective January 1, 2018. This new requirement's purpose is to improve the quality of encounter data in accuracy and completeness.

Step 2. Verify the Integrity of the MCOs' Encounter Data Files

Encounter data was reviewed for accuracy and completeness by conducting integrity checks of the data files and analyses automation. The analysis verified the state's identifiers (IDs) are accurately incorporated into the MCO information system and other consistency checks were applied, such as verifying critical fields containing non-missing data. The data fields for quality and general validity were also inspected. Hilltop compared the number of participants to total accepted encounters by MCO, assessing whether the distribution is similar across the MCOs. Selected fields not verified by MDH during Step 1 of the EDI process were assessed for completeness and accuracy. Payment field entries were further reviewed per the new mandate effective January 1, 2018. Finally, the MCO provider number was evaluated to ensure that encounters received and accepted were only for current contracted MCOs with the HealthChoice program. Encounters received and accepted with MCO provider numbers not active within the HealthChoice program were excluded from the analysis. Due to ABH joining the HealthChoice program in late 2017, its encounters were excluded from the CY 2017 analysis but included in the CY 2018 analysis.

Step 3. Generate and Review Analytic Reports

The analysis addressing volume and consistency of encounter data is focused in four primary areas: time, provider, service type, and the age and sex appropriateness of diagnostic and procedure codes. MDH helped identify several specific analyses for each primary area related to policy interests.

Analysis of encounter data by time dimensions (e.g., service date and processing date) allows for an evaluation of consistency. Trends in encounter submission and dates of service are included. Hilltop completed a comparison of time dimension data between MCOs to determine whether MCOs process data within similar time frames.

Provider analysis evaluates trends in provider services and seeks to determine any fluctuation in visits during CY 2017 and CY 2018. Provider analysis is focused on primary care visits, specifically the number of participants who had a visit within the year.

The service type analysis concentrated on three main service areas: inpatient hospitalizations, observation stays, and Emergency Department (ED) visits. The CY 2017 analysis provides baseline data and allows MDH to identify any inconsistencies in utilization patterns for these types of services in CY 2018.

Finally, Hilltop analyzed age and sex appropriateness using diagnoses related to pregnancy or dementia. There is a generally accepted age range for these two conditions. Participants over the age of 65 were screened, as these individuals are also ineligible for HealthChoice, so any encounters received for this population may indicate a participant date of birth issue. Analysis of a sex-appropriate diagnosis was conducted in terms of pregnancy. Analysis of an age-appropriate diagnosis was conducted for dementia.

Step 4. Compare Findings to State-Identified Standards

In both Steps 2 and 3, Hilltop compared the encounter data submitted by each MCO to standards and benchmarks identified by MDH. Analyses were completed by MCOs and calendar years as a means to benchmark each MCO against their own performance over time as well as against other MCOs. Outlier data was compared with overall trends seen from the MCOs.

Results of Activity 3: Analysis of MCO's Electronic Encounter Data

Step 1. Develop a Data Quality Test Plan

MDH initiated the evaluation of MCO encounter data with a series of validation checks on the encounter data received through EDI. These validation checks include analysis of critical data fields, consistency between data points, duplication, and validity of data received. Encounters failing to meet these standards are reported back to the MCO for possible correction and re-submission. Both the 835 report and the 8ER report are distributed to the MCOs.

MDH provided the CY 2017 and CY 2018 8ER reports to Hilltop for analysis of encounters failing initial EDI edits. Table 2 provides an overview of the 8ER data. Rejected encounters were classified into five categories: missing data, participant not eligible for service, value not valid for the field, inconsistent data, and duplicates.

Checks were performed on critical fields for missing or invalid data, including provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Eligibility issues were identified for participants not eligible for MCO services at the time of the service. Inconsistent data refers to an inconsistency between two data points. Examples of inconsistency include discrepancies between dates, inconsistencies between diagnosis and age or sex, and inconsistencies between original and re-submitted encounters.

Table 25 presents the distribution of rejected encounters submitted by all MCOs, by category, for CY 2017 and CY 2018.

Table 25. Distribution of Rejected Encounter Submissions by Category, CY 2017 and CY 2018

Category For Rejection	CY 2017		CY 2018	
	Number of Rejected	Percentage of Total	Number of Rejected	Percentage of Total
Missing	677,840	36.8%	725,751	38.4%
Not Eligible	558,483	30.3%	638,633	33.8%
Not Valid	276,763	15.0%	317,356	16.8%
Inconsistent	244,463	13.3%	113,383	6.0%
Duplicate	86,127	4.7%	96,115	5.1%
Total	1,843,676	100.0%	1,891,238	100.0%

Overall, the number of rejected encounters increased by 2.6 percentage points during the evaluation period. This increase may be attributed to the inclusion of ABH in CY 2018 analysis.

The two primary reasons encounters were rejected in CY 2017 and CY 2018 were missing data (36.8% and 38.4%, respectively) and participants not eligible for MCO services (30.3% and 33.8%, respectively). While invalid encounters increased slightly (1.8 percentage points) during the evaluation period, there was a notable decrease (7.3 percentage points) of encounters rejected for inconsistency.

Analyzing the rejected encounters submitted by each MCO is useful for assessing trends, as well as identifying issues particular to each MCO. This allows MDH to follow up with each MCO and focus on potential problem areas.

Table 26 presents the distribution of rejected and accepted encounter submissions across MCOs for CY 2017 and CY 2018.

Table 26. Distribution of Rejected and Accepted Encounter Submissions by MCO, CY 2017 and CY 2018

		ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of Rejected	CY 2017		439,491	27,402	302,080	138,900	150,129	389,589	280,033	116,052	1,843,676
	CY 2018	3,772	272,351	19,539	144,737	222,191	275,397	390,459	323,288	239,504	1,891,238
Percentage of All Rejected	CY 2017		23.8%	1.5%	16.4%	7.5%	8.1%	21.1%	15.2%	6.3%	100.0%
	CY 2018	0.2%	14.4%	1.0%	7.7%	11.7%	14.6%	20.6%	17.1%	12.7%	100.0%
Number of Accepted	CY 2017		7,971,592	1,163,215	1,756,975	7,278,036	3,077,930	10,405,569	5,444,030	1,385,451	38,482,798
	CY 2018	238,382	8,104,745	1,167,013	1,822,032	7,586,969	3,390,876	10,767,991	5,109,989	1,701,329	39,889,326
Percentage of All Accepted	CY 2017		20.7%	3.0%	4.6%	18.9%	8.0%	27.0%	14.1%	3.6%	100.0%
	CY 2018	0.6%	20.3%	2.9%	4.6%	19.0%	8.5%	27.0%	12.8%	4.3%	100.0%

PPMCO had the highest rejection rate of 20.6% in CY 2018, which was only a slight decrease of 0.5 percentage points from CY 2017. This is followed by UHC, with a rejection rate of 17.1% in CY 2018. MSFC submitted 14.6% of the total rejected encounters in CY 2018, a pronounced increase of 6.5 percentage points from CY 2017. While ACC had the highest rejection rate of 23.8% in CY 2017 and a high rejection rate of 14.4% in CY 2018, they substantially decreased their number of rejected submissions by 39.5% during the evaluation period. MPC and UMHP both increased their number of rejected submissions between CY 2017 and CY 2018. MPC increased their rejection rate during the evaluation period from 7.5% to 11.7% and UMHP increased from 6.3% to 12.7%. ABH, JMS, and KPMAS are the three MCOs with less than 10% of the rejected encounters in CY 2018. KPMAS reduced its number of rejected encounters by more than 50% from CY 2017 to CY 2018, while JMS slightly decreased its rejection rate.

Although there was some variation between each MCO's distribution of the total rejected encounters from CY 2017 to CY 2018, there was very little variation for each MCO's rate of accepted encounters during the evaluation period. For accepted encounter submission rates, the only MCO to change by more than 1 percentage point was UHC, which decreased from 14.1% in CY 2017 to 12.8% in CY 2018.

The rate of encounters rejected by category and MCO are shown in both Tables 31 and 32. Specifically, Table 27 presents the percentage of encounters rejected by category and MCO for CY 2018.

Table 27. Percentage of Encounters Rejected by EDI rejection Category by MCO, CY 2018

Category for Rejection	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Duplicate	0.9%	11.4%	1.1%	0.6%	2.0%	13.7%	1.4%	3.0%	2.8%
Not Valid	26.7%	27.2%	23.8%	11.4%	27.2%	9.3%	11.6%	14.3%	18.3%
Inconsistent	3.8%	9.5%	2.1%	34.5%	3.7%	2.3%	1.1%	3.9%	2.4%
Missing	53.4%	22.9%	47.3%	48.1%	44.7%	54.8%	39.8%	41.7%	17.5%
Not Eligible	15.2%	29.0%	25.7%	5.5%	22.3%	19.9%	46.1%	37.1%	59.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The primary reason for rejection of encounters for MSFC, ABH, KPMAS, JMS, MPC, and UHC was the submission of missing data (ranging from 41.7% to 54.8%). Over 50% of both ABH's and MSFC's CY 2018 encounters were rejected due to missing data.

For UMHP, PPMCO, and ACC, the primary category for rejection in CY 2018 was the submission of encounters for participants who were not yet eligible for MCO services at the time of the service (59.1%, 46.1%, and 29.0%, respectively). Duplicate rejections are low across all MCOs but represent 11.4% of ACC rejections and 13.7% of MSFC rejections. Encounters rejected for inconsistencies were also low across all MCOs, with the exception of KPMAS, which had inconsistencies account for 34.5% of its rejected encounters (all other MCOs ranged from 1.1% to 9.5%).

Table 28 presents the distribution of the category for rejection and how it changed for each MCO between CY 2017 and CY 2018.

Table 28. Percentage of Encounters Rejected by Category and by MCO, CY 2017 and CY 2018

Category For Rejection	Year	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Duplicate	CY 2017		48,559 11.0%	632 2.3%	307 0.1%	7,176 5.2%	6,250 4.2%	7,352 1.9%	9,867 3.5%	5,984 5.2%	86,127 4.7%
	CY 2018	33 0.9%	30,922 11.4%	218 1.1%	909 0.6%	4,499 2.0%	37,728 13.7%	5,491 1.4%	9,712 3.0%	6,603 2.8%	96,115 5.1%
Inconsistent	CY 2017		46,947 10.7%	49 0.2%	173,764 57.5%	4,428 3.2%	363 0.2%	449 0.1%	14,448 5.2%	4,015 3.5%	244,463 13.3%
	CY 2018	142 3.8%	25,843 9.5%	406 2.1%	49,883 34.5%	8,292 3.7%	6,301 2.3%	4,332 1.1%	12,525 3.9%	5,659 2.4%	113,383 6.0%
Missing	CY 2017		69,659 15.8%	6,290 23.0%	79,215 26.2%	81,800 58.9%	63,331 42.2%	182,650 46.9%	136,725 48.8%	58,170 50.1%	677,840 36.8%
	CY 2018	2,016 53.4%	62,431 22.9%	9,238 47.3%	69,573 48.1%	99,356 44.7%	150,950 54.8%	155,476 39.8%	134,715 41.7%	41,996 17.5%	725,751 38.4%
Not Eligible	CY 2017		204,349 46.5%	11,670 42.6%	20,390 6.7%	18,265 13.1%	56,521 37.6%	135,337 34.7%	84,345 30.1%	27,606 23.8%	558,483 30.3%
	CY 2018	575 15.2%	79,098 29.0%	5,018 25.7%	7,916 5.5%	49,572 22.3%	54,879 19.9%	180,036 46.1%	120,087 37.1%	141,452 59.1%	638,633 33.8%
Not Valid	CY 2017		69,977 15.9%	8,761 32.0%	28,404 9.4%	27,231 19.6%	23,664 15.8%	63,801 16.4%	34,648 12.4%	20,277 17.5%	276,763 15.0%
	CY 2018	1,006 26.7%	74,057 27.2%	4,659 23.8%	16,456 11.4%	60,472 27.2%	25,539 9.3%	45,124 11.6%	46,249 14.3%	43,794 18.3%	317,356 16.8%
Total	CY 2017		439,491 100.0%	27,402 100.0%	302,080 100.0%	138,900 100.0%	150,129 100.0%	389,589 100.0%	280,033 100.0%	116,052 100.0%	1,843,676 100.0%
	CY 2018	3,772 100.0%	272,351 100.0%	19,539 100.0%	144,737 100.0%	222,191 100.0%	275,397 100.0%	390,459 100.0%	323,288 100.0%	239,504 100.0%	1,891,238 100.0%

The total number of rejected encounters increased from CY 2017 to CY 2018 in all categories except for inconsistent rejections. PPMCO and UHC remained relatively consistent across the majority of rejection categories. The number of encounters submitted with inconsistencies by PPMCO increased from 449 in CY 2017 to 4,332 in CY 2018. UHC had an increase in rejections from participants being ineligible: from 84,345 in CY 2017 to 120,087 in CY 2018.

UMHP's ineligible rejected encounters increased from 27,606 in CY 2017 to 141,452 in CY 2018. MSFC experienced an increase in rejections for duplicates, inconsistencies, not valid, and, most notably, missing data (63,331 in CY 2017 and 150,950 in CY 2018). MPC more than doubled the number of encounters rejected for invalid data and participants being ineligible during the evaluation period.

The total number of rejections for KPMAS decreased by more than 60% during the evaluation period due to improvements in two rejection categories: inconsistent and not eligible. Both ACC and JMS substantially decreased the number of rejections due to participants not being eligible for MCO services between CY 2017 and CY 2018. Specifically, ACC decreased from 204,349 to 79,098, and JMS decreased

from 11,670 to 5,018. ABH was not included in the CY 2017 analysis; however, in CY 2018, the majority of its rejections were due to missing data.

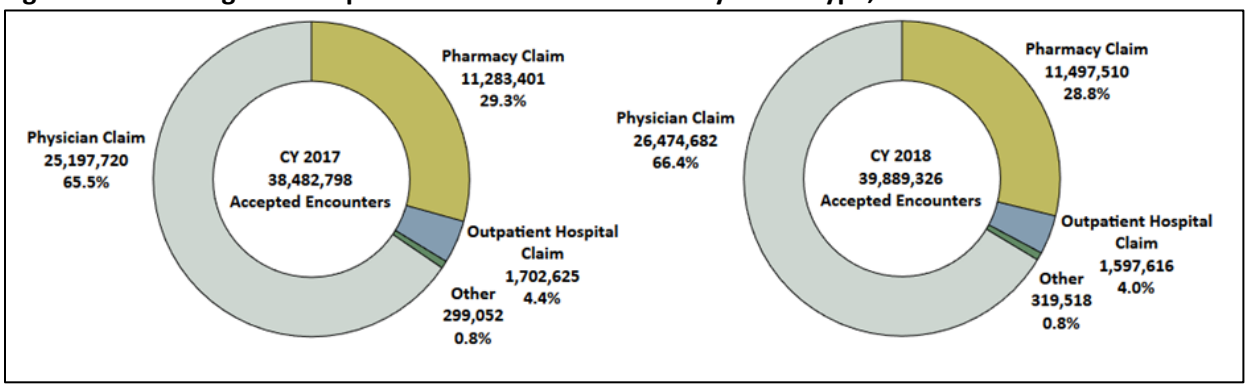
Step 2. Verify the Integrity of the MCOs' Encounter Data Files

During CY 2018, the MCOs submitted a total of 39.9 million accepted encounters, up from 38.5 million in CY 2017. Although the above 8ER data received do not include dates of service, Hilltop estimated the total number of encounters submitted by summing the number of EDI rejected encounters and the number of accepted encounters. Approximately 40.3 million encounters were submitted in CY 2017, which increased to 41.7 million encounters submitted in CY 2018. Approximately 95% of the CY 2018 encounters were accepted into MMIS2, which is consistent with CY 2017 encounters.

Hilltop received a monthly copy of all encounters accepted by MMIS2. Upon receipt of the accepted encounters, several validation assessments and integrity checks of the data fields were performed to analyze the accuracy and completeness of the data. The assessments included determining whether there is an invalid end date of service or other fatal errors. Data with errors were excluded from the main data files before being loaded into Hilltop's data warehouse.

Figure 4 shows the rate of accepted encounter submissions by claim type in CY 2017 and CY 2018.

Figure 4. Percentage of Accepted Encounter Submissions by Claim Type, CY 2017 and CY 2018



The percentage of encounters distributed across all claim types was consistent between CY 2017 and CY 2018. At 65.2% in CY 2017 and 66.4% in CY 2018, the majority of encounters during the evaluation period were physician claims. Of all the encounters accepted into MMIS2 in CY 2018, pharmacy encounters and outpatient hospital encounters accounted for 28.8% and 4.0%, respectively. "Other" encounters—including inpatient hospital stays, community-based services, long-term care services, and dental services—accounted for 0.8% of encounters in both CY 2017 and CY 2018.

Table 29 provides the percentage and number of encounters by type for each MCO in CY 2017 and CY 2018.

Table 29. Percentage and Number of Encounters by Claim Type and MCO, CY 2017 and CY 2018

Claim Type	Year	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Physician Claim	CY 2017		67.2%	58.4%	73.9%	63.4%	62.9%	65.0%	66.9%	65.6%
			5,358,249	679,329	1,297,859	4,611,977	1,936,747	6,763,482	3,641,194	908,883
	CY 2018	73.0%	68.8%	58.9%	72.7%	65.0%	63.7%	65.5%	66.4%	68.8%
		173,944	5,576,838	687,893	1,324,970	4,934,269	2,158,695	7,054,378	3,393,761	1,169,934
Pharmacy Claim	CY 2017		27.2%	36.6%	23.8%	31.4%	31.7%	29.7%	28.5%	26.5%
			2,165,826	426,312	418,584	2,284,909	976,952	3,089,710	1,553,692	367,416
	CY 2018	21.1%	26.5%	36.8%	24.9%	30.1%	30.8%	29.6%	29.0%	24.2%
		50,297	2,148,714	429,537	454,451	2,283,293	1,045,091	3,190,789	1,483,839	411,499
Outpatient Hospital Claim	CY 2017		4.8%	4.5%	1.6%	4.4%	4.4%	4.7%	3.8%	6.7%
			379,686	52,804	28,151	318,877	135,609	485,270	209,156	93,072
	CY 2018	4.6%	3.9%	3.9%	1.7%	4.0%	4.4%	4.2%	3.8%	5.6%
		11,077	316,337	44,933	30,480	301,331	147,731	455,721	194,020	95,986
Other	CY 2017		0.9%	0.4%	0.7%	0.9%	0.9%	0.6%	0.7%	1.2%
			67,831	4,770	12,381	62,273	28,622	67,107	39,988	16,080
	CY 2018	1.3%	0.8%	0.4%	0.7%	0.9%	1.2%	0.6%	0.8%	1.4%
		3,064	62,856	4,650	12,131	68,076	39,359	67,103	38,369	23,910
Total	CY 2017		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
			7,971,592	1,163,215	1,756,975	7,278,036	3,077,930	10,405,569	5,444,030	1,385,451
	CY 2018	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		238,382	8,104,745	1,167,013	1,822,032	7,586,969	3,390,876	10,767,991	5,109,989	1,701,329

The distribution of encounters is relatively consistent across MCOs and calendar years. In CY 2018, physician encounters ranged from 58.9% of encounters (JMS) to 73.0% of encounters (ABH). JMS had the largest percentage of CY 2018 pharmacy encounters (36.8%), while ABH had the lowest percentage (21.1%). Outpatient hospital encounters ranged from a low of 1.7% for KPMAS to a high of 5.6% for UMHP.

Table 30 illustrates the distribution of all enrolled HealthChoice participants and the volume of accepted encounters for each MCO during CY 2017 and CY 2018.

Table 30. Distribution of Participant and Accepted Encounters by MCO, CY 2017 and CY 2018

MCO	CY 2017		CY 2018	
	Percent of Total Participants	Percent of Total Encounters	Percent of Total Participants	Percent of Total Encounters
ABH			1.6%	0.6%
ACC	23.5%	20.7%	23.5%	20.3%
JMS	2.4%	3.0%	2.4%	2.9%
KPMAS	6.0%	4.6%	6.0%	4.6%
MPC	18.6%	18.9%	18.6%	19.0%
MSFC	8.3%	8.0%	8.3%	8.5%
PPMCO	25.5%	27.0%	25.5%	27.0%
UHC	13.2%	14.1%	13.2%	12.8%
UMHP	4.6%	3.6%	4.6%	4.3%
Total	100.0%	100.0%	100.0%	100.0%

PPMCO and ACC are the largest MCOs, followed by MPC, UHC, MSFC, KPMAS, UMHP, JMS, and ABH in that order. The distribution of accepted encounters among MCOs in CY 2017 and in CY 2018 is proportional to the participant distribution among the MCOs for those years. For example, in CY 2018, PPMCO had 25.5% of all HealthChoice participants and 27.0% of all MMIS2 encounters.

Managed Care Regulations: Accurate and Complete Encounter Data

In 2016, CMS issued its final rule updating Medicaid managed care regulations.[3] One of the new requirements specified that MCOs must submit encounter data that are accurate and complete by January 2018.[4] To address this requirement, MDH notified Maryland MCOs in September 2017 that all encounter data submitted to MDH on or after January 1, 2018, must include allowed amounts and paid amounts on each encounter.[5]

In 2010, MDH and the MCOs worked together to ensure complete and accurate submission of paid amounts on pharmacy encounters. Pharmacy encounter data flow through a point of sale (POS) system, ensuring data accuracy at the time of submission. For nearly a decade, pharmacy encounters have been reliable and MDH has confidence in the integrity and quality of these pay data. Beginning in October 2017, MDH used the pharmacy paid encounter process as a framework to begin receiving paid data for all encounters.

MDH staff prepared MMIS2 to accept paid data for all encounters in the fall of 2017, convened technical MCO workgroups, and updated the 837 Companion Guides for professional and institutional encounters. Soon after MCOs began submitting pay data for all encounters in January 2018, MDH staff discovered errors in processing the paid amount for medical and institutional encounters. By February 2018, MDH reviewed MCO paid submissions to determine the amount of encounters that were without paid amounts or with zero dollars populated (separated by denied and sub-capitated) from those that were populated accurately. MDH staff met with the MCOs individually and shared their findings to improve their submission processes. By August 2018, MMIS2 had received complete pay data for all medical encounters. While the completeness of these data is now sufficient, the accuracy of the data remains unassessed.

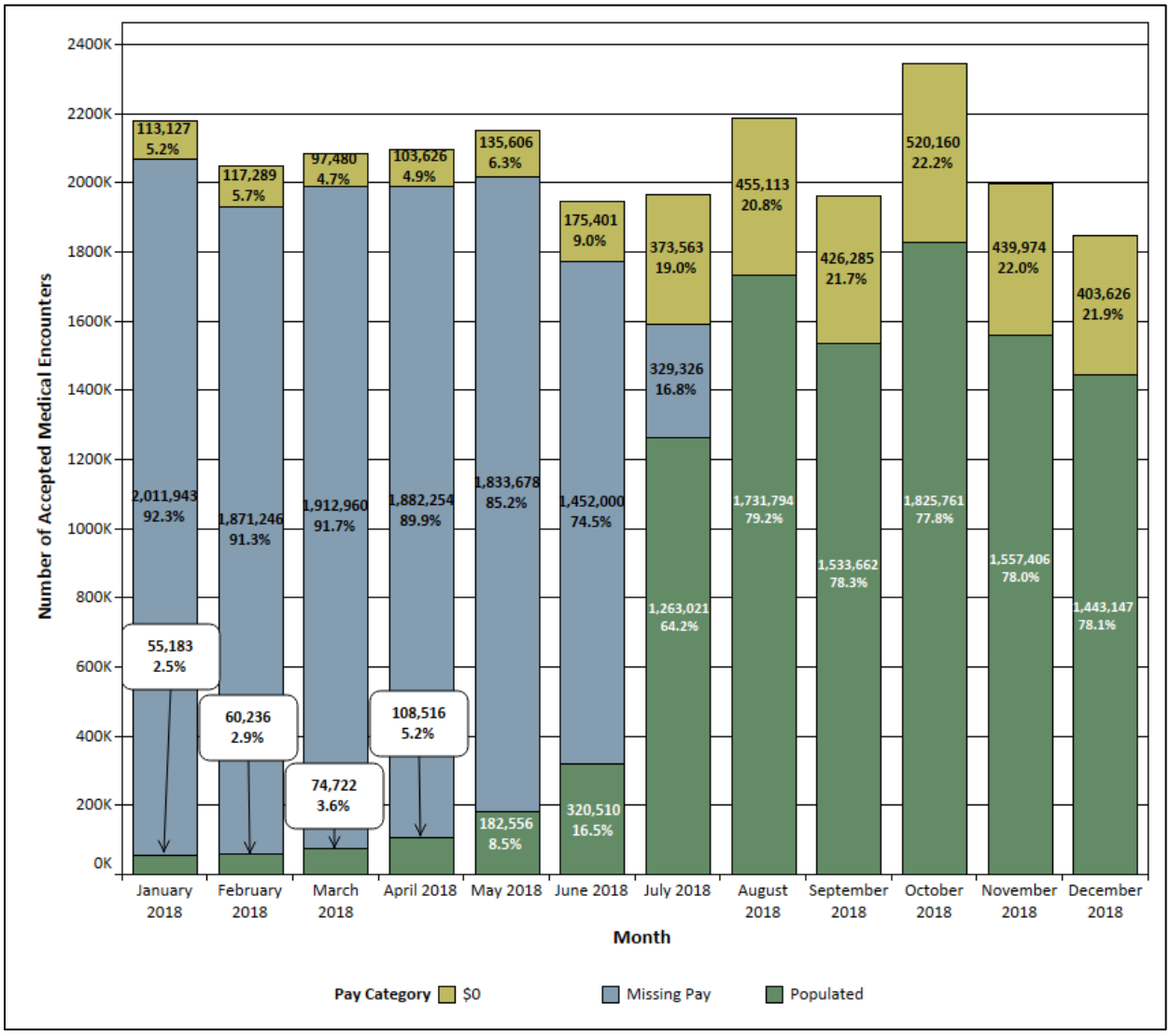
In fall 2018, MDH staff discovered that only the paid amount for the first service line of each institutional encounter was being recorded, which underreported the total amount paid. Payment fields also were not populated sufficiently enough to be used for accurate analysis. MDH staff expect that by early 2020, MMIS2 will store the correct sum for all of the total paid institutional service lines. MDH continues to work with the MCOs to ensure the validity of institutional and medical encounters.

Hilltop conducted an analysis to assess the completeness of the payment fields from medical encounters in CY 2018. This analysis only focuses on payment fields from medical encounters to assess each MCO's quality of data submissions for payment fields throughout CY 2018.

Figure 5 provides a monthly breakdown of accepted medical encounters submitted by pay category in CY 2018.

[3] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498, (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).
[4] 42 CFR § 438.818(a)(2).
[5] Maryland Department of Health. (September 20, 2017). Maryland Medical Assistance Program: MCO Transmittal No. 120. Retrieved from https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_04-18.pdf

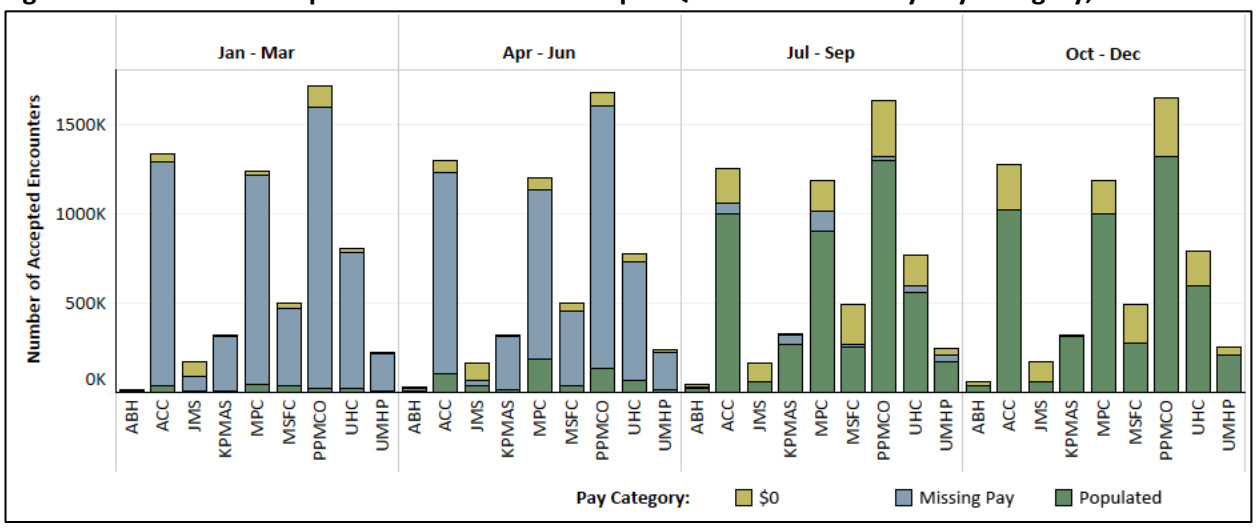
Figure 5. Number and Percentage of Accepted Medical Encounters per Month by Pay Category, CY 2018



MCOs demonstrated an improvement in the quality of their data submissions over the course of CY 2018. The greatest improvement can be seen from June 2018 to July 2018, in part because MDH met with MCOs individually in the spring of 2018 to improve their submission and intake process of medical encounters. By August 2018, MCOs were no longer submitting encounters with missing pay data and paid fields with $0; therefore, an increase registered monthly for pay category from August to the end of CY 2018.

Figure 6 displays the distribution of pay category for each MCO's accepted medical encounter data, by quarter, in CY 2018.

Figure 6. Number of Accepted Medical Encounters per Quarter and MCO by Pay Category, CY 2018



Step 3. Generate and Review Analytic Reports

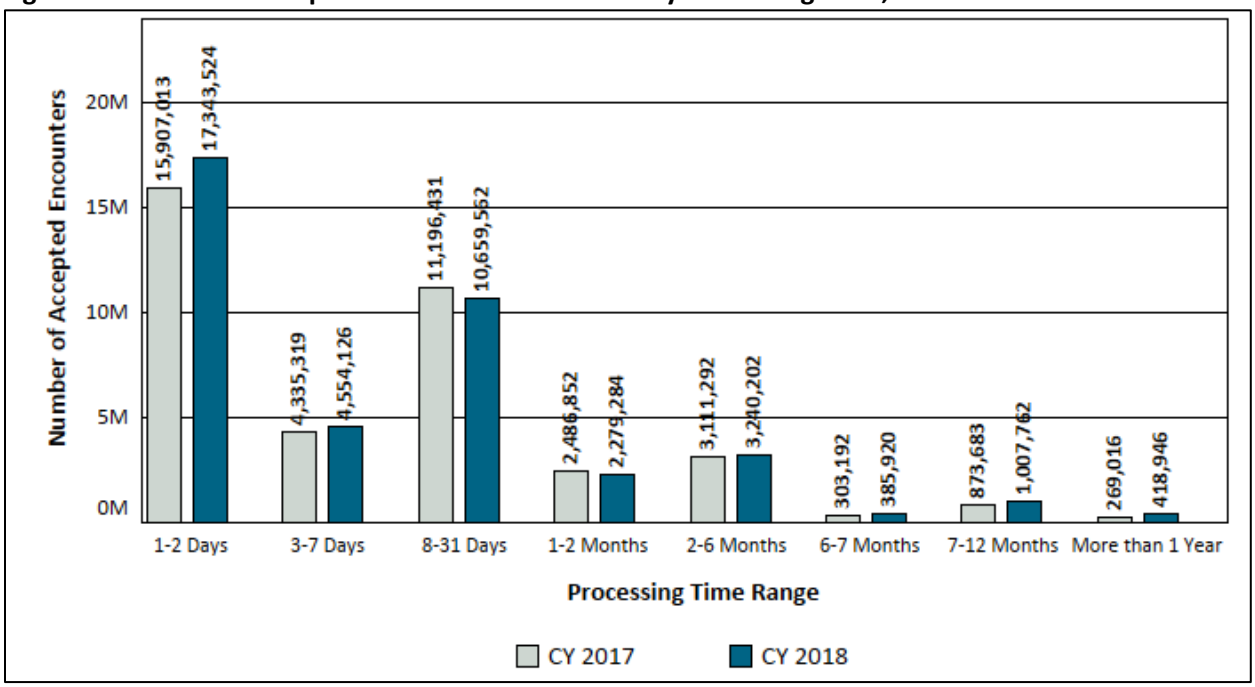
Time Dimension Analysis

Effective analysis of the Medicaid program requires complete and accurate data. The encounter data processing time spans the interval between the end date of service and when the encounter is submitted to MDH. Once a provider has provided a service, they are required to submit a claim to the MCO within six months. Once invoiced, the MCO must adjudicate clean claims within 30 days. Maryland regulations require MCOs to submit encounter data based on its claims to MDH within 60 calendar days after receipt of the claim from the provider. Therefore, the maximum time allotted for an encounter to be submitted to MDH from the date of service is eight months.

The Medicaid program requires MCOs to submit encounters in a timely fashion; however, delays in submission due to various reasons from month to month is expected. Noticeable changes related to timeliness may indicate irregularity in encounter data submissions.

Figure 7 provides the timeliness of accepted encounter submissions from the end date of service for CY 2017 and CY 2018.

Figure 7. Number of Accepted Encounters Submitted by Processing Time, CY 2017 and CY 2018



Note for Figure 7: An encounter is labeled as "1-2 months" if the encounter was submitted between 32 and 60 days from the date of service; "2-6 months" if the encounter was submitted between 61 and 182 days from the date of service; "6-7 months" if the encounter was submitted between 183 and 212 days from the date of service; and "7-12 months" if the encounter was submitted between 213 and 364 days from the date of service.

The majority of MCOs submitted encounters to MDH within 1 to 2 days of the end date of service, followed by 8 to 31 days and 3 to 7 days. Very few encounters were submitted more than 6 months past the end date of service. A greater number of MCOs submitted encounters within 1 to 2 days in CY 2018 than in CY 2017. There was a small increase in encounters submitted within 3 to 7 days and a small decrease in encounters submitted within 8 to 31 days in CY 2018, which could signify a positive trend.

Table 31 shows the processing times for encounters submitted by claim type for CY 2017 and CY 2018.

Table 31. Percentage of the Total Number of Encounters Submitted by Claim Type and Processing Time, CY 2017 and CY 2018

Processing Time Range	Pharmacy Claim		Physician Claim		Outpatient Hospital Claim		Other	
	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018
1-2 days	76.4%	82.1%	27.7%	28.6%	16.0%	18.0%	11.2%	13.1%
	8,619,318	9,441,541	6,981,577	7,572,249	272,764	287,972	33,354	41,762
3-7 days	12.7%	11.8%	10.9%	11.5%	8.2%	8.8%	6.8%	7.0%
	1,431,810	1,358,174	2,742,752	3,032,872	140,365	140,852	20,392	22,228
8-31 days	10.2%	3.9%	37.3%	36.4%	32.5%	30.4%	31.9%	29.2%
	1,149,490	445,107	9,398,983	9,635,210	552,633	486,022	95,325	93,223
1-2 months	0.7%	0.1%	8.6%	7.8%	11.6%	9.9%	15.1%	12.9%
	77,737	12,188	2,166,724	2,067,369	197,339	158,648	45,052	41,079
2-6 months	0.0%	2.1%	10.8%	10.1%	19.3%	17.2%	20.2%	20.0%
	4,713	240,199	2,718,181	2,661,452	327,927	274,734	60,471	63,817
More than 6 Months	0.0%	0.0%	4.7%	5.7%	12.4%	15.6%	14.9%	18.0%
	333	301	1,189,503	1,505,530	211,597	249,388	44,458	57,409
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	11,283,401	11,497,510	25,197,720	26,474,682	1,702,625	1,597,616	299,052	319,518

The majority of pharmacy encounters were submitted within 1 to 2 days of the end date of service for both CY 2017 and CY 2018 (76.4% and 82.1%, respectively), and over 75% of all physician encounters were submitted within 31 days (75.9% in CY 2017 and 76.5% in CY 2018). Nearly all claim types in CY 2018 had a higher percentage of encounters submitted within 1 to 2 days and 3 to 7 days than in CY 2017.

Table 32 displays the monthly processing time for submitted encounters in CY 2018.

Table 32. Percentage of Encounters Submitted by Month and Processing Time, CY 2018

Processing Time Range	January	February	March	April	May	June	July	August	September	October	November	December	Total
1-2 days	43.8%	39.3%	38.9%	46.6%	44.9%	44.1%	40.6%	42.8%	45.1%	48.4%	43.7%	42.5%	43.4%
3-7 days	11.2%	11.7%	11.1%	11.9%	8.8%	10.8%	10.2%	12.2%	15.3%	10.9%	13.1%	9.9%	11.4%
8-31 days	25.0%	27.0%	27.2%	24.2%	29.9%	25.2%	31.2%	28.2%	22.5%	24.4%	26.1%	30.7%	26.8%
1-2 months	5.0%	8.3%	5.4%	6.8%	4.2%	6.8%	5.7%	4.7%	4.8%	5.5%	6.0%	5.8%	5.7%
2-6 months	8.1%	7.0%	11.7%	4.9%	6.5%	8.7%	7.6%	7.5%	9.0%	7.4%	9.6%	9.8%	8.1%
6-7 months	0.8%	0.4%	0.5%	0.7%	1.9%	0.7%	0.6%	2.0%	0.4%	2.2%	0.4%	0.6%	1.0%
7-12 months	2.6%	2.6%	3.5%	3.4%	3.2%	3.0%	3.6%	2.3%	2.9%	1.2%	1.1%	0.8%	2.5%
More than 1 Year	3.4%	3.6%	1.8%	1.5%	0.7%	0.6%	0.5%	0.1%					1.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Across all 12 months, timeliness of encounter submissions remained relatively consistent. For all encounters submitted in CY 2018, an average of 43.4% were submitted by the MCOs and processed by MDH within 1 to 2 days of the end date of service.

Table 33 displays processing times for encounters submitted to MDH by MCO in CY 2017 and CY 2018.

Table 33. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2017 and CY 2018

MCO	1-2 days		3-7 days		8-31 days		1-2 months		2-6 months		6-7 months		7-12 months		More than 1 Year		Total
	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	CY 2017	CY 2018	
ABH		22.7%		5.9%		15.0%		7.9%		18.5%		7.0%		17.2%		6.1%	100.0%
ACC	36.2%	40.4%	11.3%	11.3%	33.9%	27.4%	7.2%	6.1%	7.9%	7.9%	0.7%	1.4%	2.1%	3.7%	0.7%	1.8%	100.0%
JMS	28.4%	30.7%	4.8%	4.4%	9.8%	6.0%	12.0%	9.7%	39.3%	32.0%	2.9%	4.8%	2.6%	11.5%	0.3%	1.0%	100.0%
KPMAS	56.9%	55.8%	12.1%	12.6%	17.5%	22.9%	3.1%	3.7%	4.2%	3.2%	1.0%	0.4%	4.4%	1.4%	0.8%	0.1%	100.0%
MPC	46.1%	47.3%	11.6%	12.0%	26.0%	24.4%	4.8%	4.7%	7.3%	9.1%	0.8%	0.6%	3.1%	1.6%	0.2%	0.4%	100.0%
MSFC	28.1%	34.1%	8.7%	10.2%	36.7%	34.4%	14.0%	7.3%	9.1%	8.9%	0.7%	1.2%	1.9%	3.1%	0.8%	0.9%	100.0%
PPMCO	48.6%	48.2%	12.7%	12.3%	27.8%	26.8%	4.6%	4.7%	4.1%	5.0%	0.4%	0.4%	1.1%	1.2%	0.6%	1.4%	100.0%
UHC	32.7%	35.7%	10.7%	11.1%	34.0%	33.7%	6.5%	7.1%	11.2%	8.9%	1.2%	0.9%	3.1%	2.1%	0.7%	0.5%	100.0%
UMHP	45.9%	51.6%	11.0%	11.8%	22.3%	17.3%	7.2%	6.4%	6.9%	8.5%	0.6%	1.1%	2.2%	2.6%	3.9%	0.7%	100.0%

All MCOs submitted a higher percentage of their encounters within 1 to 2 days in CY 2018 than in CY 2017 except for KPMAS and PPMCO, who had slightly lower percentages in CY 2018. In CY 2018, the percentage of encounters submitted by MCO within 1 to 2 days ranged from 22.7% (ABH) to 55.8% (KPMAS). The submission of encounters within 3 to 7 days also increased for all MCOs except for JMS and PPMCO (both reported within 1 percentage point lower than the previous year).

Provider Analysis

Evaluating encounters by provider type for fluctuations across MCOs contributes to the assessment of encounter data volume and consistency. The following provider analysis examines encounter data for primary care providers (PCPs) and establishes a comparison rate of PCP visits in HealthChoice.

Table 34 shows the number of all HealthChoice participants enrolled for any length of time that received a PCP service by MCO during CY 2017 and CY 2018.

Table 34. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with a PCP Visit by MCO, CY 2017 and CY 2018

	Year	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of Participants (Any Period of Enrollment)	CY 2017		328,265	31,842	80,858	259,140	109,884	345,541	189,658	55,968	1,401,156
	CY 2018	21,615	326,719	32,957	82,798	114,508	258,807	354,934	63,463	182,703	1,438,504
Percentage of Participants with a Visit with Any PCP in any MCO network	CY 2017		75.2%	66.1%	54.5%	68.0%	60.0%	71.1%	69.7%	58.9%	65.4%
	CY 2018	10.3%	75.1%	67.9%	59.6%	61.9%	67.3%	70.4%	59.1%	67.3%	67.7%
Percentage of Participants with a Visit with their Assigned PCP	CY 2017		41.5%	23.5%	45.0%	30.4%	26.0%	19.8%	38.1%	22.8%	30.9%
	CY 2018	2.1%	39.6%	1.0%	50.1%	27.6%	29.9%	20.2%	23.3%	34.7%	29.9%
Percentage of Participants with a Visit with their Assigned PCP, Group Practice, or Partner PCPs	CY 2017		58.7%	51.4%	50.3%	49.3%	39.3%	22.0%	52.0%	36.0%	44.9%
	CY 2018	3.1%	57.1%	45.7%	55.4%	43.2%	47.4%	22.3%	36.0%	46.3%	42.2%

Notes: Because a participant can be enrolled in multiple MCOs during the year, the total number of participants shown above is not a unique count. These counts also do not include fee-for-service claims. Please read PPMCO's results with caution; the analysis relied heavily on matching providers using a National Provider Identifier (NPI), but PPMCO's PCP assignment files and supplemental PCP assignment files submitted to Hilltop for analysis were missing the NPI field. However, the NPI field was present in MMIS2.

The total number of participants for each MCO in Table 11 differs from the totals shown in Table 7 because this provider analysis is based on monthly PCP assignment files submitted by the MCOs to Hilltop rather than MMIS2 data. For this analysis, Hilltop matched the Medicaid identification numbers the MCOs provided for their members to the eligibility data in MMIS2. Only participants listed in an MCO's files and with enrollment in MMIS2 were included in this analysis.

During CY 2018, the percentage of participants with a visit to their assigned PCP, group practice, or partner PCP for each MCO was between 22.3% (PPMCO) and 57.1% (ACC) (excluding ABH). Using the broadest definition of a PCP visit: a visit to any PCP within any MCO's network, the MCOs' percentage of participants with at least one PCP visit ranged from 59.1% (UHC) to 75.1% (ACC) (excluding ABH). From CY 2017 to CY 2018, the overall MCOs percentage of participants with a visit to both assigned PCP and assigned PCP, group practice, or partner PCP categories decreased by 1.0 and 2.7 percentage points, respectively; however, the participants with a visit to any PCP category increased by 2.3 percentage points during the evaluation period.

Service Type Analysis

The analysis of CY 2017 inpatient hospitalizations, observation stays, and ED visits serves as baseline to CY 2018 encounter data.

Table 35 shows the number and percentage of encounter visits for each service type, by MCO, for CY 2017 and CY 2018.

Table 35. Number and Percentage of Inpatient Visits, ED Visits, and Observation Stays by MCO, CY 2017 and CY 2018

	Year	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of Visits	CY 2017		4,132,631	498,738	751,725	3,954,165	1,530,576	5,373,077	2,712,108	649,151	19,602,171
	CY 2018	105,638	4,066,620	493,254	832,237	3,970,844	1,632,551	5,457,692	2,528,972	764,310	19,852,118
Percentage of All Visits	CY 2017		21.1%	2.5%	3.8%	20.2%	7.8%	27.4%	13.8%	3.3%	100.0%
	CY 2018	0.5%	20.5%	2.5%	4.2%	20.0%	8.2%	27.5%	12.7%	3.9%	100.0%
Number of Inpatient Visits	CY 2017		24,702	3,564	4,964	24,691	9,297	33,945	15,904	4,509	121,576
	CY 2018	1,013	24,222	3,378	5,302	24,769	9,871	33,665	14,206	5,693	122,119
Percentage of Visits that were Inpatient	CY 2017		0.6%	0.7%	0.7%	0.6%	0.6%	0.6%	0.6%	0.7%	0.6%
	CY 2018	1.0%	0.6%	0.7%	0.6%	0.6%	0.6%	0.6%	0.6%	0.7%	0.6%
Number of ED Visits	CY 2017		178,774	26,028	16,895	168,083	59,954	204,714	105,954	28,002	788,404
	CY 2018	5,229	109,846	23,451	18,116	160,857	62,405	201,630	94,837	35,068	711,439
Percentage of Visits that were ED	CY 2017		4.3%	5.2%	2.2%	4.3%	3.9%	3.8%	3.9%	4.3%	4.0%
	CY 2018	4.9%	2.7%	4.8%	2.2%	4.1%	3.8%	3.7%	3.8%	4.6%	3.6%
Number of Observation Stays	CY 2017		8,435	1,444	719	9,871	3,040	8,705	6,088	1,250	39,552
	CY 2018	266	3,180	1,267	792	10,077	3,255	9,350	6,120	1,887	36,194
Percentage of Visits that were Observation Stays	CY 2017		0.2%	0.3%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
	CY 2018	0.3%	0.1%	0.3%	0.1%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%

Note: Visits were not unduplicated between inpatient visits, ED visits, and observation stays.

For this analysis, a visit is defined as one encounter per person per provider per day. MCOs reported a consistent distribution of visits by service type for both years of the evaluation period. The percentage for both the total inpatient hospitalizations and observation stays combined were less than 1.0% of visits

each year. ED visits, which were 3.6% of all visits in CY 2018, ranged from 2.2% (KPMAS) to 4.9% (ABH). ACC reported substantially fewer ED visits in CY 2018 than in CY 2017 (109,846 and 178,774, respectively).

Analysis by Age and Sex

An analysis of encounter data submitted by MCOs was conducted to determine the effectiveness of encounter data edit checks in CY 2018 as compared to CY 2017. The following three areas were analyzed to determine the effectiveness of encounter data edit checks:

- Individuals over 65 with encounters, since this population is ineligible for HealthChoice
- Age-appropriate and sex-appropriate diagnoses for pregnancy
- Age-appropriate dementia diagnoses.

There are expected age ranges for pregnancy and dementia used to identify potential outliers within MMIS2 encounter data. High percentages of participants with these diagnoses outside of the established appropriate age range and sex could indicate potential errors within the data. Any outliers identified were provided to MDH in individual-level reports for further investigation.

Individuals Over 65 Enrolled in HealthChoice

Because participants older than 65 are ineligible for HealthChoice, data was reviewed for any encounters for those aged 66 or older. Across all MCOs, encounters were submitted in CY 2018 for 22 participants who were over age 66 or who did not have a reported date of birth; this is half of what was reported in CY 2017 (44).

Age-Appropriate and Sex-Appropriate Diagnoses for Pregnancy

The first pregnancy analysis checked the percentage of participants who had a diagnosis for pregnancy by age group. Participants aged 0 to 12 and 51 or older typically are outside of the expected age range for pregnancy. This analysis only considers female participants with a pregnancy diagnosis. Across all MCOs, 47 female participants were identified as being pregnant outside of the expected age ranges in CY 2018. In CY 2017, 61 participants were identified using the same criteria. The data substantiate that the encounters are age-appropriate for pregnancy. All MCOs have similar distributions, with most participants between the ages of 12 and 50 years. Several MCOs have participants outside this age range with a pregnancy diagnosis; however, the number of outliers is negligible. The data substantiate that the encounters are age-appropriate for pregnancy.

Encounter data were also validated for pregnancy diagnosis being sex-appropriate. A diagnosis for pregnancy should typically be present on encounters for female participants. All MCOs have similar distribution, with nearly 100% of all pregnancies being reported for females. Pregnancy diagnoses for male participants in the encounter data are negligible, accounting for only 40 reported pregnancies across all MCOs, nearly the same as what was reported in CY 2017 (43).

Age-Appropriate Diagnoses of Dementia

The dementia analysis focused on age appropriate screenings and diagnoses of dementia. While dementia is a disease generally associated with older age, early onset can occur as early as 30 years of age. Thus, prevalence of dementia diagnoses should increase with age after 30. As expected, the majority (89.4%) of participants with a diagnosis of dementia are aged 30 or older. While each MCO does have participants under the age of 30 with a dementia diagnosis, the numbers are relatively small (344 participants were reported across all MCOs). In CY 2018, a more comprehensive diagnostic definition was used to identify participants with a dementia diagnosis, compared to CY 2017, causing an increase in the number of participants who met the criteria for having dementia. Starting CY 2018, ICD-10 diagnosis codes G30 and G31 were included in this analysis, and the numbers are not comparable to what was reported in CY 2017.

Activity 4: Medical Record Validation

Medical Record Sampling

Qlarant requested and received a random sample of HealthChoice encounter data for hospital inpatient, outpatient, and physician office (office visit) services that occurred in CY 2018 from Hilltop. The sample size used was determined to achieve a 90% confidence interval.

Medical Record Validation

Medical records were first validated as being the correct medical record requested. The documentation in the medical record was compared to the encounter data to determine if the submitted encounter data could be validated against the findings in the medical record.

The medical records were reviewed by either a certified coder or a nurse with coding experience.

Determinations were made as either a “match” when documentation was found in the record or a “no match” when there was a lack of documentation in the record.

A definition of EDV terms are provided in Table 36.

Table 36. EDV Definition of Terms

Term	Definition
Encounter	A unique date of service with coded diagnoses and procedures for a single provider or care/service provided on a unique date of service by the provider.
Review Element	Specific element in the encounter data which is being compared to the medical record; elements in this review include diagnosis, procedure, and revenue codes.
Match Rate	Rate of correct record elements to the total elements presented as a percent.

Medical Record Review Guidelines

The following reviewer guidelines were used to render a determination of "yes" or "match" between the encounter data and the medical record findings:

- As directed by the CMS Protocol, medical record reviewers cannot infer a diagnosis from the medical record documentation. Reviewers are required to use the diagnosis listed by the provider. For example, if the provider recorded "fever and chills" in the medical record, and the diagnosis in the encounter data is "upper respiratory infection," the record does not match for diagnosis even if the medical record documentation would support the use of that diagnosis.
- For inpatient encounters with multiple diagnoses listed, the medical record reviewers are instructed to match the first listed diagnosis (as the principal diagnosis) with the primary diagnosis in the encounter data.
- Procedure data is matched to the medical record regardless of sequencing.

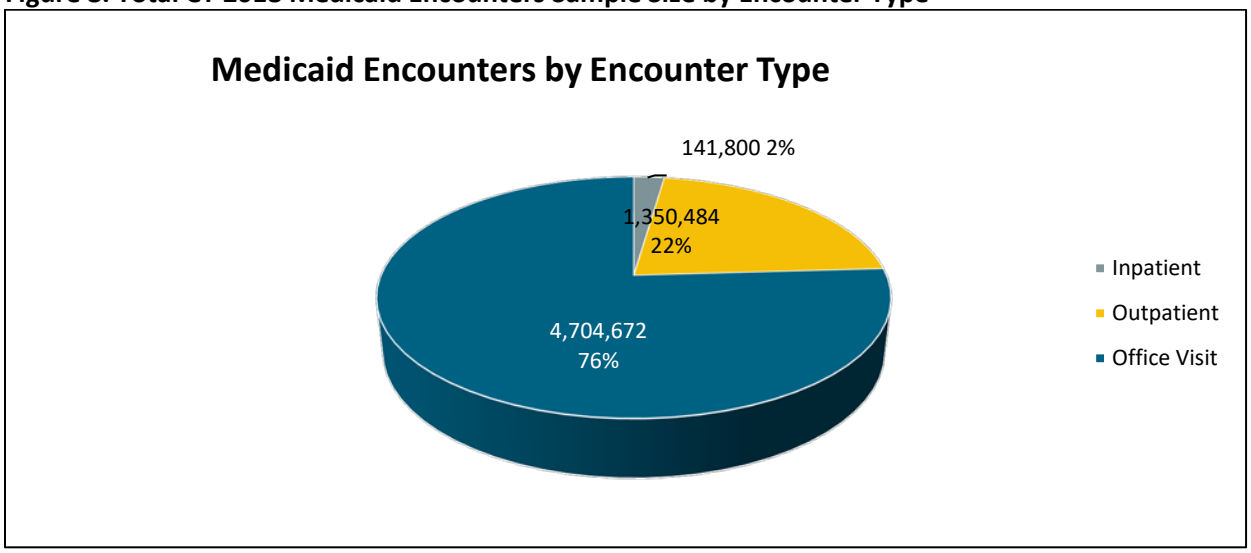
Results of Activity 4: Medical Record Validation

Medical Record Sampling

Qlarant requested and received the CY 2018 random sample of hospital inpatient, outpatient, and office visit services that occurred in CY 2018. The sample drawn was determined to achieve a 90% confidence interval with a 5% margin of error.

A representation of the total CY 2018 sample size of encounters by setting is demonstrated in Figure 8.

Figure 8. Total CY 2018 Medicaid Encounters Sample Size by Encounter Type



The majority of the CY 2018 encounters sampled were office visits at 76% (4,704,672), followed by outpatient encounters at 22% (1,350,484), and inpatient encounters making up the smallest portion at 2% (141,800). Please refer to Table 37 for the distribution of the EDV sample by encounter type from CY 2016 to CY 2018.

Table 37. CY 2016 - CY 2018 EDV Sample by Encounter Type

Encounter Type	CY 2016			CY 2017			CY 2018		
	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	126,905	1.4%	42	133,974	2.2%	48	141,800	2.3%	60
Outpatient	1,337,141	14.4%	458	1,349,781	21.9%	467	1,350,484	21.8%	531
Office Visit	7,809,270	84.2%	2,572	4,679,773	75.9%	1,653	4,704,672	75.9%	1,853
Total	**9,273,316**	**100.0%**	**3,072**	**6,163,528**	**100.0%**	**2,168**	**6,196,956**	**100.0%**	**2,444**

The proportion of inpatient and outpatient visits has increased from CY 2016 through CY 2018. However, the office visit encounters in CY 2017 appears considerably lower than in CY 2016 due to a change in how office visits were identified. In prior years, the data were generated at the service level, whereas each procedure provided on the same date of service was treated as one encounter. In CY 2017 and CY 2018, the data was generated at the visit level, whereas all procedures provided on one date of service were collectively treated as one encounter to provide a more thorough review of the physician encounter data.

The total number of records reviewed was higher in CY 2016, as MDH changed from a statewide review to an MCO-specific review. The sampling methodology was revised in CY 2017 to reflect a 90% confidence level with a 5% margin of error. This resulted in a slight decrease in records reviewed per MCO.

Once sampling was complete, Qlarant faxed medical records requests to the service providers. Non-responders were further contacted by the MCOs to aid the providers to be in compliance by submitting their medical records. Table 38 outlines the total number of records reviewed and required by MCO and encounter type.

Table 38. CY 2018 MCO EDV Medical Record Review Response Rates by Encounter Type

MCO	Inpatient Records			Outpatient Records			Office Visit Records		
	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?
ABH	9	9	Yes	68	67	Yes	195	195	Yes
ACC	6	5	Yes	68	53	Yes	215	213	Yes
JMS	7	7	Yes	84	82	Yes	182	182	Yes
KPMAS	5	5	Yes	22	18	Yes	251	248	Yes
MPC	6	6	Yes	82	66	Yes	200	199	Yes
MSFC	7	6	Yes	51	50	Yes	216	215	Yes
PPMCO	8	7	Yes	69	67	Yes	202	198	Yes
UHC	7	7	Yes	61	59	Yes	213	209	Yes

MCO	Inpatient Records			Outpatient Records			Office Visit Records		
	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?
UMHP*	5	8	No	70	69	Yes	197	194	Yes
Total	**60**	**60**	**No**	**575**	**531**	**Yes**	**1,871**	**1,853**	**Yes**

*UMHP did not submit a sufficient number of medical records to meet the minimum samples required for the inpatient setting.

All MCOs submitted a sufficient number of medical records to meet the minimum samples required for each setting type of the encounter data review except for UMHP, which did not submit the required number of inpatient records. Overall, there were more records reviewed than were required for outpatient and office visit settings.

Analysis Methodology

Data from the database were used to analyze the consistency between submitted encounter data and corresponding medical records. Results were analyzed and presented separately by encounter type and review element. Match rates (medical record review supporting the encounter data submitted) and reasons for "no match" errors for diagnosis code, procedure code, and revenue code elements are presented for inpatient, outpatient, and office visit encounter types in the results below.

Exclusion Criteria

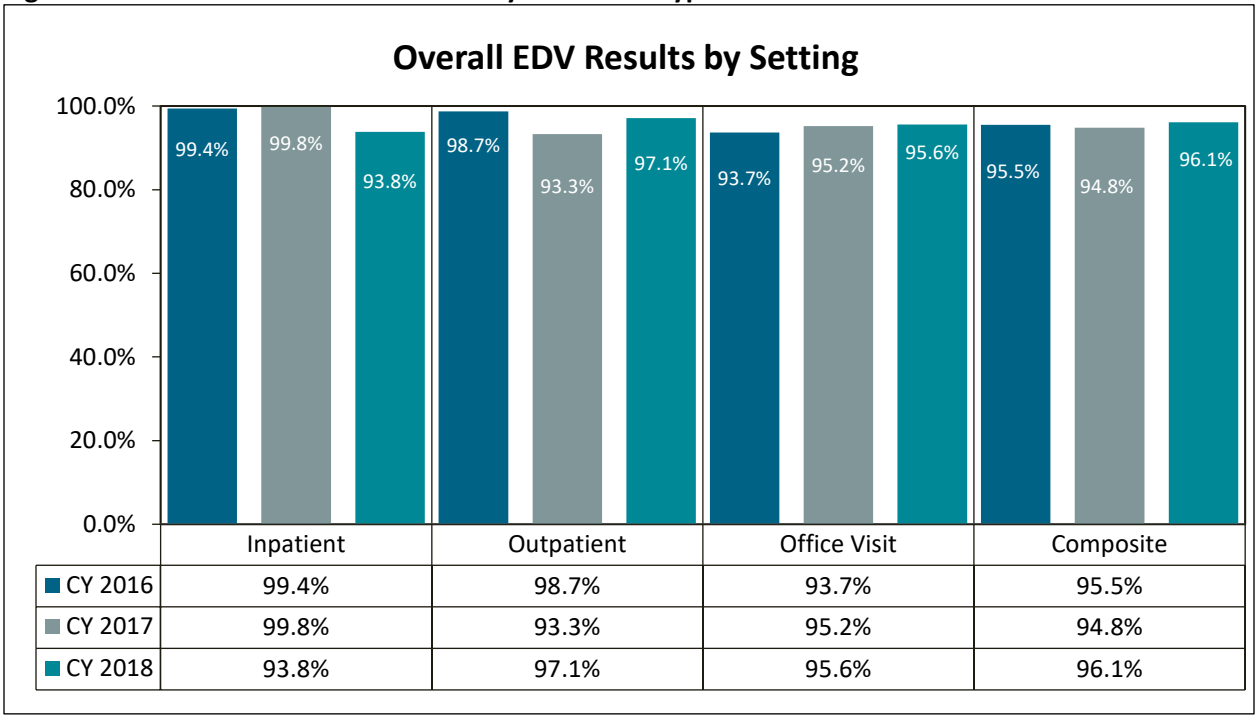
Cases where a match between the medical record and encounter data could not be verified because it was not legible or the date of birth, date of service, gender, or name were missing or incorrect were excluded from the review and determined invalid. Nearly 10% (269) of the total available records (2,783) were determined to be invalid. Of those records, 71% were for office visits, 22% were outpatient, and 7% were inpatient records.

Results

The analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes. A total of 2,506 medical records were reviewed.

The overall EDV results for CY 2016 through CY 2018 by encounter type are displayed in Figure 9.

Figure 9. CY 2016 - CY 2018 EDV Results by Encounter Type



The CY 2018 overall match rate was 96.1%, which represents a 1.3 percentage point increase from CY 2017 and a 0.6 percentage point increase from CY 2016. Match rates for both outpatient and office visit settings increased, while inpatient match rates declined 6 percentage points.

Table 39 provides trending of the EDV records for CY 2016 through CY 2018 by encounter type.

Table 39. CY 2016 – CY 2018 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements*			Total Matched Elements			Percentage of Matched Elements		
	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018
Inpatient	54	48	60	1,117	1,005	1,289	1,110	1,003	1,209	99.4%	99.8%	93.8%
Outpatient	473	474	575	4,448	5,479	7,386	4,389	5,113	7,170	98.7%	93.3%	97.1%
Office Visit	2,584	1,695	1,871	9,778	7,269	8,597	9,160	6,921	8,220	93.7%	95.2%	95.6%
Total	**3,111**	**2,217**	**2,506**	**15,343**	**13,753**	**17,272**	**14,659**	**13,037**	**16,599**	**95.5%**	**94.8%**	**96.1%**

*Possible elements include diagnosis, procedure, and revenue codes.

The overall element match rate increased by 1.3 percentage points from 94.8% in CY 2017 to 96.1% in CY 2018 and is 0.6 percentage points above the CY 2016 rate of 95.5%.

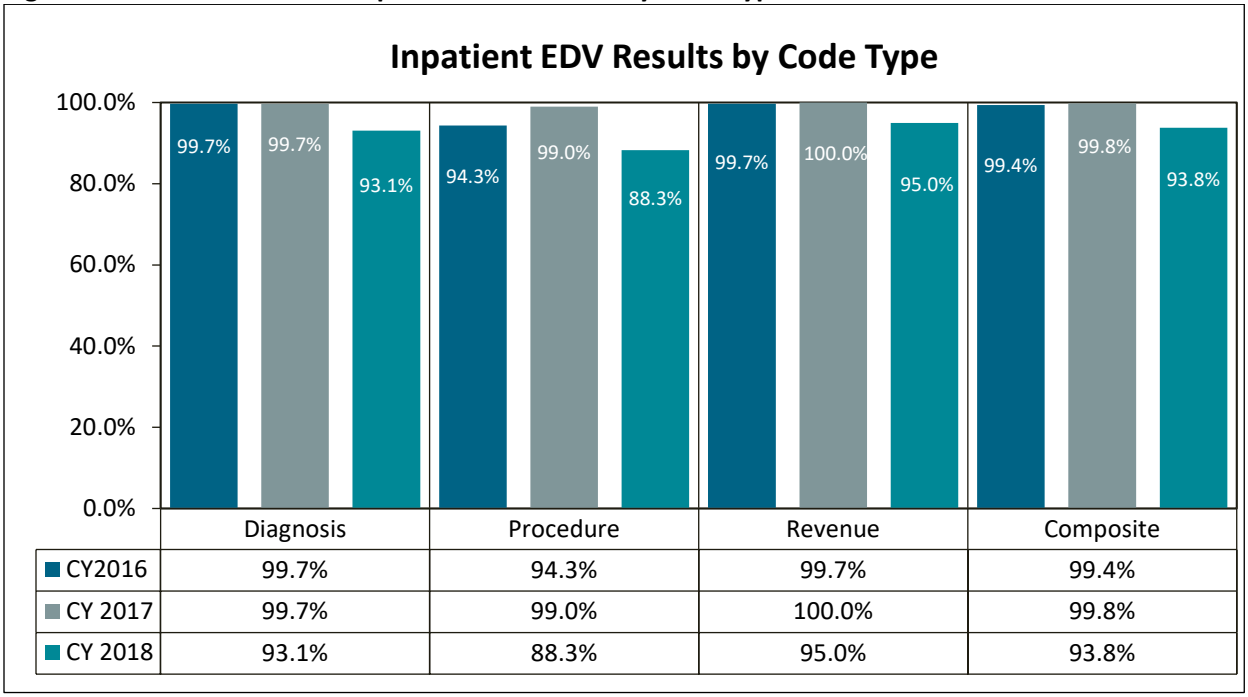
Results by Review Element

The EDV review element match rates were analyzed by code type including diagnosis, procedure, and revenue codes. The following section outlines those results.

Inpatient Encounters

The inpatient EDV results by code type for CY 2016 through CY 2018 are displayed in Figure 10.

Figure 10. CY 2016 - CY 2018 Inpatient EDV Results by Code Type



	Diagnosis	Procedure	Revenue	Composite
CY2016	99.7%	94.3%	99.7%	99.4%
CY 2017	99.7%	99.0%	100.0%	99.8%
CY 2018	93.1%	88.3%	95.0%	93.8%

Overall, the composite inpatient encounter match rate for inpatient encounters across all code types declined 6 percentage points in CY from 99.8% in CY 2017 to 93.8% in CY 2018 and is 5.6 percentage points below the CY 2016 rate of 99.4%.

Table 40 provides trending of EDV inpatient encounter type results by code from CY 2016 through CY 2018.

Table 40. CY 2016 – CY 2018 EDV Inpatient Encounter Type Results by Code

Inpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018
Match	367	328	446	66	103	83	677	572	680	1,110	1,003	1,209
No Match	1	1	33	4	1	11	2	0	36	7	2	80
Total Elements	368	329	479	70	104	94	679	572	716	1,117	1,005	1,289
Match Percent	**99.7%**	**99.7%**	**93.1%**	**94.3%**	**99.0%**	**88.3%**	**99.7%**	**100%**	**95.0%**	**99.4%**	**99.8%**	**93.8%**

The CY 2018 match rate of 93.1% for diagnosis code declined 6.6 percentage points from the CY 2017 and CY 2016 rate of 99.7%.

The CY 2018 match rate of 88.3% for procedure code registered the most decline of 10.7 percentage points from the CY 2017 rate of 99% and is 6 percentage points lower than the CY 2016 rate of 94.3%.

The CY 2018 match rate of 95% for revenue code declined 5 percentage points from the CY 2017 rate of 100% and 4 percentage points from the CY 2016 rate of 99.7%.

The CY 2018 MCO-specific inpatient results by code type are shown in Table 41.

Table 41. MCO Inpatient Results by Code Type

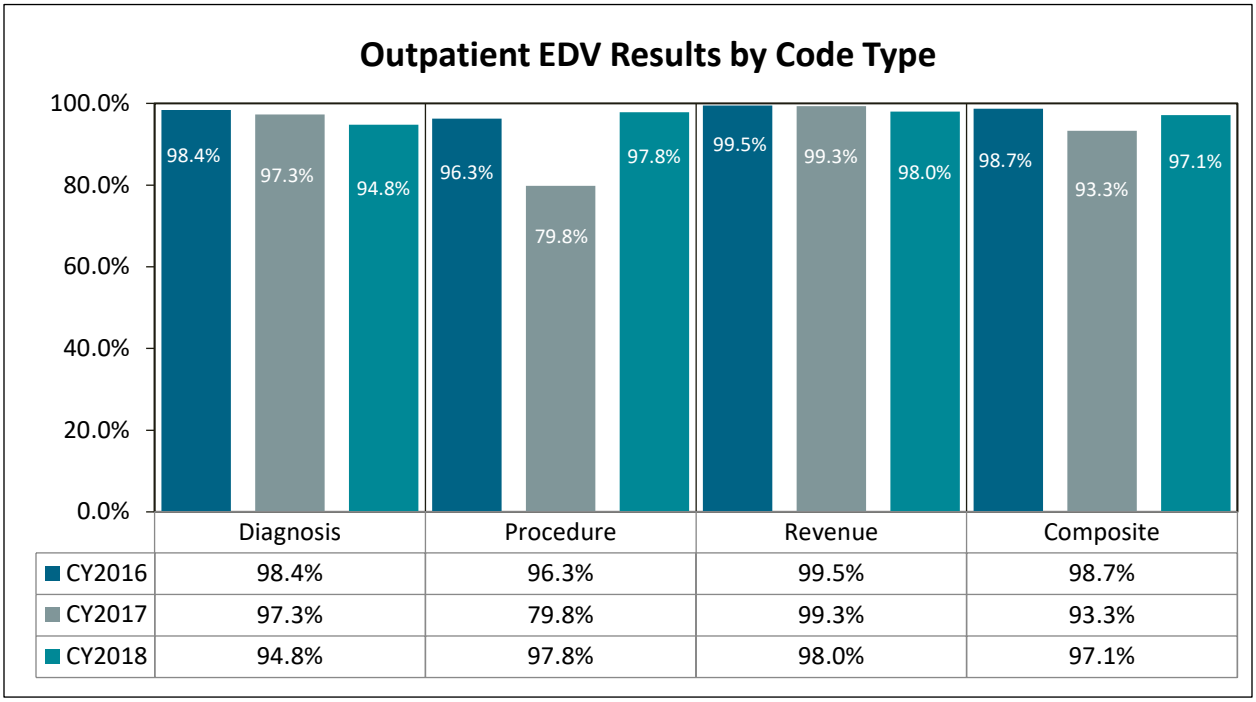
MCO	# of Reviews	Diagnosis Codes			Procedures Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ABH	9	72	73	98.6%	14	14	100.0%	104	104	100.0%	190	191	99.0%
ACC	6	38	41	92.7%	7	9	77.8%	59	59	100.0%	104	109	95.0%
JMS	7	60	60	100.0%	10	18	55.6%	95	95	100.0%	165	173	95.0%
KPMAS	5	26	27	96.3%	12	12	100.0%	43	44	97.7%	81	83	98.0%
MPC	6	50	53	94.3%	16	16	100.0%	81	81	100.0%	147	150	98.0%
MSFC	7	55	58	94.8%	10	10	100.0%	107	107	100.0%	172	175	98.0%
PPMCO	8	67	68	98.5%	11	11	100.0%	71	71	100.0%	149	150	99.0%
UHC	7	53	58	91.4%	2	2	100.0%	88	91	96.7%	143	151	95.0%
UMHP	5	25	41	61.0%	1	2	50.0%	32	64	50.0%	58	107	54.0%

Two of the nine MCOs (ABH and PPMCO) achieved a match rate of 99% for inpatient encounters across all code types. KPMAS, MPC, and MSFC received an overall rate of 98%, and ACC, JMS, and UHC received an overall rate of 95%. UMHP did not meet the minimum sample size, resulting in a 54% match rate.

Outpatient Encounters

The outpatient EDV results by code type for CY 2016 through CY 2018 are displayed in Figure 11.

Figure 11. CY 2016 - CY 2018 Outpatient EDV Results by Code Type



Overall, the total match rate for outpatient encounters across all code types increased 3.8 percentage points from 93.3% in CY 2017 to 97.1% in CY 2018 and 1.6 percentage points lower than the CY 2016 rate of 98.7%. The decline in CY 2017 was primarily due to the large decrease in match rate for procedure codes, which dropped 16.5 percentage points from a rate of 96.3% in CY 2016. Procedure codes match rates increased by 18 percentage points in CY 2018 (97.8%) from previous calendar year (79.8%). Match rates for diagnosis codes declined 2.5 percentage points from 97.3%% in CY 2017 to 94.8% in CY 2018 and 3.6 percentage points lower than the CY 2016 rate of 98.4%.

Table 42 provides trending of EDV outpatient encounter type results by code from CY 2016 through CY 2018.

Table 42. CY 2016 – CY 2018 EDV Outpatient Encounter Type Results by Code

Outpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018
Match	1,436	1,597	1,903	626	1,206	2,475	2,327	2,310	2,792	4,389	5,113	7,170
No Match	24	44	104	24	305	56	11	17	56	59	366	216
Elements	1,460	1,641	2,007	650	1,511	2,531	2,338	2,327	2,848	4,448	5,479	7,386
Match Percent	**98.4%**	**97.3%**	**94.8%**	**96.3%**	**79.8%**	**97.8%**	**99.5%**	**99.3%**	**98.0%**	**98.7%**	**93.3%**	**97.1%**

The CY 2018 outpatient diagnosis code match rate decreased by 2.5 percentage points to 94.8% from the CY 2017 rate of 97.3% and remains below the CY 2016 rate of 98.4%.

Outpatient procedure code match rates have fluctuated from CY 2016 to CY 2018 and had a substantial increase of 18 percentage points from 79.8% in CY 2017 to 97.8% in CY 2018. CY 2018 also had a 1.5 percentage increase from CY 2016 rate of 96.3%.

Outpatient revenue code match rate has a negative trend year over year from CY 2016 to CY 2018. The CY 2018 MCO-specific outpatient results by code type are shown in Table 43.

Table 43. MCO Outpatient Results by Code Type

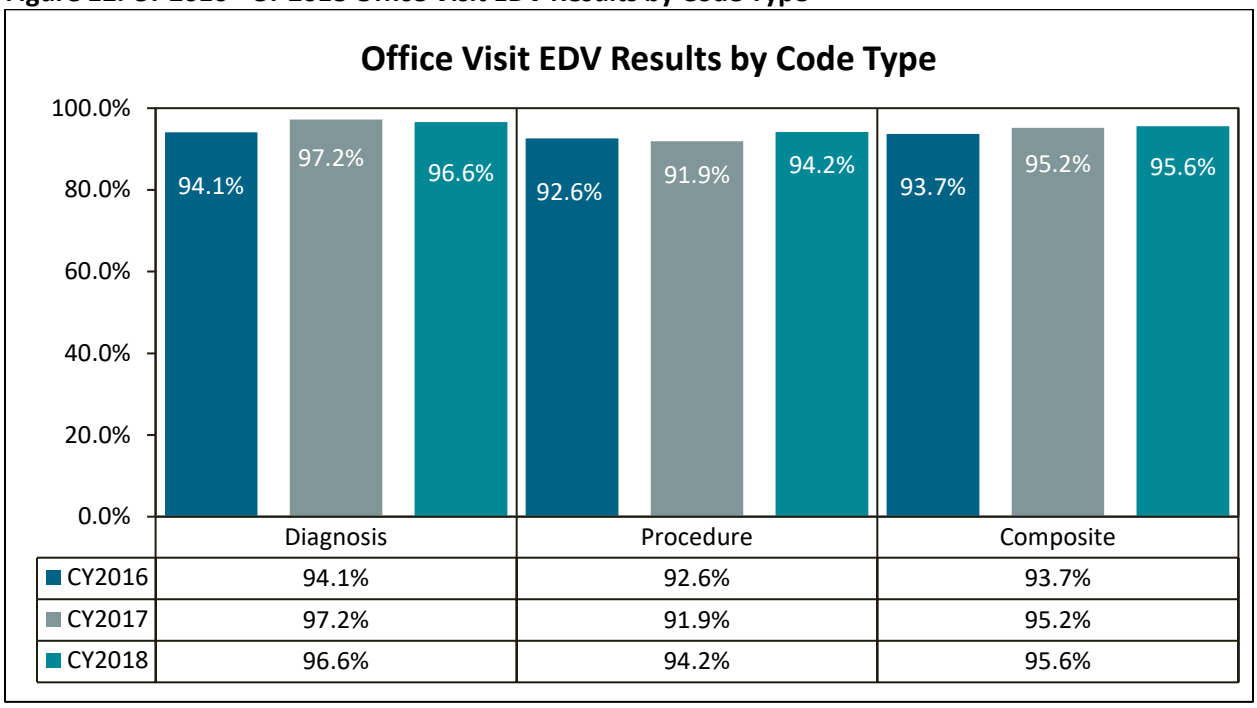
MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ABH	68	210	223	94.2%	348	355	98.0%	399	402	99.3%	957	980	97.7%
ACC	68	187	197	94.9%	244	246	99.2%	273	276	98.9%	704	719	97.9%
JMS	84	313	316	99.1%	312	317	98.4%	349	353	98.9%	974	986	98.8%
KPMAS	22	67	67	100.0%	146	147	99.3%	165	166	99.4%	378	380	99.5%
MPC	82	286	293	97.6%	357	359	99.4%	400	403	99.3%	1,043	1,055	98.9%
MSFC	51	178	197	90.4%	248	266	93.2%	281	299	94.0%	707	762	92.8%
PPMCO	69	224	233	96.1%	206	208	99.0%	233	236	98.7%	663	677	97.9%
UHC	61	168	196	85.7%	271	280	96.8%	315	326	96.6%	754	802	94.0%
UMHP	70	270	285	94.7%	343	353	97.2%	377	387	97.4%	990	1,025	96.6%

MCOs total match rate across all code types ranged from 92.8% (MSFC) to 99.5% (KPMAS). Overall, outpatient revenue codes were the highest scoring elements. The lowest scoring element was diagnosis codes with MCO scores ranging from a low of 85.7% (UHC) to a high of 100% (KPMAS).

Office Visit Encounters

The office visit EDV results by code type for CY 2016 through CY 2018 are displayed in Figure 12.

Figure 12. CY 2016 - CY 2018 Office Visit EDV Results by Code Type



Overall, the office visit match rate increased slightly by 0.4 percentage points to 95.6% in CY 2018 from 95.2% in CY 2017 and 1.9 percentage points from 93.7% in CY 2016. The overall composite rate has a positive trend year over year.

Table 44 provides trending of EDV office visit encounter type results by code from CY 2016 through CY 2018.

Table 44. CY 2016 – CY 2018 EDV Office Visit Encounter Type Results by Code

Office Visit Encounter Type	Diagnosis Codes			Procedure Codes			Total		
	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018	CY 2016	CY 2017	CY 2018
Match	6,740	4,405	4,991	2,420	2,516	3,229	9,160	6,921	8,220
No Match	425	123	178	193	223	199	618	348	377
Total Elements	7,165	4,530	5,169	2,613	2,739	3,428	9,778	7,269	8,597
Match Percent	**94.1%**	**97.2%**	**96.6%**	**92.6%**	**91.9%**	**94.2%**	**93.7%**	**95.2%**	**95.6%**

*Revenue codes are not applicable for office visit encounters.

The diagnosis code match rate decreased slightly by 0.6 percentage points from 97.2% in CY 2017 to 96.6% in CY 2018 and remains higher than the CY 2016 rate of 94.1%.

The procedure code match rate improved 2.3 percentage points from 91.9% in CY 2017 to 94.2% in CY 2018 and remains above the CY 2016 rate of 92.6%.

The CY 2018 MCO specific office visit match rates by code type are shown in Table 45.

Table 45. MCO Office Visit Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%
ABH	195	539	554	97.3%	324	349	92.8%	863	903	95.6%
ACC	215	519	537	96.6%	353	380	92.9%	872	917	95.1%
JMS	182	562	601	93.5%	252	287	87.8%	814	888	91.7%
KPMAS	251	675	683	98.8%	497	504	98.6%	1,172	1,187	98.7%
MPC	200	532	559	95.2%	346	360	96.1%	878	919	95.5%
MSFC	216	545	568	96.0%	353	379	93.1%	898	947	94.8%
PPMCO	202	495	509	97.2%	370	391	94.6%	865	900	96.1%
UHC	213	527	545	96.7%	385	406	94.8%	912	951	95.9%
UMHP	197	597	613	97.4%	349	372	93.8%	946	985	96.0%

*Revenue codes are not applicable for office visit encounters.

Overall, diagnosis codes yielded the highest match rates, ranging from 98.8% (KPMAS) to 93.5% (JMS). The lowest scoring element was procedure codes, ranging from 87.8% (JMS) to 98.6% (KPMAS).

"No Match" Results by Element and Reason

Table 46 illustrates the reasons for "no match" errors. The reasons for determining a "no match" error for the diagnosis, procedure, and revenue code elements were:

- Lack of medical record documentation.
- Incorrect principal diagnosis (inpatient encounters) or incorrect diagnosis codes.
- Upcoding

Table 46. CY 2016-CY 2018 Reasons for "No Match" by Encounter Type

Encounter Type	CY 2016							CY 2017							CY 2018						
	Coding Error		Lack of Documentation		Upcoding		Total Elements	Coding Error		Lack of Documentation		Upcoding		Total Elements	Coding Error		Lack of Documentation		Upcoding		Total Elements
	#	%	#	%	#	%	%	#	%	#	%	#	%	#	#	%	#	%	#	%	%
Diagnosis																					
Inpatient	1	100%	0	0%	NA	NA	1	1	100%	0	0%	NA	NA	1	2	6%	31	94%	NA	NA	33
Outpatient	13	54%	11	46%	NA	NA	24	44	100%	0	0%	NA	NA	44	16	15%	88	85%	NA	NA	104
Office Visit	208	49%	217	51%	NA	NA	425	123	98%	2	2%	NA	NA	125	39	22%	139	78%	NA	NA	178
Procedure																					
Inpatient	4	100%	0	0%	NA	NA	4	1	100%	0	0%	NA	NA	1	4	36%	7	64%	0	0%	11
Outpatient	23	96%	1	4%	NA	NA	24	305	100%	0	0%	NA	NA	305	9	16%	45	80%	2	4%	56
Office Visit	151	78%	42	22%	NA	NA	193	179	80%	44	20%	NA	NA	223	104	52%	74	37%	21	11%	199

Encounter Type	CY 2016							CY 2017							CY 2018						
	Coding Error		Lack of Documentation		Upcoding		Total Elements	Coding Error		Lack of Documentation		Upcoding		Total Elements	Coding Error		Lack of Documentation		Upcoding		Total Elements
	#	%	#	%	#	%	%	#	%	#	%	#	%	#	#	%	#	%	#	%	%
Revenue																					
Inpatient	0	0%	2	100%	NA	NA	2	0	0%	0	0%	NA	NA	0	0	0%	36	100%	0	0%	36
Outpatient	6	55%	5	45%	NA	NA	11	16	94%	1	6%	NA	NA	17	11	20%	44	79%	1	2%	56

Lack of documentation accounted for the majority of all diagnosis, procedure, and revenue code mismatches in CY 2018. This is a substantial change from CY 2017 and CY 2016 when the majority of mismatches resulted from coding errors.

Activity 5: EDV Findings

After completion of Steps 1, 2, and 4, Qlarant created data tables that display summary statistics for the information obtained from these activities for each MCO. Summarizing the information in tables makes it easier to evaluate by highlighting patterns in the accuracy and completeness of encounter data. Qlarant also provided a narrative accompanying these tables, highlighting individual MCO issues and providing recommendations to each MCO and DHQA about improving the quality of the encounter data.

Results of Activity 5: EDV Findings

The HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. The MCOs use standard forms and coding schemes that allow for capturing appropriate data elements for claims processing. MDH has a comprehensive 837 process, which instructs the MCOs on the collection and submission of encounter data.

The encounter data submitted by the HealthChoice MCOs for CY 2018 can be considered reliable for reporting purposes, as the EDV overall match rate was 96.1%. This rate exceeded the recommended match rate standard of 90% for EDV set by Qlarant. The CY 2018 overall match rate reflected a 1.3 percentage point increase from the CY 2017 rate of 94.8% and slight increase of 0.6 percentage points from the CY 2016 rate of 95.5%.

While the outpatient and office visit match rates increased in CY 2018, these were offset by the 6 percentage point decrease in the inpatient match rate.

In CY 2018, 94% of mismatched diagnosis codes for inpatient encounters, 85% for outpatient encounters, and 78% of office visit encounters were due to lack of documentation. Coding errors accounted for 6% of inpatient encounter mismatches, 15% of outpatient mismatches, and 22% of the office visit mismatches.

For procedure codes in CY 2018, 64.0% of inpatient encounters, 80% of outpatient encounters, and 37% of office visit encounters were mismatched due to lack of documentation. Coding errors accounted for 36% of inpatient encounter mismatches, 16% of outpatient mismatches, and 52% of the office visit procedure code mismatches. Upcoding errors accounted for 4% of outpatient procedure code

mismatches and 11% of office visit procedure code mismatches. There were no inpatient encounters that were mismatched for upcoding errors.

Lack of documentation resulted in 100% of the mismatched revenue codes for inpatient encounter and 79% for outpatient encounters. Coding errors accounted for 20% of outpatient encounter revenue code mismatches and 2% were due to upcoding errors. There were no inpatient encounter revenue codes that were mismatched for coding or upcoding errors.

MCO-specific results are outlined below. Except for UMHP, all MCOs achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.

Aetna Better Health of Maryland

- ABH, a new MCO without prior encounter data submissions, achieved match rates above the standard of 90% in all areas of review for its first validation:
    - 99.0% for all inpatient codes reviewed.
    - 97.7% for all outpatient codes reviewed.
    - 95.6% for all office visit codes reviewed.

AMERIGROUP Community Care

- ACC achieved match rates above the standard of 90% in all areas of review:
    - 95.0% for all inpatient codes reviewed; a 4 percentage point decrease from 99.0% in CY 2017 and a 5 percentage point decrease from 100% in CY 2016. The rates are in a negative trend year over year.
    - 97.9% for all outpatient codes reviewed; a 6.7 percentage point increase from 91.2% in CY 2017 and a 0.2 percentage point decrease from 98.1% in CY 2016.
    - 95.1% for all office visit codes reviewed; a 1.7 percentage point increase from 93.4% in CY 2017 and a 2.4 percentage point increase from 92.7% in CY 2016. ACC is showing positive improvement over a three-year period.

Jai Medical Systems, Inc.

- JMS achieved match rates above the standard of 90% in all areas of review:
    - 95.0% for all inpatient codes reviewed; a 4 percentage point decrease from 99.0% in CY 2017 and a 3 percentage point decrease from 98.0% in CY 2016.
    - 98.8% for all outpatient codes reviewed; a 4 percentage point increase from CY 2017 of 94.8% and a 0.4 percentage point decrease from the CY 2016 rate of 99.2%.
    - 91.7% for all office visit codes reviewed; a decrease of 3.4 percentage points from the CY 2017 rate of 95.1% and a decrease of 1.4 percentage points from the CY 2016 rate of 93.1%.

Kaiser Permanente of the Mid-Atlantic States, Inc.:

- KPMAS achieved match rates above the standard of 90% in all areas of review:
    - 98.0% for all inpatient codes reviewed; a 2 percentage point decrease from the CY 2017 and CY 2016 rate of 100%.
    - 99.5% for all outpatient codes reviewed; a 6.8 percentage point increase from the CY 2017 rate of 92.7% and an increase of 1.8 percentage points from the CY 2016 rate of 97.7%.
    - 98.7% for all office visit codes reviewed; an increase of 3.5 percentage points from the CY 2017 rate of 95.2% and a 2.1 percentage point increase from the CY 2016 rate of 96.6%.

Maryland Physicians Care:

- MPC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 98.0% for all inpatient codes reviewed; a 2 percentage point decrease from the CY 2017 and CY 2016 rate of 100%.
    - 98.9% for all outpatient codes reviewed; an increase of 6.1 percentage points from the CY 2017 rate of 92.8% and 0.8 percentage points above the 98.1% CY 2016 rate.
    - 95.5% for all office visit codes reviewed; an increase of 1.8 percentage points over the CY 2017 rate of 93.7% and an increase of 3.9 percentage points over the 91.6% CY 2016 rate. MPC has shown improvement in office visit codes for three successive years.

MedStar Family Choice, Inc.:

- MSFC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 98.0% for all inpatient codes reviewed; improvement decrease of 2 percentage points from the CY 2017 rate of 100% and 1 percentage point below the CY 2016 rate of 99.0%.
    - 92.8% for all outpatient codes reviewed; a slight 0.1 percentage point decrease from the CY 2017 rate of 92.9% and still below the CY 2016 rate of 97.3%. There is a noticeable downward trend for outpatient codes over a three-year period.
    - 94.8% for all office visit codes reviewed; a 1.4 percentage point improvement over the CY 2017 rate of 93.4% and an increase of 2.5 percentage points over the CY 2016 rate of 92.3%.

Priority Partners:

- PPMCO achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 99.0% for all inpatient codes reviewed; a slight 1 percentage point decrease from the 100% CY 2017 and CY 2016 rates.

- 97.9% for all outpatient codes reviewed; a 3.9 percentage point increase over the 94% CY 2017 rate and a decrease of 1.6 percentage points from the CY 2016 rate of 99.5%.
- 96.1% for all office visit codes reviewed; a decrease of 0.9 percentage points from the CY 2017 rate of 97.0% and 1 percentage point increase from the CY 2016 rate of 95.1%.

UnitedHealthcare Community Plan:

- UHC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:

  - 95.0% for all inpatient codes reviewed; a 5 percentage point decline from the CY 2017 and CY 2016 rate of 100%.
  - 94.0% for all outpatient codes reviewed; an increase of 1.3 percentage points from the CY 2017 rate of 92.7% and a decrease of 4.9 percentage points from the CY 2016 rate of 98.9%.
  - 95.9% for all office visit codes reviewed; a slight decrease of 0.6 percentage points below the CY 2017 rate of 96.5% and an improvement of 1.9 percentage points over the CY 2016 rate of 94.0%.

University of Maryland Health Partners:

- UMHP achieved match rates above the standard of 90% recommended by Qlarant in 2 of the 3 areas of review:

  - 54.0% for inpatient codes reviewed; a 46 percentage point decrease from the 100% CY 2017 rate and a 45 percentage point decrease over the CY 2016 rate of 99.0%. It should be noted that the UMHP providers did not submit sufficient inpatient records to meet the minimum sample required for the review. Therefore, the remaining number of records required to meet the minimum sample (three) received a finding of no match for all elements reviewed.
  - 96.6% for all outpatient codes reviewed; an increase of 2.8 percentage points from the CY 2017 rate of 93.8% and a decrease of 2.9 percentage points from the CY 2016 rate of 99.5%.
  - 96.0% for all office visit codes reviewed; a decrease of 1.3 percentage points over the CY 2017 rate of 97.3% and an increase of 2.4 percentage points over the CY 2016 rate of 93.6%.

Corrective Action Plans

For CY 2018 EDV, eight of the HealthChoice MCOs achieved match rates above the 90% standard and were not required to submit a CAP. A CAP is required for UMHP for its inpatient encounters.

Recommendations

Qlarant and Hilltop recommend the following to MDH based on the CY 2018 EDV:

- Continue to monitor 8ER reports to identify trends and encourage improvement of encounter data quality, especially for MCOs with higher rates of rejection. Out of approximately 41.8 million overall encounters, over 1.9 million encounters were rejected through the EDI process in CY 2018. MCOs had fewer encounters rejected for inconsistencies in CY 2018 compared to CY 2017; however, in CY 2018, more encounters were rejected for missing data, providing services to ineligible participants, invalid data, and duplicate data.

- Continue to work with the MCOs to improve the quality of encounter submissions with complete and accurate pay data. For the first time, an analysis of paid information on medical encounters and found that there was significant improvement in completeness of paid information over the course of CY 2018. When reviewing CY 2019 data, accuracy of the payment field will be assessed by comparing it to a benchmark amount. The CY 2019 review will also include an analysis to determine the accuracy of an MMIS2 indicator that designates $0 encounter payments as either sub-capitated or denied.

- Continue to monitor monthly encounter submissions to ensure that the MCOs submit data in a timely manner. MCOs that submit encounters more than 8 months after the date of service, which is the maximum time allotted for an encounter to be submitted should be identified. The outlier MCOs should be reminded of the encounter submission timeframe and provided appropriate technical assistance to identify the cause of the timeliness issue and a resolution, if needed.

- Monitor PCP visits by MCO in future encounter data validations. The percentage of participants with a PCP visit by MCO between CY 2017 and CY 2018 were compared and revealed that the only PCP visits to increase were participants with a visit to any PCP within any MCO's network.

- Continue to review the volume of inpatient visits, ED visits, and observation stays by MCO and compare trends in future annual encounter data validations to look for consistency. The CY 2018 analysis indicated that service type trends continue to be consistent across MCOs and years.

- Review and audit the participant-level reports that Hilltop generated for pregnancy, dementia, and individuals over age 65, as well as missing age outlier data. MCOs submitting the encounter outliers should be notified, and demographic information should be updated or adjustments should be made as needed.

- Instruct MCOs to monitor providers' use of appropriate codes that reflect what is documented in the medical record. The mismatch reasons are due to either incorrect codes, upcoding, or a lack of medical record documentation.

- Remind provider offices to to supply all supporting medical record documentation for the encounter data review so that all minimum samples for validation can be met.

- Instruct MCOs to have providers update and maintain accurate billing/claims address information to reduce returned mail and increase the amount of records received for review.

Conclusion

HealthChoice is a mature managed care program and, overall, analysis and validation of the electronic encounter data submitted by MCOs indicates that the data are complete and accurate.

The volume of accepted encounters was generally consistent with MCO enrollment. The time-dimension analysis indicated some variation between MCOs regarding the timeliness of encounter submissions by MCOs to MDH; however, most encounters submitted by all MCOs occur within the 8-month maximum time allotted by MDH for processing.

ABH joined the HealthChoice program in November 2017 and was new to this year's analysis. The CY 2018 encounter data should be considered benchmark data for ABH. It may take a few years for ABH to submit encounters with the same accuracy and consistency as more established MCOs. Despite being a new MCO, ABH achieved match rates above the standard compliance rate for its first validation.

Based on the Medicaid and CHIP Managed Care Final Rule and federal guidance, MDH modified its regulations and managed care contracts to establish minimum elements for encounter data to improve the accuracy and completeness of submissions. In the reporting requirements section of the CY 2019 managed care contract, MCOs have a requirement to ensure that they transmit allowed, paid, participant-responsibility, and third-party liability amounts with all encounters.[6] By August 2018, all MCOs were submitting complete data for all medical encounters.

For next year's analysis, the accuracy of these data will be determined by comparing the paid amount field to a benchmark amount. An additional analysis will be conducted to assess how many encounters with an amount paid of $0 are sub-capitated payments or denied payments. In CY 2020, an analysis of the accuracy of the institutional paid amounts will be conducted. MDH should continue to work with MCOs to review the process for submitting complete and valid encounter data, particularly for payment fields. MDH should also review the content standards and criteria for accuracy and completeness with the MCOs. Continuing to work with each MCO to address any identified discrepancies will improve the quality of encounter submissions and increase MDH's ability to assess the efficiency and effectiveness of the Medicaid program.

[6] Maryland Department of Health. (September 2018). *HealthChoice Managed Care Organization Agreement, page 11*. Retrieved from https://mmcp.health.maryland.gov/healthchoice/Documents/MCO%20Agreement%202019%20for%20CY%202019%20MCO%20file.pdf.

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) Medical Record Review

Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents 0 through 20 years of age [as defined by the Omnibus Budget Reconciliation Act of 1989]. Each State determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

This report summarizes the findings from the EPSDT medical record review for CY 2018. Approximately 642,271 children were enrolled in the HealthChoice Program during this period. All nine MCOs were evaluated for CY 2018.

Program Objectives

The Maryland EPSDT Program's mission is to promote access to and assure availability of quality health care for Medical Assistance children and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to collect and analyze data to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components and their respective subcategories:

Health and developmental history requires evaluation and includes documentation of:

- Medical, family, and psychosocial histories with annual updates
- Perinatal history through 2 years of age
- Maternal depression screening at child's 1, 2, 4, and 6 month visits
- Developmental history/surveillance through 20 years of age
- Mental health assessment beginning at 3 years of age
- Substance abuse screening beginning at 11 years of age, younger if indicated
- Developmental screening using a standardized screening tool at the 9, 18, and 24-30 month visits
- Autism screening required at the 18 and 24-30 month visits
- Depression screening beginning at 11 years of age

Comprehensive, unclothed, physical exam requires evaluation and includes documentation of:

- A complete assessment of no fewer than five body systems
- Age-appropriate vision and hearing assessments (subjective or objective) at every visit
- Assessment of nutritional status at every age
- Oral assessment at all ages
- Height and weight measurement with graphing through 20 years of age
- Head circumference measurement and graphing through 2 years of age
- BMI calculation and graphing beginning at 2 years of age

- Blood pressure measurement beginning at 3 years of age

Laboratory tests/at-risk screenings requires evaluation and includes documentation of:

- Newborn metabolic screening test results at birth and again by 8 weeks of age
- Tuberculosis assessment required at 1, 6, and 12 months then annually with appropriate follow up for positive or at-risk results
- Cholesterol risk assessment beginning at 2 years of age then annually
- Dyslipidemia lab test results for 9-11 and 18-21 years of age
- Anemia risk assessment beginning at 11 years of age
- Anemia test results at 1, 2, and 3-5 years of age
- Lead risk assessment beginning at 6 months through 6 years of age
- Referral to the lab for blood lead testing or follow up at appropriate ages
- Blood lead test results at 1 and 2 years of age
- Baseline blood lead test results at 3 to 5 years of age when not done at 24 months of age
- Sexually Transmitted Infection/Human Immunodeficiency Virus (STI/HIV) risk assessment beginning at 11 years of age, or younger if indicated
- HIV lab test required between ages of 15 and 18

Immunizations require assessment of need and documentation that:

- The MDH Immunization Schedule is being followed in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines
- Age-appropriate vaccines are not postponed for inappropriate reasons
- Children and/or adolescents who are delayed in their immunizations are brought current with the MDH Immunization Schedule

Health education and anticipatory guidance requires documentation that the following were provided:

- Age appropriate anticipatory guidance
- Counseling and/or referrals for health issues identified by the parent(s) or provider
- Referral to dentist beginning at 12 months of age
- Requirements for return visit specified

CY 2018 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2018 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample is drawn from preventive care encounters per MCO, including a 10% over sample
- Sample size per MCO provides a 90% confidence level and 5% margin of error
- Sample includes only participants through 20 years of age as of the last day of the measurement year

- Sample includes EPSDT participants enrolled on last day of the measurement year, and for at least 320 days in the same MCO
  Exception – If the participant's age on the last day of selected period is less than 365 days, the criteria is modified to read same MCO for 180 days, with no break in eligibility
- Sample includes participants who had a preventive care encounter (CPT 99381-85 or 99391-95). For children less than 2 years of age who may have had 4-6 preventive visits within a 12-month period, only one date of service was selected
- Sample includes participants when visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, or general practice

Scoring Methodology

Data from the medical record reviews were entered into Qlarant's EPSDT Evaluation Tool. The analysis of the data was organized by the following age groupings:

- Birth through 11 months of age
- 12 through 35 months of age
- 3 through 5 years of age
- 6 through 11 years of age
- 12 through 20 years of age

The following scores were provided to the specific elements within each age group based on medical record documentation is shown in Table 47:

Table 47. Score for Finding

Score	Finding
2	Complete
1	Incomplete
0	Missing

Exception – When an element is not applicable to a child, such as a vision assessment for a blind child or a documented refusal for a flu vaccine by a parent, a score of two was given.

Elements, each weighted equally, within a component were scored and added together to derive the final component score. Similarly, the composite score (or overall score) follows the same methodology.

Scoring reflects the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum compliance score is 80% for each component. If the minimum compliance score is not met, a CAP will be required.

New elements and elements with revised criteria are scored as baseline.

The following should be considered when assessing results based on the random sampling methodology:

- Randomized record sampling does not assure that all providers and practices within the MCO network are included in the sample.
- Conclusions about individual provider performance in meeting program requirements cannot be made if the sample size per provider is too small (less than 10 charts) or the case mix does not include all ages.
- A randomized sample of preventive encounters may include both EPSDT-certified and non-certified providers. Providers who have not been certified by the program may not be familiar with the preventive care requirements. However, MCOs are still required by regulation to assure that preventive services are rendered to Medicaid participants through 20 years of age.
- MCOs with low membership are likely to have the same providers reviewed every year to meet the minimum record sampling requirement.

Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices, with the exception of providers with only one child in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Qlarant for review. A total of 2,407 medical records were reviewed in CY 2018.

The review criteria used by Qlarant's review nurses were the same as those developed and used by MDH's Healthy Kids Program nurse consultants. The review nurses successfully completed annual training and conducted inter-rater reliability prior to the EPSDT review.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80% for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP. Table 48 displays the MCO results for CY 2018.

Table 48. CY 2018 EPSDT Component Results by MCO

Component	CY 2018 MCO Results									HealthChoice Aggregate Results		
	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2016	CY 2017	CY 2018
Health & Developmental History	95%	91%	99%	98%	92%	93%	93%	92%	94%	92%	92%	94%

Component	CY 2018 MCO Results									HealthChoice Aggregate Results		
	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2016	CY 2017	CY 2018
Comprehensive Physical Examination	97%	95%	100%	98%	96%	98%	98%	97%	97%	96%	96%	97%
Laboratory Tests/At-Risk Screenings	86%	79%	99%	96%	85%	82%	86%	81%	87%	85%	82%	87%
Immunizations	94%	91%	94%	97%	93%	93%	96%	91%	92%	83%	90%	93%
Health Education/ Anticipatory Guidance	95%	89%	99%	99%	91%	96%	94%	90%	90%	95%	94%	94%
Total Score	**95%**	**91%**	**98%**	**98%**	**93%**	**94%**	**95%**	**92%**	**94%**	**90%**	**91%**	**94%**

Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

All MCOs except for ACC met the minimum compliance score of 80% for all five components in CY 2018. ACC did not meet the minimum compliance score for the Laboratory Tests/At-Risk Screenings component and was required to submit a CAP.

The following section provides a description of each component along with a summary of each HealthChoice MCOs' performance.

Health and Developmental History

Rationale: A comprehensive medical and family history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance.

Components: Medical history includes personal, family, perinatal, psychosocial, developmental, and mental health information. Psychosocial history assesses support systems and exposure to family and/or community violence, which may adversely affect the child's mental health. Developmental, autism, and depression screenings determine the need for referral and/or follow-up services. The mental health assessment provides an overall view of the child's personality, behaviors, social interactions, affect, and temperament. The substance abuse assessment identifies children who should be referred for counseling and/or treatment.

Documentation: Annual updates for personal, family, and psychosocial histories are required to ensure the most current information is available. The use of a standard age-appropriate history form (such as the Maryland Healthy Kids Program Medical/Family History) or a similarly comprehensive history form is recommended. While the CRAFFT assessment tool and those used for developmental and autism screening are suggested, the PHQ-9 or HEAD screen is mandatory for the depression screening.

Table 49. CY 2018 Health and Developmental History Element Results

CY 2018 Health and Development History Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Recorded Medical History	98%	96%	99%	100%	96%	98%	99%	97%	98%	98%
Recorded Family History	95%	89%	97%	98%	93%	89%	94%	92%	94%	93%
Recorded Perinatal History	90%	88%	100%	96%	95%	91%	88%	94%	100%	93%
Recorded Maternal Depression Screening[3]	47%	39%	63%	50%	50%	75%	50%	0%	62%	50%
Recorded Psychosocial History	96%	93%	100%	98%	96%	95%	97%	96%	96%	96%
Recorded Developmental Surveillance/ History (0-5 yrs.)	99%	96%	96%	100%	97%	97%	95%	96%	99%	97%
Recorded Developmental Surveillance/ History (6-20 yrs.)	97%	95%	100%	98%	96%	98%	98%	99%	95%	98%
Recorded Developmental Screening Tool	100%	85%	97%	91%	72%	76%	89%	93%	89%	88%
Recorded Autism Screening Tool	91%	94%	100%	100%	81%	74%	74%	68%	85%	86%
Recorded Mental/ Behavioral Health Assessment	97%	96%	100%	98%	94%	98%	95%	93%	95%	96%
Recorded Substance Abuse Assessment[1]	80%	78%	100%	99%	80%	84%	74%	79%	81%	84%
Depression Screening[2]	72%	66%	97%	95%	72%	80%	70%	68%	76%	77%
Component Score	**95%**	**91%**	**99%**	**98%**	**92%**	**93%**	**93%**	**92%**	**94%**	**94%**

[1]CY 2016 scores not applicable; element criteria revised and scored baseline in CY 2017.
[2]New element scored as baseline in CY 2017.
[3]New element scored as baseline in CY 2018 and 2019.
Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

Health and Developmental History Results

- All MCO component scores exceeded the minimum compliance score of 80% in CY 2018.
- The HealthChoice Aggregate component score increased 2 percentage points to 94% in CY 2018. This score had been at 92% since CY 2014.

Comprehensive Physical Examination

Rationale: The comprehensive physical exam uses a systems review method that requires documentation of a minimum of five systems (example - heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) to meet EPSDT standards.

Components & Documentation: A comprehensive physical exam includes documentation of:

- Subjective or objective vision and hearing assessments at every well-child visit
- Measuring and graphing head circumference through 2 years of age
- Recording blood pressure annually for children beginning at 3 years of age
- Oral assessment at each well-child visit including a visual exam of the mouth, gums, and teeth
- Nutritional assessment, including typical diet, physical activity, and education provided with graphing of weight and height through 20 years of age on a growth chart
- Calculating and graphing BMI beginning at 2 years of age

Table 50. CY 2018 Comprehensive Physical Examination Element Results

CY 2018 Comprehensive Physical Exam Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Documentation of Minimum 5 Systems Examined	100%	99%	100%	100%	100%	99%	100%	100%	99%	100%
Vision Assessment	98%	94%	100%	98%	95%	95%	96%	93%	95%	96%
Hearing Assessment	95%	91%	100%	97%	91%	94%	91%	90%	93%	94%
Nutritional Assessment	97%	94%	100%	99%	94%	98%	97%	96%	96%	97%
Conducted Oral Assessment	92%	97%	99%	100%	96%	96%	97%	97%	98%	97%
Measured Height	100%	100%	100%	98%	99%	99%	99%	100%	100%	99%
Graphed Height	96%	92%	100%	97%	96%	99%	98%	98%	97%	97%
Measured Weight	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%
Graphed Weight	96%	93%	100%	99%	97%	99%	99%	98%	97%	98%
BMI Percentile	98%	97%	100%	97%	96%	98%	98%	98%	99%	98%
BMI Graphing	96%	92%	100%	97%	93%	98%	97%	97%	97%	96%
Measured Head Circumference	97%	91%	100%	97%	95%	100%	98%	100%	100%	97%
Graphed Head Circumference	93%	84%	100%	97%	95%	95%	100%	92%	97%	95%
Measured Blood Pressure	100%	98%	99%	96%	96%	98%	97%	97%	98%	98%

CY 2018 Comprehensive Physical Exam Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Component Score	**97%**	**95%**	**100%**	**98%**	**96%**	**98%**	**98%**	**97%**	**97%**	**97%**

Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

Comprehensive Physical Examination Results

- All MCO component scores exceeded the minimum compliance score of 80% in CY 2018.
- The HealthChoice Aggregate component score increased 1 percentage point to 97% in CY 2018.

Laboratory Tests/At-Risk Screenings

Rationale: The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis, lead exposure, and STI/HIV.

Components: Assessment of risk factors includes:

- A second newborn metabolic screen (lab test) by 8 weeks of age
- Tuberculosis risk assessment annually after 1 and 6 months of age
- Cholesterol risk assessment annually beginning at 2 years of age
- Dyslipidemia lab test results at 9-11 and 18-21 years of age
- Lead risk assessment at every well-child visit from 6 months through 6 years of age with appropriate testing if positive or at-risk
- Blood lead test at 12 and 24 months of age
- Baseline/3-5 year blood lead test if the 24 month test is not documented
- Documented referral to lab for age appropriate blood lead test
- Anemia risk assessment annually beginning at 11 years of age
- Anemia test results at 1, 2, and 3-5 years of age
- STI/HIV risk assessment annually beginning at 11 years of age
- HIV lab test required between ages of 15 and 18

Table 51. CY 2018 Laboratory Test/At–Risk Screenings Element Results

CY 2018 Laboratory Test/At-Risk Screenings Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Newborn Metabolic Screen	70%	92%	100%	95%	86%	80%	100%	75%	84%	83%
Recorded TB Risk Assessment[3]	70%	77%	99%	99%	85%	79%	89%	85%	86%	86%
Recorded Cholesterol Risk Assessment	86%	74%	100%	89%	85%	83%	89%	82%	83%	86%

CY 2018 Laboratory Test/At-Risk Screenings Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Dyslipidemia Lab Test[1]	77%	74%	96%	99%	64%	81%	66%	64%	80%	78%
Conducted Lead Risk Assessment	96%	86%	99%	100%	94%	85%	92%	93%	94%	93%
12 Month Blood Lead Test	100%	100%	100%	100%	100%	89%	100%	90%	100%	98%
24 Month Blood Lead Test	100%	100%	100%	100%	100%	81%	100%	75%	93%	94%
3 – 5 Year (Baseline) Blood Lead Test	89%	93%	100%	100%	90%	89%	92%	83%	98%	93%
Referral to Lab for Blood Lead Test	92%	85%	99%	100%	89%	80%	89%	83%	91%	90%
Conducted Anemia Risk Assessment[1]	80%	66%	99%	92%	77%	76%	74%	73%	76%	79%
Anemia Test[2]	84%	84%	96%	97%	87%	73%	87%	85%	88%	87%
Recorded STI/HIV Risk Assessment[1]	80%	81%	100%	98%	84%	88%	80%	82%	76%	86%
HIV Test Per Schedule[4]	50%	56%	86%	93%	31%	57%	25%	24%	45%	52%
Component Score	**86%**	**79%**	**99%**	**96%**	**85%**	**82%**	**86%**	**81%**	**87%**	**87%**

[1]CY 2016 scores not applicable; element criteria revised and scored baseline in CY 2017.
[2]New element scored as baseline in CY 2017.
[3]CY 2016 and CY 2017 scores not applicable; element criteria revised and scored as baseline in 2018 and 2019.
[4]New element scored as baseline in 2018 and 2019.
Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

Laboratory/At-Risk Screening Results

- All MCO component scores except for ACC exceeded the minimum compliance score of 80% in CY 2018. ACC submitted a CAP in this area of assessment.
- After a decrease of 3 percentage points in CY 2017, the HealthChoice Aggregate component score increased by 5 percentage points to 87% in CY 2018.

Immunizations

Rationale: Children on Medical Assistance must be immunized according to the current MDH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society and is based on the current recommendations of the U.S. Public Health Service's ACIP and the American Academy of Pediatrics. Primary care providers who see Medicaid

participants through 18 years of age must participate in MDH's Vaccines for Children (VFC) Program. **Documentation:** The VFC Program requires completion of the VFC Patient Eligibility Screening Record for each patient receiving free vaccines. Additionally, federal law requires documentation of date, dosage, site of administration, manufacturer, lot number, publication date of Vaccine Information Statement (VIS), and name/location of provider. Immunization components are listed in Table 52.

Table 52. CY 2018 Immunizations Element Results

CY 2018 Immunization Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Hepatitis B	96%	93%	96%	97%	96%	96%	99%	96%	94%	96%
DTaP	99%	97%	97%	99%	98%	97%	98%	97%	98%	98%
HIB	100%	99%	99%	99%	97%	98%	99%	97%	98%	99%
PCV-7 or PCV-13	99%	96%	99%	100%	97%	96%	100%	98%	97%	98%
IPV	97%	93%	96%	97%	96%	96%	98%	96%	95%	96%
MMR	92%	93%	96%	97%	96%	96%	99%	95%	94%	96%
VAR	91%	94%	96%	97%	96%	96%	98%	95%	93%	96%
TDAP	84%	94%	97%	99%	93%	99%	98%	95%	92%	95%
Influenza	90%	84%	89%	99%	86%	85%	88%	82%	87%	88%
MCV4	83%	91%	96%	93%	96%	92%	98%	92%	85%	93%
Hepatitis A	87%	89%	94%	94%	89%	93%	96%	90%	92%	92%
Rotavirus	95%	93%	77%	96%	100%	97%	100%	94%	91%	94%
HPV[1]*	76%	89%	97%	95%	89%	88%	95%	84%	80%	89%
Assessed Immunizations Up-to-Date	89%	83%	86%	93%	83%	84%	91%	83%	86%	86%
Component Score	**94%**	**91%**	**94%**	**97%**	**93%**	**93%**	**96%**	**91%**	**92%**	**93%**

[1]CY 2016 scores not applicable; element criteria revised and scored baseline in CY 2017.
*Data collected for informational purposes only; not used in the calculation of the overall component score.
Immunizations: Diphtheria/Tetanus/Acellular Pertussis (DTaP); Haemophilus Influenza Type B (HIB); Pneumococcal (PCV-7 or PCV-13 [Prevnar]); Polio (IPV); Measles/Mumps/Rubella (MMR); Varicella (VAR); Tetanus/Diphtheria/Acellular Pertussis (TDAP); Meningococcal (MCV4); Human Papillomavirus (HPV)
Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

Immunizations Results

- All MCO component scores exceeded the minimum compliance score of 80% in CY 2017.
- The HealthChoice Aggregate component score continues to improve. After an increase of 7 percentage points in CY 2017, the aggregate score increased another 3 percentage points in CY 2018 to 93%.

Health Education/Anticipatory Guidance

Rationale: Health education enables the patient and family to make informed health care decisions. Anticipatory guidance provides the family with information on what to expect in terms of the child's current and next developmental stage. Information should be provided about the benefits of healthy lifestyles and practices, as well as injury and disease prevention.

Components: A minimum of three topics must be discussed at each Healthy Kids Preventive Care visit. These topics may include, but are not limited to, social interactions, parenting, nutrition, health, play, communication, sexuality, and injury prevention. Beginning at 2 years of age, annual routine dental referrals are required for the purpose of educating the parents about appropriate dental care, providing a cursory view of the child's dental health, and familiarizing the child with the dental equipment. Educating the family about the preventive care schedule and scheduling the next preventive care visit increases the chances of having the child or adolescent return for future preventive care visits. Additionally, follow-up for missed appointments needs to occur as soon as possible when the well-child visit is missed to prevent the child or adolescent from becoming "lost to care."

Documentation: The primary care provider must specifically document whenever 2-year intervals for preventive care are the usual and customary schedule of the practice instead of annual visits.

Table 53. CY 2018 Health Education/Anticipatory Guidance Element Results

CY 2018 Health Education/Anticipatory Guidance Element Results										
Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Documented Age Appropriate Anticipatory Guidance	98%	97%	100%	100%	97%	99%	98%	97%	97%	98%
Documented Health Education/ Referral for Identified Problems/Tests	100%	97%	100%	100%	98%	99%	98%	99%	98%	99%
Documented Referral to Dentist	74%	74%	99%	98%	78%	87%	87%	75%	73%	83%
Specified Requirements for Return Visit	95%	88%	97%	100%	92%	96%	93%	89%	90%	94%
Component Score	**95%**	**89%**	**99%**	**99%**	**91%**	**96%**	**94%**	**90%**	**90%**	**94%**

Red highlighted scores denote compliance below the 80% minimum threshold requirement. Green highlighted scores denote compliance above the 80% minimum threshold requirement.

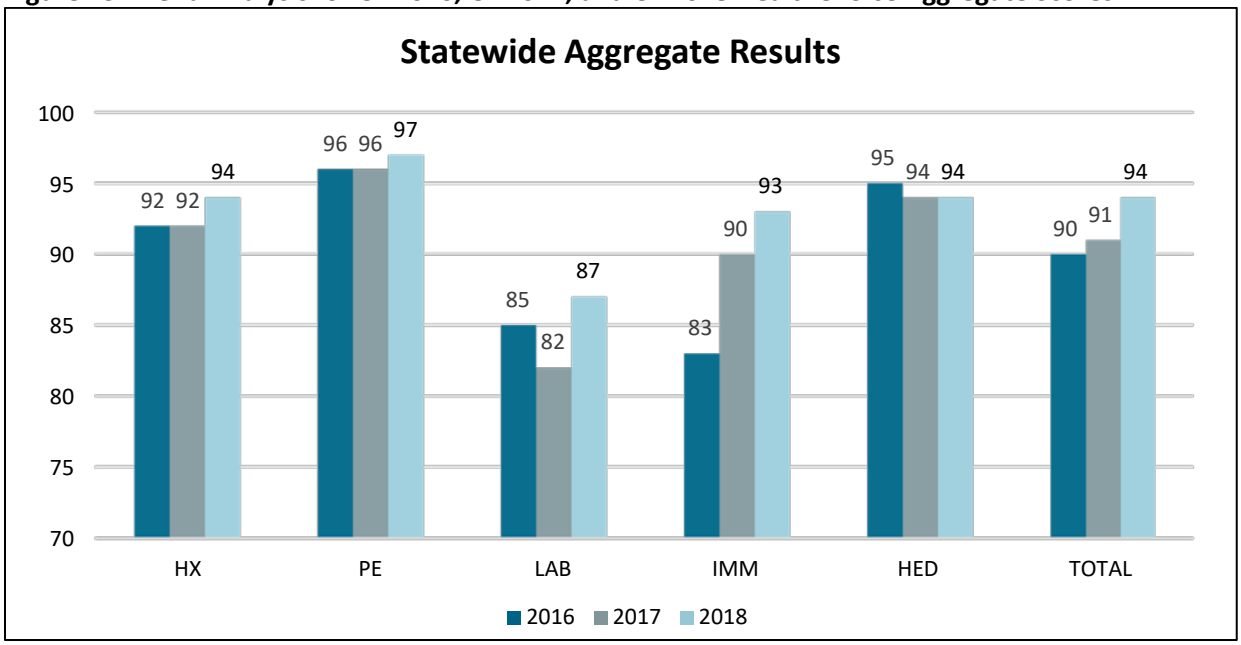
Health Education/Anticipatory Guidance Results

- All MCO component scores exceeded the minimum compliance score of 80% in CY 2018.
- The HealthChoice Aggregate component score remained the same in CY 2018 at 94%.

Trending Analysis of Aggregate Compliance Scores

The purpose of this trend analysis is to demonstrate changes in patterns of care at multiple points in time. Score variation is to be expected; not all increases or decreases from CY 2016 through CY 2018 can be interpreted as reflecting differences in quality of care. Potential effects of demographic factors or changes in case mix must also be considered. One must evaluate both the magnitude and pattern of the change in terms of potential clinical impact in order to determine whether the results reflect a change in the quality of care being delivered to enrollees.

Figure 13. Trend Analysis for CY 2016, CY 2017, and CY 2018 HealthChoice Aggregate Scores



The Total HealthChoice Aggregate scores demonstrate continuous improvement with increases in the total score by 1 percentage point (90% to 91%) from CY 2016 to CY 2017, and 3 percentage points (91% to 94%) from CY 2017 to CY 2018.

In CY 2018, the LAB (Laboratory Test/At-Risk Screenings) and IMM (Immunizations) component scores demonstrated significant improvements of 5 and 3 percentage points, respectively. Two component scores (HX – Health and Developmental History and PE – Comprehensive Physical Exam) increased by 2 and 1 percentage points, respectively. The Health Education/Anticipatory Guidance component remained the same. All Statewide Aggregate Component scores remained above the 80% minimum compliance threshold in CY 2018.

Corrective Action Plan Process

MDH sets high performance standards for the Maryland EPSDT Program. In the event the minimum compliance score is not met, MCOs are required to submit a CAP. The CAPs are then evaluated by Qlarant. In the event that a CAP is deemed unacceptable, Qlarant provides recommendations to the MCOs until an acceptable CAP is submitted.

Required Contents of EPSDT CAPs

Each required CAP must include, at a minimum, the following components:

- Methodology for assessing and addressing the problem.
- Threshold(s) or benchmark(s).
- Planned interventions.
- Methodology for evaluating effectiveness of actions taken.
- Plans for re-measurement.
- Timeline for the entire process, including all action steps and plans for evaluation.

EPSDT CAP Evaluation Process

The review team evaluates the effectiveness of any CAPs initiated as a result of the prior year's review. A review of all required EPSDT components are completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT review determines whether the CAPs were implemented and effective. In order to make this determination, Qlarant evaluates all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH may take further action.

CY 2018 CAPs

ACC was required to submit a CAP in the area of Laboratory Tests/At–Risk Screenings because they did not meet the minimum compliance score of 80%. The CAP was evaluated by Qlarant and determined acceptable to address the areas of deficiency.

Conclusion

HealthChoice Aggregate scores for each of the five components were above the 80% minimum compliance threshold set by MDH. Additionally, four of the five component scores for CY 2018 increased, with the last component remaining consistent with the CY 2017 score. As the Health and Development History and Comprehensive Physical Exam component scores increased slightly (2 and 1 percentage points, respectively), the largest improvements were seen in the Laboratory Test/At-Risk Screenings and Immunizations components, with increases of 5 and 3 percentage points, respectively. Although there are continual year-over-year improvements demonstrated in the Laboratory Test/At-Risk Screenings component scores, this area of review continues to be the lowest scoring review component. It is recommended that MCOs continue their concerted efforts in this area, with specific focus on dyslipidemia lab tests, anemia risk assessments, and HIV tests per schedule.

The MCO results of the EPSDT review demonstrate strong compliance with the timely screening and preventive care requirements of the Maryland EPSDT Program. Overall scores indicate that the MCOs, in collaboration with PCPs, are committed to MDH's goals to provide care that is patient-focused, prevention-oriented, and in compliance with the Maryland Schedule of Preventive Health Care.

Consumer Report Card

Introduction

The Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes performance measures from HEDIS, the CAHPS survey, and Maryland's encounter data measures. The results of the CY 2019 Consumer Report Card are below.

Results

Table 54. CY 2019 Report Card Results

HealthChoice MCOs	Performance Area					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ABH	N/A	N/A	N/A	N/A	N/A	N/A
ACC	★★	★★	★★★	★	★★	★★
JMS	★★★	★★	★★★	★★	★★★	★★★
KPMAS	★	★★	★★	★★	★★★	★★★
MPC	★★	★★	★	★★	★	★
MSFC	★	★★	★★	★★	★	★★
PPMCO	★★★	★★★	★★	★★	★	★
UHC	★★★	★★★	★★	★★	★	★★
UMHP	★	★★	★	★★	★★	★

★ Below HealthChoice Average
★★ HealthChoice Average
★★★ Above HealthChoice Average
Note: N/A means that ratings are not applicable and does not describe the performance or quality of care provided by the health plan.

This report provides a brief overview of the reporting strategy and analytic methods Qlarant used in developing the Report Card that the MDH released in 2019, based on data reported in 2018 (HEDIS 2018). In developing the Report Card consideration was given to *the Maryland Consumer Report Card Market Research Report*, which is included in the following section.

Information Reporting Strategy

In determining the appropriate content for Maryland's HealthChoice Report Card, principles were identified that addressed these fundamental questions:

- Is the information meaningful for the target audience?
- Will the target audience understand what to do with the information?
- Are the words or concepts presented at a level that the target audience is likely to understand?
- Does the information contain an appropriate level of detail?

The reporting strategy presented incorporates methods and recommendations based on experience and research about presenting quality information to consumers.

Organizing Information

Relevant information is grouped in a minimal number of reporting categories and in single-level summary scores to enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience. Qlarant has designed the Report Card to include six categories, with one level of summary scores (measure roll-ups) per MCO, for each reporting category.

Measures are grouped into reporting categories that are meaningful to consumers. Based on a review of the potential measures available for the Report Card (HEDIS, CAHPS, and the MDH's encounter data measures), the team recommends the following reporting categories:

- Access to Care
- Doctor Communication and Service
- Keeping Kids Healthy
- Care for Kids with Chronic Illness
- Taking Care of Women
- Care for Adults with Chronic Illness

Consumers will be directed to focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness.

Measure Selection

The measures that the project team considered for inclusion in the Report Card are derived from those that MDH requires MCOs to report, which include HEDIS measures; the CAHPS results from both the Adult Questionnaire and the Child Questionnaire; and MDH's encounter data measures. Each year, the team has created measure selection criteria that has a consistent and logical framework for determining which quality of care measures are to be included in each composite.

- **Meaningful.** Do results show variability in performance in order to inform health care choices?
- **Useful.** Does the measure relate to the concerns of the target audience?
- **Understandable.** Are the words or concepts presented in a manner that the target audience is likely to understand?

HEDIS 2018 Measure Changes. NCQA retired the *Frequency of Ongoing Prenatal Care* measure. Additionally, there were updates made to several HEDIS measures, however, these modifications do not affect the Report Card methodology. For detailed changes, refer to *HEDIS 2018, Volume 2: Technical Specifications for Health Plans.* NCQA also revised the Systematic Sampling Methodology to require organizations to report using the Minimum Required Sample Size. Reporting using a Final Sample Size is no longer permitted.

CAHPS 2018 Patient Experience Measure Changes. No modifications were made to the CAHPS Survey for CY 2018.

In addition, the following reporting category changes were made:

- **Care for Kids with Chronic Illness**
  - Removed the Medication Management for People with Asthma [5-18 years (combine 5-11 years and 12-18 years); use 75% indicator] measure.
  - Added the Asthma Medication Ratio [5-18 years (combine 5-11 years and 12-18 years) measure.
- **Taking Care of Women**
  - Removed *Frequency of Ongoing Prenatal Care* as the measure has been retired.
- **Care for Adults with Chronic Illness**
  - Removed the Medication Management for People with Asthma [19-64 years (combine 19-50 years and 51-64 years); use 75% indicator] measure.
  - Added the Asthma Medication Ratio [19-64 years (combine 19-50 years and 51-64 years) measure.

Format

It is important to display information in a format that is easy to read and understand by the member. The following principles are important when designing Report Cards:

- ***Space.*** Maximize the amount to display data and explanatory text.
- ***Message.*** Communicate MCO quality in positive terms to build trust in the information presented.
- ***Instructions.*** Be concrete about how consumers should use the information.
- ***Text.*** Relate the utility of the Report Card to the audience's situation (e.g., new participants choosing an MCO for the first time, participants receiving the Annual Right to Change Notice and prioritizing their current health care needs, current participants learning more about their MCO) and reading level.
- ***Narrative.*** Emphasize *why* what is being measured in each reporting category is important, rather than giving a detailed explanation of *what* is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"
- ***Design.*** Use color and layout to facilitate navigation and align the star ratings to be left justified ("ragged right" margin), consistent with the key.

A 24 x 9.75-inch pamphlet folded in thirds, with English on one side and Spanish on the opposite side is used to display the report card (See Appendix A5). Pamphlets allow one-page presentation of all information. Measure explanations can be integrated on the same page as performance results, helping readers match the explanation to the data.

Pamphlet contents are drafted at a sixth-grade reading level, with short, direct sentences intended to relate to the audience's particular concerns. Explanations of performance ratings, measure descriptions, and instructions for using the Report Card are straightforward and action-oriented.

The report card is then translated into Spanish using an experienced translation vendor.

Rating Scale

MCOs are rated on a tri-level rating scale. The report card compares each MCO's performance with the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice MCOs ("the Maryland HealthChoice MCO average"). Stars are used to represent performance that is "above," "the same as," or "below" the Maryland HealthChoice MCO average.

A tri-level rating scale in a matrix that displays performance across selected performance categories provides participants with an easy-to-read "picture" of quality performance across plans and presents data in a manner that emphasizes meaningful differences between MCOs that are available to them. This approach is more useful in an environment where consumers must choose from a group of MCOs. The current reporting strategy allows Report Card users to decide which performance areas are most important to them when selecting an MCO.

Methodology

Analytic Method

The Report Card compares each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. The goal of analysis is to generate reliable and useful information that can be used by Medicaid participants to make relative comparisons of the quality of health care provided by Maryland's HealthChoice MCOs. This information should allow consumers to easily detect differences in MCO performance. The index of differences should compare MCO-to-MCO quality performance directly, and the differences between MCOs should be statistically reliable.

Handling Missing Values

Maryland HealthChoice MCOs serve as the pool from which replacement values for missing data are generated. MCOs are sometimes unable to provide suitable data (for example, if too few of their members meet the eligibility criteria for a measure), despite their willingness to do so. These missing data are classified as "Not Applicable" (NA).

- For HEDIS, health plans that followed the specifications but had too small a denominator (<30) to report a valid rate are assigned a measure result of NA.
- For CAHPS, MCOs must achieve a denominator of at least 100 responses to obtain a reportable result. MCOs whose denominator for a survey result calculation is <100 are assigned a measure result of NA.

If the NCQA HEDIS Compliance Audit finds a measure to be materially biased, the HEDIS measure is assigned a "Biased Rate" (BR) and the CAHPS survey is assigned "Not Reportable" (NR). For Report Card purposes, missing values for MCOs will be handled in this order:

- If fewer than 50 percent of the MCOs report a measure, the measure is dropped from the Report Card category.

- If an MCO has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- MCOs missing more than 50 percent of the measures composing a reporting category are given a designation of "Insufficient Data" for the measurement category.

Calculations in each category were based on the remaining reportable measures versus reportable MCOs. "NA" and "BR/NR" designations have been treated differently where values are missing. "NA" values were replaced with the *mean* of non-missing observations and "BR/NR" values werereplaced with the *minimum value* of non-missing observations. This minimized any disadvantage to MCOs that are willing to report data but are unable to. Variances for replaced rates were calculated differently for CAHPS survey measures and for non-survey measures (HEDIS, Maryland encounter data).

Handling New MCOs

MCOs are eligible for inclusion in the star rating of the report card when they are able to report the required HEDIS and CAHPS measures according to the methodology outlined in the Information Reporting Strategy and Methodology document set forth by MDH.

Members Who Switch Products/Product Lines. Per HEDIS guidelines, members who are enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report.

Members who "age in" to a Medicare product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps. The organization must use claims data from all products/product lines, even when there is a gap in enrollment.

Case-Mix Adjustment of CAHPS Data

Several field-tests indicate a tendency for CAHPS respondents in poor health to have lower satisfaction scores. It is not clear whether this is because members in poor health experience lower-quality health care or because they are generally predisposed to give more negative responses (the halo effect).

However, it is believed that respondents in poor health receive more intensive health care services—and their CAHPS responses do contain meaningful information about the quality of care delivered in this more intensive environment; therefore, case-mix adjusting was not used for the CAHPS data in this analysis.

Statistical Methodology

The statistical methodology includes the following steps:

1. Create standardized versions of all measures for each MCO so that all component measures contributing to the summary scores for each reporting category are on the same scale. Measures are standardized by subtracting the mean of all MCOs from the value for individual MCOs and dividing by the standard deviation of all MCOs.
2. Combine the standard measures into summary scores in each reporting category for each MCO.
3. Calculate standard errors for individual MCO summary scores and for the mean summary scores for all MCOs.
4. Calculate difference scores for each reporting category by subtracting the mean summary score for all MCOs from individual MCO summary score values.
5. Use the standard errors to calculate 95 percent confidence intervals (CI) for the difference scores.
6. Categorize MCOs into three categories on the basis of these CIs. If the entire 95 percent CI is in the positive range, the MCO is categorized as "above average." If an MCO's 95 percent CI includes zero, the MCO is categorized as "average." If the entire 95 percent CI is in the negative range, the individual MCO is categorized as "below average."

This procedure generates classification categories, so differences from the group mean for individual MCOs in the "above average" and "below average" categories are statistically significant at $\alpha = .05$. Scores of MCOs in the "average" category are not significantly different from the group mean.

Quality Control

Qlarant includes quality control processes for ensuring that all data in the Report Card are accurately presented. This includes closely reviewing the project's agreed upon requirements and specifications of each measure so that impacts of any changes are assessed and clearly delineated, and cross-checking all data analysis results against two independent analysts. Qlarant will have two separate programmers independently review the specifications and code the Report Card. The analysts will both complete quality reviews of the data, discuss and resolve any discrepancies in analysis. Following the quality control processes, Qlarant will deliver the data analysis necessary to support public reporting in the Report Card.

Maryland Consumer Report Card Market Research Report

Introduction

A Performance Report Card for Consumers (report card) enrolled in HealthChoice, Maryland's Medicaid health plan program, is a tool to assist enrollees in selecting one of the participating MCOs. Information in the report card includes performance results from 24 HEDIS measures, 15 CAHPS survey questions, and 3 Maryland encounter data measures. The report card has been updated annually and is currently printed in both English and Spanish.

Qlarant has produced this report card since 2003 as a component of its External Quality Review contract with MDH. The current report card design and content resulted from field testing with Medicaid enrollees using a focus group format. No changes have been made to it since its introduction. During CY 2018, under the direction of MDH, Qlarant invited HealthChoice enrollees throughout the state to participate in focus groups to identify the need for any enhancements to the report card that will increase its effectiveness as a decision-making aid for health plan selection.
Ongoing challenges were encountered in recruiting the participation of HealthChoice members in the report card focus groups. A decision was made to enlist the support of the MCOs in utilizing an existing Consumer Advisory Board (CAB) meeting to conduct a focus group. Three such focus groups were held at CAB meetings. Two were hosted by MSFC at locations in Baltimore City and Montgomery County. PPMCO hosted a meeting at their administrative office in Anne Arundel County. The majority of these CAB members had HealthChoice for a number of years potentially impacting their accurate recall of their health plan decision-making process and receipt of the report card.

CAB members also may not be representative of the general HealthChoice population. While these CAB meetings provided a diverse representation of the HealthChoice membership based upon geographic region, race/ethnicity, age, and special needs, it is believed that this subset of the population has some major differences. The CAB members likely have a greater overall interest in the HealthChoice program and are exposed to a breadth of information presented at these meetings, contributing to a more knowledgeable consumer. Consequently, caution must be exercised in reviewing the results from the focus groups.

Supplemental data was also obtained from a survey distributed to Medicaid members by MCOs at community events and through an online survey tool. A total of 240 completed surveys were received. Survey responses were uploaded into a data collection tool developed by Qlarant. No survey responses were excluded. Three staff members conducted separate validations of each data entry in the response tool against the primary data source (survey responses). The formulas were also validated by three Qlarant analysts.

Focus Group Process

A Focus Group Discussion Guide was approved by the MDH to provide consistency in the approach and questioning among the focus groups. Participants were encouraged to share their ideas and differences in opinions were explored. A tape recorder was utilized to capture the discussion and notes were taken by a Qlarant staff member. Participants were informed that in reporting the findings from each of the focus groups no member names would be associated with any comments provided during the discussion. Poster size replicas of the report card in English and Spanish were displayed on easels and a

hard copy was provided to each participant. Additionally, a sample Medicaid consumer report card from Central New York, was distributed for comparison purposes. Paper and pens were provided to allow participants to jot down comments. Following the conclusion of each focus group, participant feedback was reviewed for each of the questions to determine any needed changes. Notes from each focus group were supplemented with sample verbatim comments retrieved from each recorded session.

Consumer Surveys

In response to the challenges encountered in recruiting focus group participants among the HealthChoice population, MDH suggested that Qlarant consider developing a brief written survey to collect supplemental data on how members use the report card. Qlarant subsequently created a brief, six question survey tool. Survey responses required either a "yes"/"no" response or the selection of one or more responses within a multiple-choice category. The last question was open-ended allowing the respondent to add anything else about the report card that was not included in the survey. The Consumer Report Card Survey tool was approved by MDH on February 9, 2018.

Target Audience and Size

Each of the HealthChoice MCOs were contacted on February 15, 2018, to request their assistance in distributing the Consumer Report Card Survey to their members in an outreach setting. A goal of at least 25 completed surveys was established for each MCO in order for Qlarant to obtain a sufficient response rate. All MCOs agreed to participate in this activity.

Consumer Survey Process

After agreeing to participate, MCOs received an electronic copy of the Consumer Report Card Survey tool and a hardcopy of the report card in color to distribute to their members in an outreach setting.

Administration of the survey by the MCOs was to occur during the time frame of February 21, 2018, through March 16, 2018. This time frame was extended to March 30, 2018, to accommodate scheduled MCO outreach activities.

Limitations

In the interest of keeping the consumer survey short and simple, no skip patterns were included. As a result, respondents generally answered most questions even if they were not applicable. For example, only 93 respondents reported that they had seen the report card, however, 110 responded to the question, "Did you see it in print?", and 96 responded to the question, "Did you view the report card online?". Additionally, 107 respondents reported that the report card helped them choose a health plan; more than the number who reported seeing the report card.

While the written surveys provided quantitative data on several measures that were also addressed within the focus groups this approach has certain limitations. It lacks the combined effect of the focus group process which produces a wider range of information, insight, and ideas than a structured questionnaire completed privately by individuals. Additionally, the group dynamics within a focus group often promote a chain of responses from other participants triggered by one individual's comment. The focus group interview also affords more flexibility that the written survey with regard to the topics covered and the depth with which they are treated.

Results from the focus groups and the consumer surveys cannot be combined based upon some of the limitations cited above. Survey results, however, can support trends identified among the focus group findings.

Findings

The focus groups and the surveys reflect different approaches to obtaining feedback from consumers on the usefulness of the report card in the MCO selection process. The focus groups provide qualitative data while the surveys provide quantitative data. Although the approaches differ there are some common themes that surfaced in addition to specific recommendations offered by the focus groups to enhance the usefulness of the report card.

Health Plan Selection

The vast majority of focus group participants and survey respondents reported that they selected a health plan rather than have the State select one for them. Most of these participants made the decision without assistance from others. Doctors, case managers, and community health workers were most frequently relied upon for assistance by those members who needed assistance with the selection process.

Key Information Utilized in the Selection of a Health Plan

Quality of care surfaced in all three focus groups as a major factor in selecting a health plan. Information sources included past experience with the provider, various provider rating websites, and performance areas on the report card. Additionally, the majority of focus group participants considered the additional services offered by each plan as an important factor in their selection process with the MCO Comparison Chart referenced as a valuable source of information.

Additional Information Needed

Generally, performance areas within the report card, the MCO Comparison Chart, or the MCO provider directories included the information participants identified as necessary to support the health plan selection process. However, there was interest raised among several participants in having access to provider ratings at the individual level including experience and communication skills. Of particular concern to one focus group was the possibility of the State eventually moving the HealthChoice selection process and related documents exclusively online. According to participants, this would result in access issues for those without an Internet connection or who have a disability, which limits their use of a computer. This suggests that participants were not aware of assistance with the application process available in their communities.

Awareness of the Report Card

While percentages cannot be applied to focus group results because of the small sample size, the number of participants who reported receiving the report card was similar to the percentage of survey respondents at 40%. The survey additionally found in separate questions that 70% of respondents viewed the report card in print while 25% reported they viewed it online.

Usefulness of the Report Card in Selecting a Health Plan

Forty-seven percent (47%) of survey respondents reported that they used the report card in choosing a health plan, which was fairly consistent with the focus group results. The use of star ratings was easily understandable by the vast majority of members. Many of the focus group participants expressed interest in moving from a three to five-star rating system to provide more differentiation. Access to Care and Doctor Communication and Service were the performance areas selected by survey respondents as most important when choosing a health plan similar to the focus group results. Focus Group participants additionally expressed interest in adding a separate Member Satisfaction performance area with results reported by adult and by child. Furthermore, subcategories were recommended for two of the existing performance areas. Separate Adult and Child subcategories under Access to Care and a further breakdown of Care for Adults with Chronic Illness by the most prevalent conditions were suggested. Focus group participants also identified the importance of the MCO Comparison Chart in selecting a health plan and recommended that it be placed on the reverse side of the report card to have these decision support tools all in one place.

The display and format of the report card received high scores from the survey respondents. Similarly, most of the focus group participants reported that the report card was “eye catching” and “easy to read.”

National Committee for Quality Assurance

Almost all focus group participants expressed interest in including the National Committee for Quality Assurance (NCQA) rating for each MCO on the report card if a “plain and simple” description of NCQA was also provided. There were mixed views on how the NCQA ratings should be displayed, since they utilize a five-point numeric system while the report card has ratings based upon a three-star system.

Recommendations

The recommendations that follow are based upon findings obtained from the three focus groups held in the fourth quarter of 2017, and the 240 completed surveys received from HealthChoice enrollees in the first quarter of 2018. Recommendations are presented under three separate categories: Access to Performance Data, Report Card Content, and Report Card Format and Display.

Recommendation 1: Access to Performance Data
Continue to provide the report card to new enrollees in MCO enrollment packets. Maintain the report card on the MDH HealthChoice website. Require MCOs to maintain an electronic copy of the report card on their website and include how to order a hard copy in the member newsletter on an annual basis.

Recommendation 2: Report Card Content
Clarify and enhance information included in the current report card to include:

- Further breakdown of Care for Adults with Chronic Illness performance area by the most prevalent chronic conditions such as respiratory, diabetes, and cardiovascular
- Further breakdown of Access to Care performance area by adult and child

- Removal of the following statement: All health plans in HealthChoice received high satisfaction ratings from the majority of their members.
- A specific performance area for Consumer Satisfaction
- A link to the MCO Comparison Chart which includes NCQA ratings of HealthChoice MCOs
- Website addresses that provide individual ratings by practitioner and hospital, such as HealthGrades.com, Vitals.com, and healthcarequality.mhcc.maryland.gov

Recommendation 3: Report Card Content
Include MCO specific NCQA ratings on the report card. At a minimum include the overall NCQA rating. Convert NCQA's numeric rating system from one to five to a five-star rating system with half star increments as needed for consistency with other performance area ratings. Provide a simple, brief description of NCQA and a website address for more information.

Recommendation 4: Report Card Format and Display
Maintain the star rating system but increase the number of potential stars from three to five.

Recommendation 5: Report Card Format and Display
Include the MCO Comparison Chart on the reverse side of the report card. Provide a separate document in Spanish for the combined MCO Comparison Chart and report card.

Focused Reviews of Grievances, Appeals, and Denials

Introduction

HealthChoice is a managed care program based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care and services received by HealthChoice enrollees.

Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial reports submitted by each MCO, along with an annual record review. This is the third annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying the performance standards defined for Calendar Year (CY) 2018. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2018, and the first and second quarters of 2019. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during CY 2018. All nine MCOs were evaluated.

Purpose and Objectives

The purpose of this review was to:

1. Assess MCO compliance with federal and state regulations governing member and provider grievances, member appeals, pre-service authorization requests, and adverse determinations; and
2. Facilitate increased compliance within these areas by illustrating trends and opportunities for improvement.

Review objectives addressed the following:

- Validate the data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports
- Provide an avenue for MCOs to compare their performance with their peers through distribution of quarterly reports
- Identify MCO opportunities for improvement and provide recommendations
- Request corrective action when an MCO demonstrates consistent non-compliance with one or more review components

Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of the quarter to Qlarant. Qlarant developed a review tool for each reporting category that MDH approved for use in validating and evaluating quarterly MCO reports.

Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of non-compliance. Qlarant aggregated MCO results to allow MCO peer group comparisons. MCO-specific trends were identified after three quarters of data was available. Quarterly reports to MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided a separate report of quarterly reviews which included areas for follow-up when data issues, ongoing non-compliance, or negative trends were identified.

In addition to quarterly reviews of MCO submitted reports, Qlarant conducted an annual record review of a sample of CY 2018 grievance, appeal, and pre-service denial records. Records were requested from February 1, 2018, based upon the revised implementation date of several regulatory changes. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for CY 2018. Qlarant selected 35 cases from each listing of grievances using a random sampling approach and requested that each MCO upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance records was reviewed. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component.

Since there were multiple changes to the appeal and preauthorization related standards for CY 2018, Qlarant selected only 13 cases from each MCO's appeal and preservice denial listings for a baseline review. A random sample of 10 appeal and 10 pre-service denial cases were reviewed. No additional reviews were conducted for any areas of non-compliance. Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each MCO's SPR report. Results of the record reviews were also shared with appropriate staff while onsite at each MCO, including technical assistance as needed, to facilitate improved compliance.

Limitations

The validity of MCO submitted quarterly grievance, appeal, and denial reports has improved over the prior annual report period; however, ongoing issues with the accuracy and completeness of the data continued for several MCOs through the first quarter of 2019. For example, ABH only reported "expedited" outpatient pharmacy denials for the first three quarters. KPMAS reported only medical necessity denials within one expedited category and all expedited (medical necessity and administrative) denials in another category for the first three quarters. During this time, technical assistance was provided to MCOs, as needed. Additionally, revisions were made to the MCO reporting forms to improve clarity.

In addition to formula errors and confusion related to reporting fields, incomplete data was reported. UHC did not provide denial reports from its dental vendor until the second quarter of 2019. JMS reported a significant increase in member grievances for the second quarter of 2019, which was attributed to a recent customer service training leading to improved identification of grievances. It is likely that other MCOs may be unaware that grievances are being under reported as well. Because of these continuing opportunities for improvement, some caution must be exercised in reviewing these results.

Results

This section provides MCO-specific review results of select grievance, appeal, and pre-service denial measures in table format. Graphical representation is also displayed, where applicable. These data facilitate comparisons of MCO performance over time and in relation to peers based on quarterly reports and annual record review results.

The percentage of compliance demonstrated for various components is represented by a review determination of met, partially met, or unmet, as shown in Table 55:

Table 55. Score Level for Compliance

Assessment	Rationale
Met (M)	Compliance consistently demonstrated
Partially Met (PM)	Compliance inconsistently demonstrated
Unmet (UM)	No evidence of compliance

Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.67.01.01B(64). COMAR 10.67.09.02C(1) describes three categories of grievances:

Category 1: Emergency medically related grievances
Example: Emergency prescription or incorrect prescription provided
Category 2: Non-emergency medically related grievances
Example: DME/DMS-related complaints about repairs, upgrades, vendor issues, etc.
Category 3: Administrative grievances
Example: Difficulty finding a network PCP or specialist

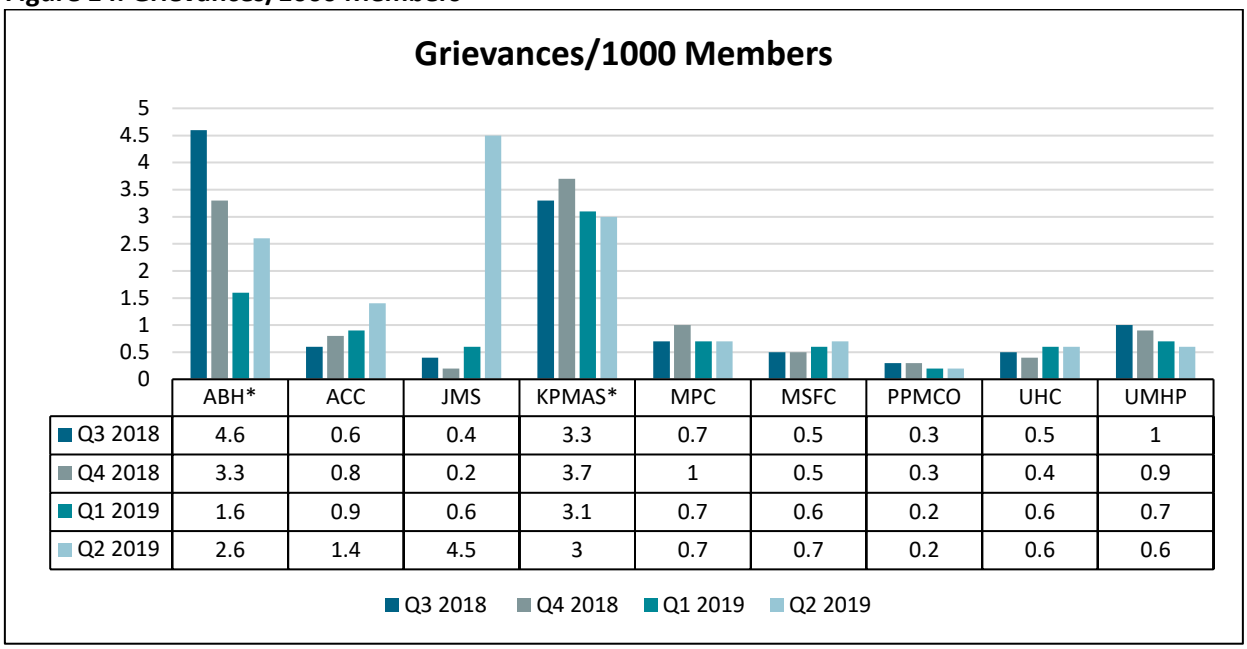
The MCO grievance review encompassed a review of comparative statistics and an assessment of compliance with federal and state laws and regulations as follows:

- Comparative Statistics
  - Grievances filed per 1000 members
  - Grievances filed per 1000 providers
- Resolution Time Frames (based upon 100% compliance)
  - Emergency medically related grievances resolved within 24 hours
  - Non-emergency medically related grievances resolved within 5 days
  - Administrative grievances resolved within 30 days
- Grievance Definitions
  - Must meet the definition of an expression of dissatisfaction about any matter other than an action.
  - May include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.
- Grievance Documentation: Grievance issue must be fully described in the enrollee record.

- Grievance Determination
  - Grievance determination must be documented in the enrollee record, appropriately address the grievance issue, and identify the steps taken to resolve the issue.
  - Written determination must be forwarded to:
    - Enrollee who filed the grievance;
    - Individuals and entities required to be notified of the grievance; and
    - MDH's complaint unit (for complaints referred to the MCO by MDH's complaint unit).

Figure 14 displays a comparison of MCO grievances per 1000 members for four quarters.

Figure 14. Grievances/1000 Members



	ABH*	ACC	JMS	KPMAS*	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	4.6	0.6	0.4	3.3	0.7	0.5	0.3	0.5	1
Q4 2018	3.3	0.8	0.2	3.7	1	0.5	0.3	0.4	0.9
Q1 2019	1.6	0.9	0.6	3.1	0.7	0.6	0.2	0.6	0.7
Q2 2019	2.6	1.4	4.5	3	0.7	0.7	0.2	0.6	0.6

*Major outlier in comparison to other MCOs

Both ABH and KPMAS were major outliers in grievances per 1000 members for all four quarters. Access related issues represented the majority of ABH grievances, while customer service-related categories represented the majority of KPMAS grievances, consistent with the prior 12-month period. JMS had a major uptick in grievances for the second quarter of 2019. JMS attributed this increase to recent customer service training focused on member grievances. In view of apparent under reporting in past quarters, it is anticipated that JMS grievances per 1000 will be reported at a much higher level in the future. For the other MCOs, reported grievances per 1000 members fall within a fairly narrow range.

Table 56 displays comparisons of MCO reported compliance with resolution time frames for member grievances based on MCO quarterly submissions.

Table 56. MCO Reported Compliance with Member Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	M	M	M	PM	M	PM	PM	M	M
Q4 2018	M	M	M	PM	M	PM	PM	M	M
Q1 2019	PM	M	PM	PM	M	PM	PM	PM	M
Q2 2019	PM	M	PM	M	M	M	PM	M	M

M=Met; PM=Partially Met; UM=Unmet; NA=Not applicable

Three MCOs (ACC, MPC, and UMHP) met the resolution time frames for member grievances in all four quarters. UHC demonstrated full compliance for three of the four quarters. ABH and JMS met the required time frames in two of the four quarters. KPMAS and MSFC only met the required time frames in Q2 2019. PPMCO did not fully meet the resolution time frames in any of the four quarters.

Table 57 offers a comparison of MCO reported grievances per 1000 providers for four quarters.

Table 57. MCO Reported Grievances/1000 Providers

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	1.79*	NA	0.36	NA	1.48*	0.17	NA	NA	0.73
Q4 2018	0.12	NA	NA	NA	0.48	0.17	NA	0.13	0.48
Q1 2019	0.10	NA	0.17	NA	0.46	0.17	1.00*	NA	0.20
Q2 2019	0.30	NA	NA	NA	1.14*	NA	NA	NA	0.30

NA-Not Applicable
*Major outlier in comparison to other MCOs

MCO reported grievances per 1000 providers consistently remained low for the majority of MCOs. For third quarter of 2018, both ABH and MPC were major outliers for this measure in comparison to all other MCOs; however, each MCO has demonstrated a downward, although uneven, trend since then. For the first quarter of 2019, PPMCO was a major outlier. For the second quarter of 2019, MPC grievances per 1000 providers exceeded all other MCOs; however, overall provider grievances have demonstrated a downward, although uneven, trend as previously noted.

Table 58 displays comparisons of MCO reported compliance with resolution time frames for provider grievances based on MCO quarterly submissions.

Table 58. MCO Reported Compliance with Provider Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	M	NA	M	NA	M	M	NA	M	M
Q4 2018	NA	NA	NA	NA	PM	M	NA	M	M
Q1 2019	M	NA	M	NA	M	M	NA	M	M
Q2 2019	M	NA	NA	NA	M	NA	NA	NA	M

M=Met; PM=Partially Met; UM=Unmet; NA=Not applicable as the MCO did not receive any provider grievances during the reporting period.

All MCOs, as applicable, met the resolution time frames for provider grievances throughout the four quarters with one exception. MPC compliance with required resolution time frames was partially met in the fourth quarter of 2018. MCOs that did not receive any provider grievances for the quarter were reported as NA for compliance for that quarter.

Table 59 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2018. Reviews were conducted utilizing the 10/30 rule.

Table 59. CY 2018 MCO Annual Grievance Record Review Results

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Appropriately Classified	M	M	M	M	PM	M	M	M	M
Issue Is Fully Described	M	M	M	M	M	M	M	M	M
Resolution Timeliness	M	M	M	PM	PM	M	PM	M	M
Resolution Appropriateness	M	M	M	PM	M	M	M	M	M
Resolution Letter	M	M	M	PM	PM	PM	M	M	M

M=Met; PM=Partially Met; UM=Unmet; NA-Not Applicable

MPC received a finding of partially met for "Appropriately Classified," as it did not correctly identify the category of the grievance. All MCO records reviewed demonstrated a full description of the grievance issue. Resolution timeliness was met by six MCOs. KPMAS, MPC, and PPMCO did not consistently meet time frames for resolution. KPMAS demonstrated an opportunity for improving the appropriateness of the resolution. Six MCOs (ABH, ACC, JMS, PPMCO, UHC, and UMHP) received a finding of met for the resolution letter. KPMAS and MSFC received a finding of partially met as resolution letters were not consistently provided in response to a member grievance. MPC received a finding of partially met as resolution letters did not identify or describe the grievance, and the resolution was not adequately documented in most cases.

Appeal Results

An appeal is a request for a review of an action as stated in COMAR 10.67.01.01B(13). The regulation provides the following definitions of an action:

- Action 1: Denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- Action 2: Reduction, suspension, or termination of a previously authorized service
- Action 3: Denial, in whole or part, of payment for a service
- Action 4: Failure to provide services in a timely manner (i.e., if the MCO fails to provide services within the time frames defined by the State in COMAR 10.67.05.07
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR (i.e., COMAR 10.67.09.05)
- Action 6: The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for appeal processing with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. Updates to COMAR 10.67.09.05 as they relate to MCO reported appeal results addressed in this report include the following:

- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a State fair hearing.
- Except for expedited appeals, MCOs shall resolve each appeal and provide notice of resolution, as expeditiously as the enrollee's health condition requires within 30 days from the date the MCO receives the appeal unless an extension is requested.
- Expedited appeals shall be resolved as expeditiously as the enrollee's health condition requires but no later than 72 hours after the MCO receives the appeal.

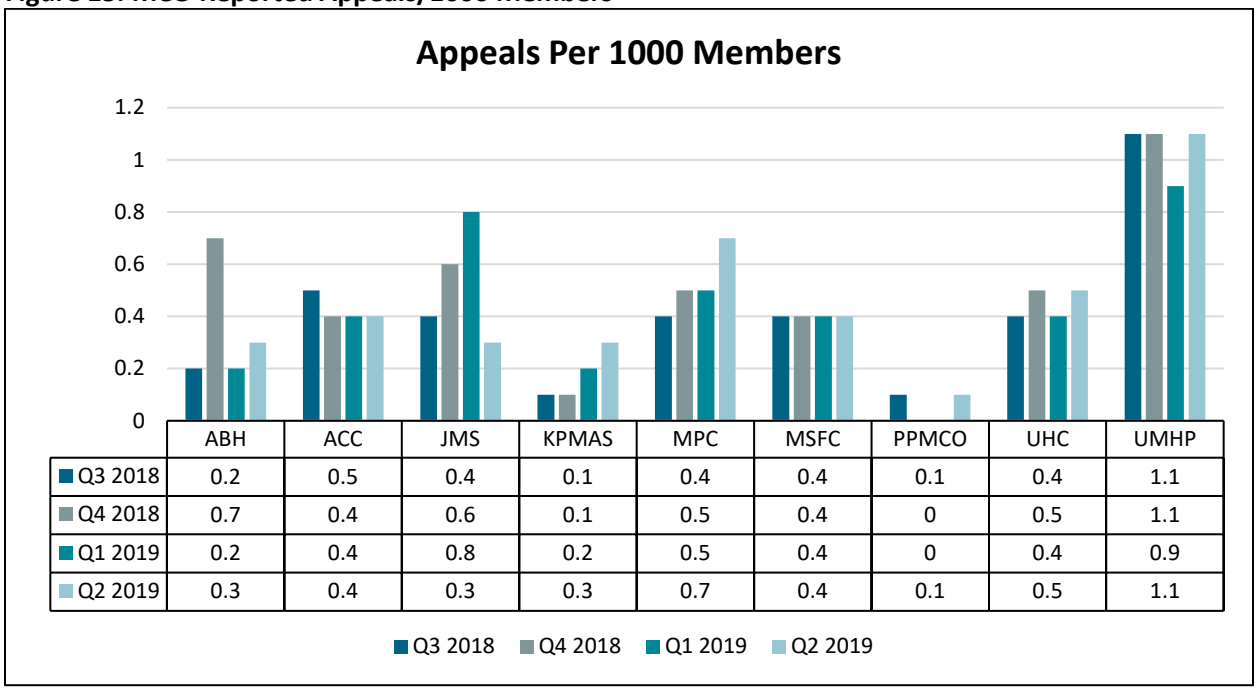
Providers can file an appeal on behalf of a member with their written consent. Maryland's regulations previously did not require the provider to seek written authorization before filing an appeal on the member's behalf.

The MCO appeal review encompassed the following comparative statistics and an assessment of compliance with federal and state laws and regulations:

- Comparative Statistics: Appeals Filed Per 1000 Members
- Resolution Time Frames (based upon 100% compliance)
  - Expedited appeals are required to be completed within 72 hours of receipt. Notification of the appeal decision is required within 24 hours of the decision and within the overall 72-hour time frame.
  - Non-emergency appeals are required to be completed within 30 days, unless an extension is requested of no more than 14 days.
- Appeal Processing: Appeals are to be processed as expeditiously as the enrollee's health requires.
- Notifications of Denial of an Expedited Request
- Appeal Documentation: Appeal decisions are to be documented fully in the enrollee record.
- Decision Made by Health Care Professional with Appropriate Expertise
- Written Notification: The appeal resolution is to be provided to the enrollee in a written letter and must include results in easy to understand language.

Figure 15 provides a comparison of MCO reported appeals per 1000 members based on MCO quarterly submissions.

Figure 15. MCO Reported Appeals/1000 Members



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	0.2	0.5	0.4	0.1	0.4	0.4	0.1	0.4	1.1
Q4 2018	0.7	0.4	0.6	0.1	0.5	0.4	0	0.5	1.1
Q1 2019	0.2	0.4	0.8	0.2	0.5	0.4	0	0.4	0.9
Q2 2019	0.3	0.4	0.3	0.3	0.7	0.4	0.1	0.5	1.1

NA – Not Applicable
*Outlier in comparison to other MCOs

UMHP has consistently been at the top of the range in reported appeals per 1000 members in comparison to all other MCOs during all four quarters. This mirrors the prior year's findings as well. For the remaining eight MCOs, appeals per 1000 members fall within a relatively narrow range from quarter to quarter for each MCO and across MCOs.

Comparisons of MCO reported compliance with resolution time frames for member appeals are displayed in Table 60 based on MCO quarterly submissions.

Table 60. MCO Reported Compliance with Member Appeal Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	M	M	M	M	M	M	PM	PM	M
Q4 2018	PM	M	M	M	M	PM	M	PM	M
Q1 2019	M	M	M	M	M	M	PM	M	M
Q2 2019	M	UM	M	PM	M	M	UM	PM	M

M=Met; PM=Partially Met; UM=Unmet; NA-Not Applicable

Three MCOs (JMS, MPC, and UMHP) consistently met appeal resolution time frames for the four quarters reviewed. Four MCOs (ABH, ACC, KPMAS, and MSFC) demonstrated compliance for three quarters. PPMCO and UHC demonstrated compliance for one quarter. It does not appear that the change in the resolution time frame for expedited appeals from three business days to 72 hours had an impact on MCO compliance results.

Table 61 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2018. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance, since this was considered a baseline review due to several changes to the standards.

Table 61. CY 2018 MCO Appeal Record Review Results

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Processed Based Upon Level of Urgency	M	M	M	M	M	M	M	M	M
Compliance with Verbal Notification of Denial of an Expedited Request	UM	M	NA	M	NA	NA	NA	M	NA
Compliance with Written Notification of Denial of an Expedited Request	M	M	NA	UM	NA	NA	NA	M	NA
Compliance with 72-hour Time Frame for Expedited Appeal Resolution	PM	M	NA	M	NA	M	NA	M	M
Compliance with Verbal Notification of Expedited Appeal Decision	UM	UM	NA	M	NA	M	NA	M	M
Compliance with 24-hour Time Frame for Written	PM	M	NA	M	NA	M	NA	M	M
Compliance with Written Notification Time Frame for Non-Emergency Appeal	M	M	M	M	M	M	PM	M	M
Appeal Decision Documented	M	M	M	M	M	M	M	M	M
Decision Made by Health Care Professional with Appropriate Expertise	M	M	M	M	M	M	M	M	M
Decision Available to Enrollee in Easy to Understand	M	M	M	M	PM	M	M	M	PM

M=Met; PM=Partially Met; UM=Unmet; NA=Not

Review of a sample of MCO records demonstrated that all nine MCOs processed appeals based upon the level of urgency; documented the appeal decision in the case record; and utilized health care professionals with appropriate clinical expertise in making appeal determinations. Of the four MCOs where a denial of a request for an expedited appeal resolution was documented, ABH did not provide evidence of a reasonable attempt to provide verbal notification of the denial and received an unmet.

KPMAS did not demonstrate compliance with the time frame for written notification of the denial of an expedited request. Six MCOs had one or more requests for expedited appeal resolution, with four (KPMAS, MSFC, UHC, and UMHP) demonstrating compliance with all resolution and notification requirements. ABH received a finding of partially met for compliance with the 72-hour time frame for appeal resolution and an unmet for compliance with verbal notification of an expedited appeal decision. ACC also received a finding of unmet for compliance with verbal notification of an expedited appeal decision. Only PPMCO received a partially met for compliance with the notification time frame for non-emergency appeals. Seven of the MCOs provided the decision to the enrollee in easily understandable language. MPC and UMHP received a finding of partially met for this requirement.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.67.09.04. In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. In response, MDH communicated to the MCOs these new regulatory requirements for services that require preauthorization. The effective date of January 1, 2018, was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. For January dates of service, compliance with determination time frames continued to be assessed based upon the prior regulation of two business days of receipt of necessary clinical information but no later than seven calendar days. Updates to COMAR 10.67.09.04 resulting from CMS regulatory changes to preauthorization determination time frames include the following:

- For standard authorization decisions, the MCO shall make a determination within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days.
- For expedited authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for services.
- For all covered outpatient drug authorization decisions, the MCO shall provide notice by telephone or other telecommunication device within 24 hours of a preauthorization request.

Additional regulatory requirements specified in COMAR 10.67.09.04 include:

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Standard and expedited authorization decisions may be extended up to 14 calendar days under certain specified conditions.
- An MCO shall give an enrollee written notice of any action within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests;
  - 72 hours from the date of determination for nonemergency, medically related requests;
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service; and
  - For denial of payment, at the time of any action affecting the claim.
- A notice of adverse action shall be in writing and:
  - Be translated for enrollees who speak prevalent non-English languages;

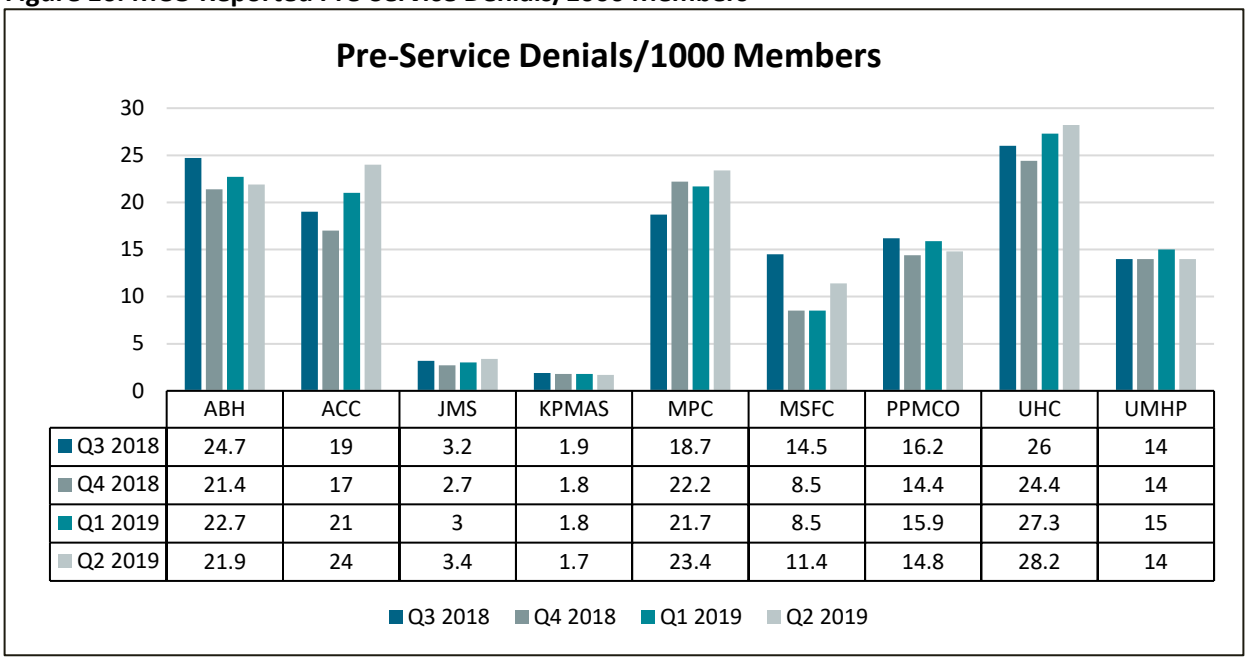
- Include language clarifying that oral interpretation is available for all languages and how to access it;
- Be written in an easily understood language and format that takes into consideration enrollees with special needs;
- Be available in alternative formats;
- Inform enrollees that information is available in alternative formats and how to access those formats; and
- Contain the following information:
  - The action the MCO has made or intends to make;
  - The reasons for the action, including the right for the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action;
  - The enrollee's right to request an appeal of the MCO's action;
  - The procedures for exercising the rights described;
  - The circumstances under which an appeal process can be expedited and how to request it;
  - The enrollee's right to have benefits continue pending resolution of the appeal;
  - How to request that benefits be continued; and
  - The circumstances under which the enrollee may be required to pay the costs of the services.

The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
- Determination time frame compliance (for dates of service as of February 1, 2019) based upon a compliance threshold of 95%:
  - For standard requests within 2 business days of receipt of necessary clinical information but no later than 14 calendar days from date of initial request.
  - For outpatient pharmacy requests within 24 hours of a preauthorization request.
  - For expedited requests determination and notice no later than 72 hours after receipt of request for service.
- Adverse determination notification time frame compliance (for dates of service as of February 1, 2019) based upon a compliance threshold of 95%:
  - For standard and outpatient pharmacy authorization decisions, within 72 hours from the date of the determination.
  - For expedited authorization decisions within 24 hours from the date of the determination.
  - For any previously authorized service at least 10 days prior to reducing, suspending, or terminating a covered service.
- Adverse Determinations
  - Must be based upon medical necessity criteria and clinical policies.
  - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 17 required regulatory components.

Figure 16 provides a comparison of MCO reported pre-service denials per 1000 members based on MCO quarterly submissions.

Figure 16. MCO Reported Pre-Service Denials/1000 Members



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2018	24.7	19	3.2	1.9	18.7	14.5	16.2	26	14
Q4 2018	21.4	17	2.7	1.8	22.2	8.5	14.4	24.4	14
Q1 2019	22.7	21	3	1.8	21.7	8.5	15.9	27.3	15
Q2 2019	21.9	24	3.4	1.7	23.4	11.4	14.8	28.2	14

Pre-service denials per 1000 members have varied by MCO but have generally remained within a fairly narrow range within each MCO over the four quarters reviewed. Pharmacy denials represent either the first or second most frequent service category for pre-service denials. While much improved over the prior four quarters, there remain some reporting inconsistencies that impact the data reported, including:

- ABH only reported “expedited” pharmacy denials for the first three quarters.
- KPMAS reported only medical necessity denials within one expedited category and all expedited (medical necessity and administrative) in another for the first three quarters.
- UHC did not report pre-service denials from its dental vendor for the first three quarters of the review period.

As noted in the prior annual report, the consistently low number of denials for JMS and KPMAS is believed to be related to their clinic-based plan models.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon self-report through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Table 62 displays results of the MCO’s reported compliance with pre-service determination time frames.

Table 62. MCO Reported Compliance with Pre-Service Determination Time Frames (Quarterly Reports)

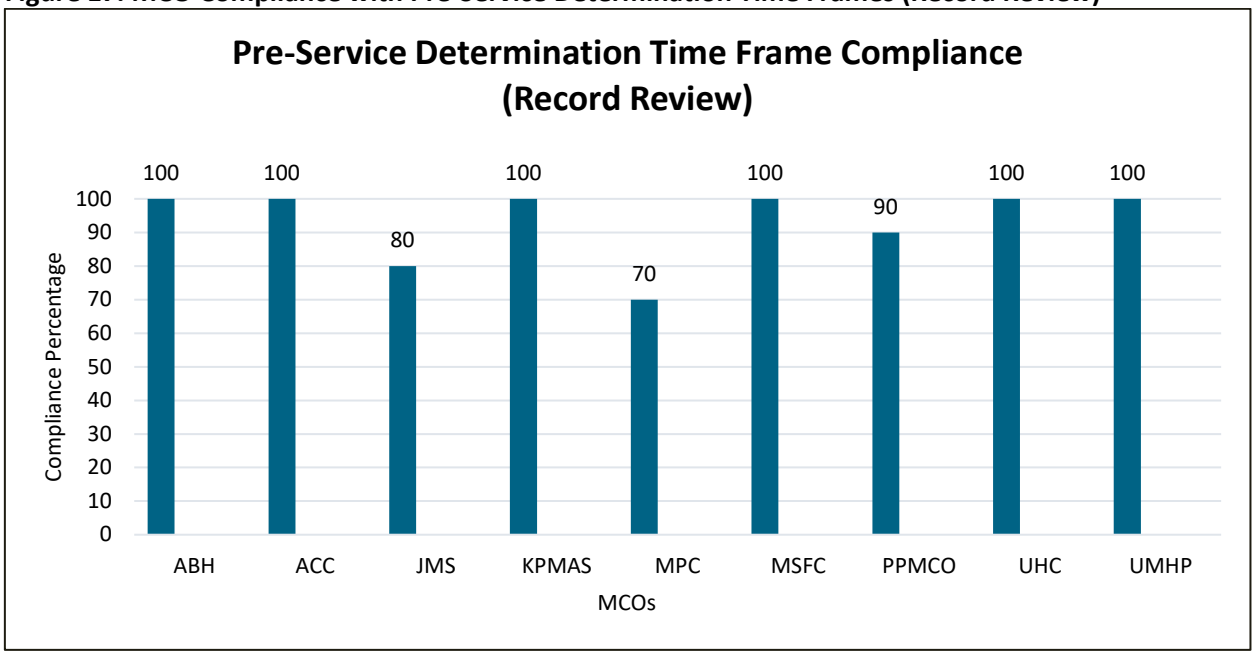
Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Compliance with Expedited Pre-Service Determination Time Frames									
Q3 2018	100%	92%	NA	100%	100%	100%	67%	99%	NA
Q4 2018	100%	100%	NA	100%	NA	NA	54%	90%	100%
Q1 2019	NA	100%	100%	100%	67%	100%	78%	93%	100%
Q2 2019	NA	100%	NA	100%	67%	100%	25%	100%	100%
Compliance with Standard Pre-Service Determination Time Frames									
Q3 2018	100%	98%	100%	97%	88%	100%	92%	98%	100%
Q4 2018	69%	96%	95%	99%	93%	100%	83%	98%	100%
Q1 2019	99%	91%	100%	98%	97%	100%	94%	99%	100%
Q2 2019	96%	97%	100%	95%	97%	100%	97%	99%	100%
Compliance with Outpatient Pharmacy Pre-Service Determination Time Frames									
Q3 2018	100%	100%	100%	NA	95%	100%	98%	100%	100%
Q4 2018	NA	100%	100%	NA	97%	100%	98%	100%	100%
Q1 2019	100%	100%	100%	NA	97%	97%	96%	100%	100%
Q2 2019	100%	100%	100%	NA	98%	96%	97%	100%	100%

NA-Not Applicable

Four of the MCOs (JMS, KPMAS, MSFC, and UMHP) met or exceeded the 95% threshold for all applicable categories based upon a review of MCO quarterly reports. Compliance results by category ranged from 25% to 94% for the remaining five MCOs (ABH, ACC, MPC, PPMCO, and UHC).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Results are highlighted in Figure 17.

Figure 17. MCO Compliance with Pre-Service Determination Time Frames (Record Review)



All but three of the MCOs (JMS, MPC, and PPMCO) met or exceeded the 95% threshold based upon the annual review of the MCO's records. JMS had a compliance rate of 80%, MPC had a rate of 70%, and PPMCO had a rate of 90%.

Compliance with COMAR requirements for the timeliness of adverse determination notifications was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Results are based upon a random selection of adverse determination records reviewed for CY 2018. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Table 63 displays the issues identified during a review of each MCO's adverse determination records.

Table 63. MCO Adverse Determination Records Review Issues

MCO	Issues Identified
ABH	Adverse Action Notice Components
ACC	Adverse Action Notice Components
JMS	Turn Around Times
KPMAS	Adverse Action Notice Components
MPC	Turn Around Times & Adverse Action Notice Components
MSFC	Adverse Action Notice Components
PPMCO	Turn Around Times & Adverse Action Notice Components
UHC	Adverse Action Notice Components
UMHP	Adverse Action Notice Components

Results of MCO reported compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Table 64.

Table 64. MCO Reported Compliance with Adverse Determination Notification Time Frames (Quarterly Reports)

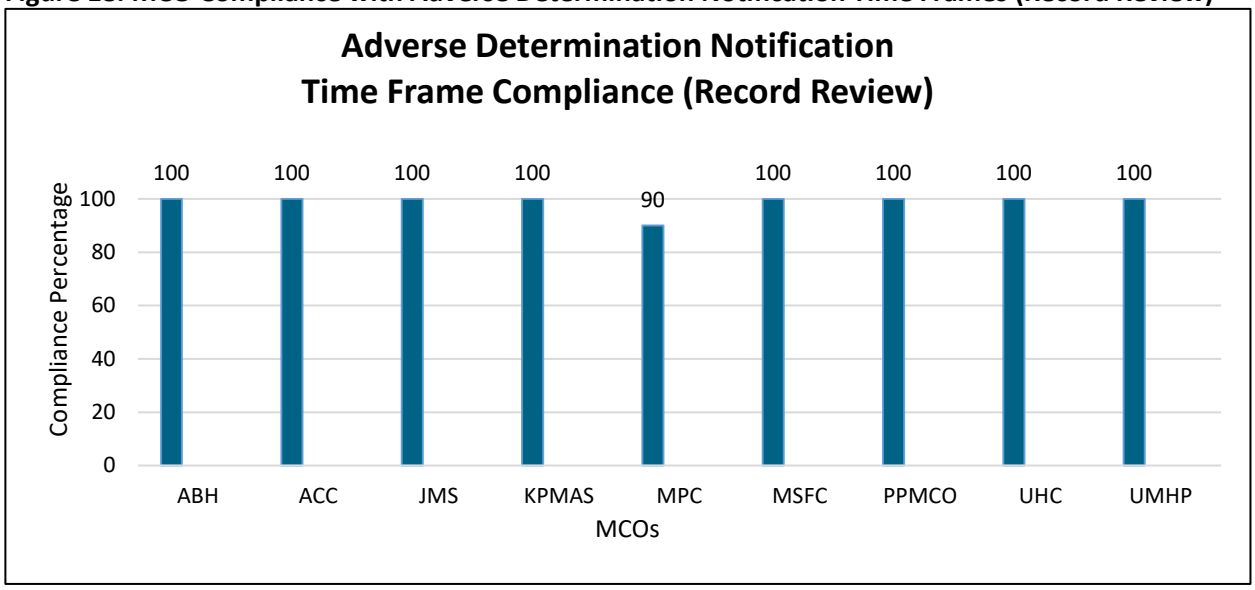
Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Compliance with Expedited Adverse Determination Notification Time Frames									
Q3 2018	100%	100%	NA	100%	50%	100%	68%	100%	N/A
Q4 2018	100%	100%	NA	100%	NA	NA	47%	100%	100%
Q1 2019	100%	100%	100%	100%	33%	100%	75%	100%	100%
Q2 2019	NA	75%	NA	100%	100%	NA	25%	100%	100%
Compliance with Standard Adverse Determination Notification Time Frames									
Q3 2018	94%	99%	100%	99%	97%	86%	93%	99%	100%
Q4 2018	60%	99%	100%	100%	98%	97%	82%	99%	100%
Q1 2019	98%	98%	100%	100%	98%	97%	91%	99%	100%
Q2 2019	99%	80%	100%	100%	98%	84%	95%	100%	100%
Compliance with Outpatient Pharmacy Adverse Determination Notification Time Frames									
Q3 2018	100%	100%	100%	NA	99%	100%	97%	100%	100%
Q4 2018	NA	100%	100%	NA	98%	100%	98%	100%	100%
Q1 2019	NA	100%	100%	NA	100%	97%	96%	100%	100%
Q2 2019	100%	100%	100%	NA	100%	96%	97%	100%	100%

NA-Not Applicable

Four of the MCOs (JMS, KPMAS, UHC, and UMHP) met or exceeded the 95% threshold for all applicable categories upon a review of MCO quarterly reports. Compliance results by category ranged from 25% to 94% for the remaining five MCOs (ABH, ACC, MPC, MSFC, and PPMCO).

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards. Results are highlighted in Figure 18.

Figure 18. MCO Compliance with Adverse Determination Notification Time Frames (Record Review)



All but MPC demonstrated 100% compliance with adverse determination notification time frames based upon the record review. MPC compliance was below the 95% threshold at 90%.

Table 65 provides a comparison of denial record review results across MCOs for CY 2018. Results are based upon a random selection of denial records. Ten records were reviewed for each MCO. Additional records were not reviewed for any areas of non-compliance since this was considered a baseline review due to several changes to the standards.

Table 65. Results of CY 2018 Denial Record Reviews

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Appropriateness of Adverse Determinations	M	M	M	M	M	M	M	M	M
Compliance with Pre-Service Determination Time Frames	M	M	PM	M	PM	M	PM	M	M
Compliance with Adverse Determination Notification Time Frames	M	M	M	M	PM	M	M	M	M
Required Letter Components	PM	PM	Met	PM	PM	PM	PM	PM	PM

M=Met; PM=Partially Met; UM=Unmet

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO-specific clinical policies. Six MCOs met or exceeded the 95% threshold for compliance with determination time frames. Three MCO (JMS, MPC, and PPMCO) did not

consistently meet the compliance threshold for determination time frames. All MCOs but MPC met or exceeded the threshold for timely notification of an adverse determination. Only JMS demonstrated compliance with all required letter components. The majority of MCOs did not provide the revised time frame for filing an appeal in the adverse determination notification letter.

Recommendations

Overall, the MCOs demonstrated fairly strong and consistent results in meeting regulations relating to grievances, appeals, and pre-service denials. Compliance with regulatory time frames continues to be the greatest challenge as evidenced by MCO results in the majority of categories. CAPs through the SPR process are in place to address MCOs that have had ongoing issues in demonstrating compliance. As necessary, MDH has also instituted a quarterly review to assess progress in CAP implementation and related performance measures.

As a result of opportunities identified following the 2018 focused review, MDH:

- Required MCOs to report quarterly compliance with outpatient drug preauthorization decision and notification time frames which assisted in bringing to light some implementation issues with this new requirement. For example, two MCOs did not have a process for documenting telephonic or other telecommunication notifications to providers within 24 hours of the request.
- Further clarified new System Performance Review standards for grievances, appeals, and pre-service denials for the CY 2019 Interim Review based upon opportunities identified during the CY 2018 SPR.

The following recommendations are offered in response to new and/or continuing opportunities for improvement:

- **MCOs:** Implement managed care model notices recently revised by MDH to reflect current regulatory requirements and increased clarity for both the MCOs and the members. The use of such templates is considered a best practice.
- **MDH:** Provide guidance to the MCOs regarding requirements for member grievances that are received from the State. This includes processing and reporting all receipts as grievances and providing a member resolution letter for each.
- **MDH:** Revise the MCO quarterly pre-service denial reporting form to improve clarity of reporting fields.
- **MDH:** Consider developing a separate denial category for “dental services” which is currently reported in the “Other” category. This would assist in highlighting any trends in this “value added” service and allow for improved peer comparisons since some MCOs do not provide adult dental services.
- **MDH:** Consider including in the next onsite SPR conducting ongoing training with front line member call center staff to assess their understanding of what constitutes a grievance in view of possible under reporting in this area.

Conclusion

This report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2018 through the second quarter of 2019. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2018. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice members is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriate classification and resolution of grievances
- Full documentation of grievance issues
- Grievance resolution letters
- Provider grievance resolution time frames
- Appeals processed based upon level of urgency
- Appeal decisions made by health care professional with appropriate expertise
- Appeal decisions documented and available to the member in easy to understand language
- Adverse determinations appropriate based upon MCO medical necessity criteria and policies

Major opportunities for improvement where five or more of the MCOs did not meet requirements on a consistent basis are identified in the following areas:

- Timely resolution of member grievances
- Timely resolution of member appeals
- Timely pre-service determinations
- Timely adverse determination notifications
- Required components in adverse determination letters

As noted in the Limitations section, the validity of the data submitted by the MCOs continues to be a challenge, although there has been marked improvement since the first quarter of 2019. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yield a greater level of confidence in the review outcomes for annual reporting.

Network Adequacy Validation

Introduction

MDH engages in a broad range of activities to monitor network adequacy and access. These areas have been subject to greater oversight since the Centers for Medicare and Medicaid Services (CMS) issued the Final Rule CMS-2390-F, the first major overhaul to Medicaid managed care regulations in more than a decade. The Final Rule requires states to adopt time and distance standards for certain network provider types during contract periods beginning on or after July 1, 2018. States must also publicize provider directories and network adequacy standards for each MCO.

Background

Beginning in 2015, MDH collaborated with The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop) to develop a validation method to test the accuracy of HealthChoice MCOs' provider directories. This was conducted in two phases. In Phase 1, Hilltop conducted a pilot survey from October to December of 2015. In Phase 2, MDH and Hilltop streamlined their survey tool and surveyed a statistically significant sample of 361 PCPs from the entire HealthChoice network by combining online provider directories from all MCOs. Surveys were conducted between January and February of 2017.

Phase 2 verified the accuracy of information in provider directories, such as name, address, phone number, whether the provider practices as a PCP, whether the provider was accepting new patients, and patient age range. Phase 2 results found that while most directory information was accurate, discrepancies existed in key areas such as contact information and PCP status.

The Phase 2 Final Report indicated MDH would require MCOs to create a Network Directory Compliance Plan to demonstrate how they will correct provider directory issues identified within the report. Due to the timing of the next provider surveys, MDH did not implement this requirement. However, MDH shared information regarding inaccurate directory entries with the MCOs to ensure follow up with the surveyed providers in order to correct their directories. MDH also distributed this report to stakeholder groups, such as the Maryland Medicaid Advisory Committee.

Following Phase 2, MDH transitioned the survey administration from Hilltop to its EQRO, Qlarant. Surveys were conducted in CY 2017 and CY 2018 to validate the MCO's online provider directories and assess compliance with State access and availability requirements. Qlarant adopted a methodology similar to Hilltop's survey and conducted calls to a statistically significant sample of PCPs within each MCO.

Survey Methodology

In CY 2019, Network Adequacy Validation (NAV) activities included PCP surveys and validation of the accuracy of MCO online provider directories in June and July. Qlarant's subcontractor, Cambridge Federal, conducted the telephonic surveys to each PCP office and validated each PCP in the MCO's online directory. Three of the four surveyors returned from CY 2018 survey activities, providing consistency in survey administration. Based on feedback provided from the CY 2018 surveys, the following improvements were made to the survey process:

- The CY 2019 survey instrument was revised. Changes included rearranging the order of questions for an easier and less burdensome call to the provider, elimination of the free text responses to improve the quality of data collection, and streamlined reporting categories to improve data analysis.
- Data requests to MCOs for contracted providers were revised to include a field for the National Provider Information (NPI) so that a unique sample size could be determined for survey calls.
- The cultural competency training question was removed from the provider directory validation due to a regulatory change.

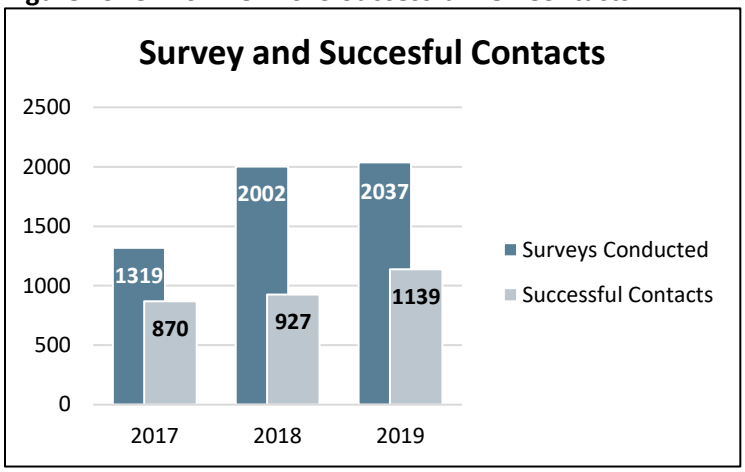
HealthChoice Results

MDH set an 80% minimum compliance score for the network adequacy assessment for CY 2019. As a result of the CY 2019 assessment, one MCO is required to submit CAP to improve compliance with routine care appointment time frames, and eight MCOs failed to meet the minimum compliance score in the area of online provider directory accuracy and were required to submit CAPs to Qlarant.

Successful Contacts

Surveys were conducted to a statistically significant sample of 2,037 PCPs in June and July 2019. A contact was considered successful if the surveyor reached the PCP and completed the telephonic survey. Figure 19 illustrates the total number of calls attempted and successful contacts for CY 2018 and CY 2019.

Figure 19. CY 2017-CY 2019 Successful PCP Contacts

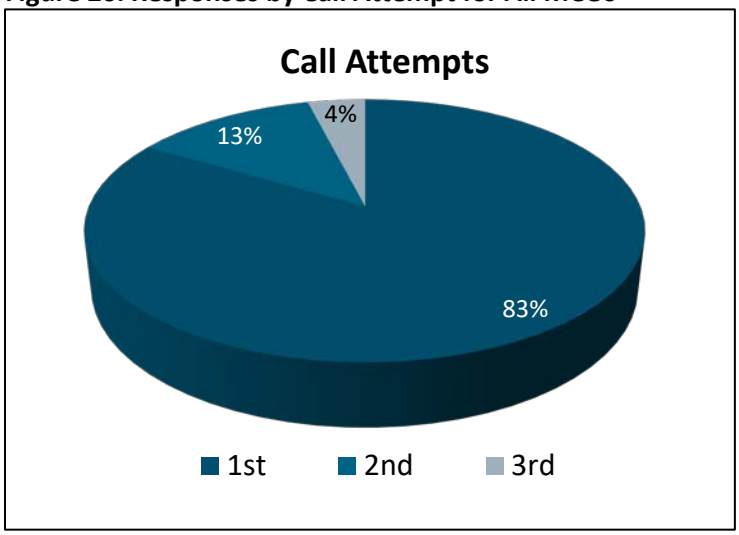


Successful PCP Contacts

- PCP surveys conducted nominally increased by 2% (35) in CY 2019 over CY 2018.
- Successful PCP contacts increased by nearly 23% (212) in CY 2019 over CY 2018.

Figure 20 illustrates the total percentages of successful PCP contacts by call attempt for all MCOs.

Figure 20. Responses by Call Attempt for All MCOs



Successful Call Attempts

- Attempts were made to contact 2,037 PCPs in CY 2019.
- Successful surveys were completed for 1,139 PCPs, yielding a response rate of 56%.
- The majority of the surveys (951 - 83%) were completed on the first contact.

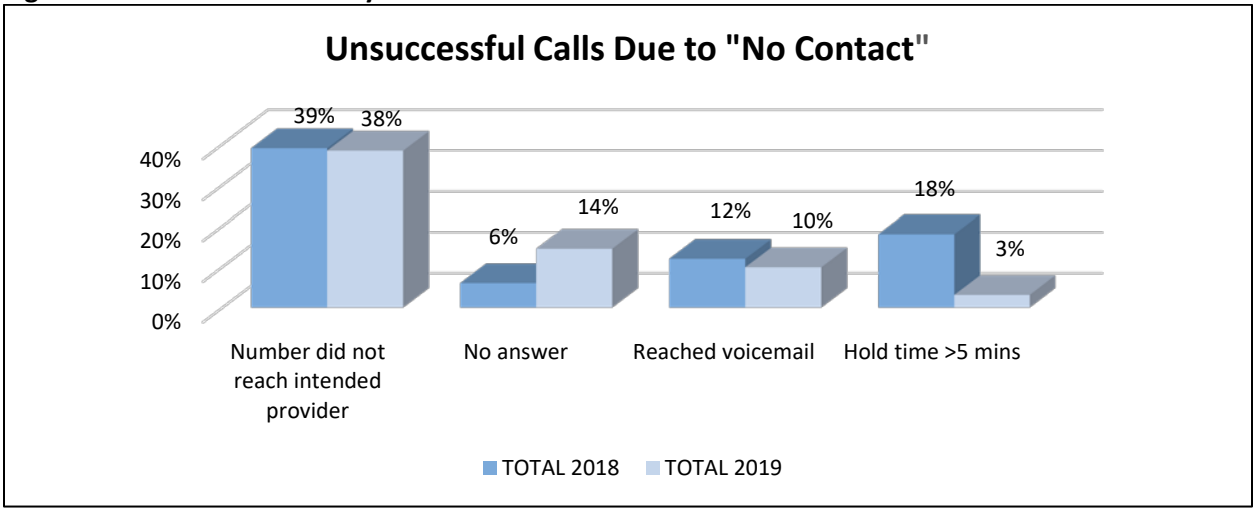
Of the 2,037 PCP surveys attempted in CY 2019, there were 1,139 successful PCP surveys completed, yielding a response rate of 56%. This was a 10 percentage point improvement over CY 2018; however, the results remain 10 percentage points lower than the CY 2017 rate of 66%. Low percentages of successful PCP contacts may indicate that members would be unable to reach the PCPs identified by the MCOs. The majority of successful surveys (951 or 83%) were completed upon the first contact to the PCP. The remaining 17% were completed on the second and third attempts.

Unsuccessful Contacts

Of the 2,037 PCP surveys attempted in CY 2019, 898 PCP surveys were unsuccessful. The reasons for unsuccessful surveys were divided into two categories, “No Contact” or “PCP Response”. Unsuccessful surveys categorized as “No Contact” were calls in which the surveyor could not reach the PCP, such as a “hold time exceeding 5 minutes” or “no answer”. Unsuccessful survey calls identified as “wrong number,” “office closed,” and “provider not with practice” were recategorized to “number did not reach intended provider” for 2019. Data from CY 2017 could not be matched and data from CY 2018 was restructured to align with the new reporting. Unsuccessful surveys categorized as “PCP Response” were calls that ended after initial contact with a live respondent. In these circumstances, the respondent may have refused to participate or noted that the provider was not a PCP.

A total of 592 (66%) telephonic surveys were unsuccessful due to “No Contact.” Reasons for unsuccessful contact with the PCP along with process descriptions are noted in Figure 21.

Figure 21. Unsuccessful Surveys Due to No Contact



If surveyors waited on hold for more than five minutes, the call was ended. Surveyors attempted to call back twice on various days and times to complete the survey. However, after the third contact, the survey was deemed unsuccessful. Hold times substantially decreased from 18% (192) in CY 2018 to 3% (28) in CY 2019.

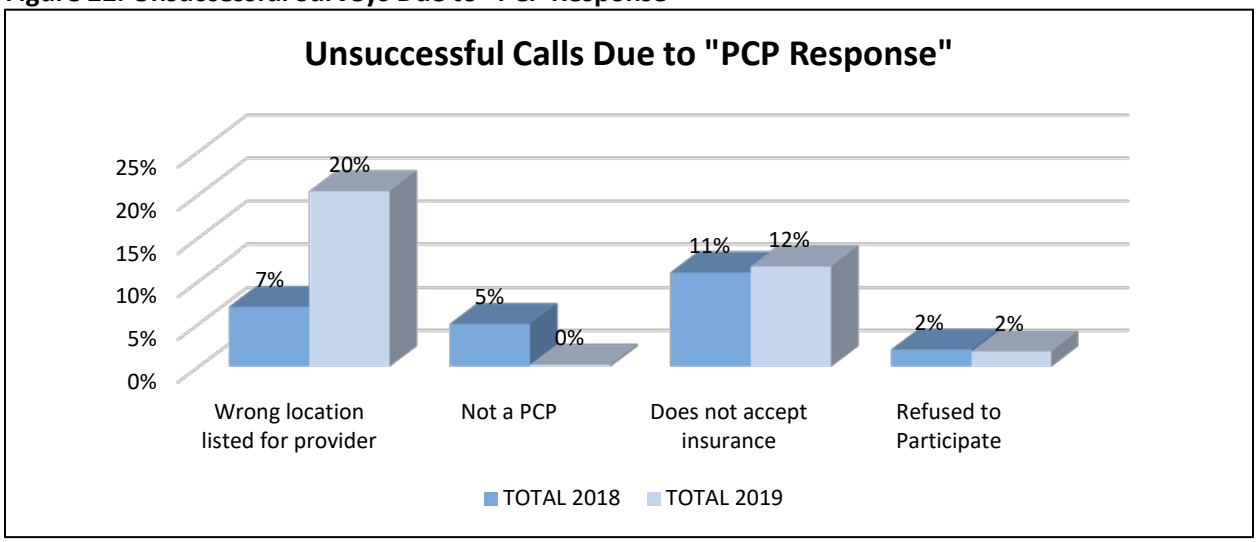
If the surveyor was asked to leave a message without getting through to a live attendant, the call was ended after the third attempt without leaving a message. PCP offices that required the surveyor to leave a message decreased from 12% (130) in CY 2018 to 10% (89) in CY 2019. However, calls that went unanswered increased significantly from 6% (62) in CY 2018 to 14% (130) in CY 2019. Members unable to speak to a live attendant or leave a message is a barrier to PCP access that MCOs should address.

If the office was closed permanently, the provider was not with the practice, or the phone number provided was incorrect, the surveyor was not able to reach the intended provider. When the telephone number was wrong, the surveyor dialed the number again to ensure that the number was dialed correctly. The number of surveys attempted that did not reach the intended provider remained consistent from CY 2018 (39% or 416) to CY 2019 (38% or 345).

A total of 306 telephonic surveys were unsuccessful due to “PCP Response”. The PCP telephonic survey ended if any of the following criteria was met and are illustrated in Figure 22.

- The provider identified for the survey was not a PCP.
- The PCP did not practice at the listed address.
- The PCP did not accept the listed insurance.
- The respondent refused to participate in the survey.

Figure 22. Unsuccessful Surveys Due to "PCP Response"



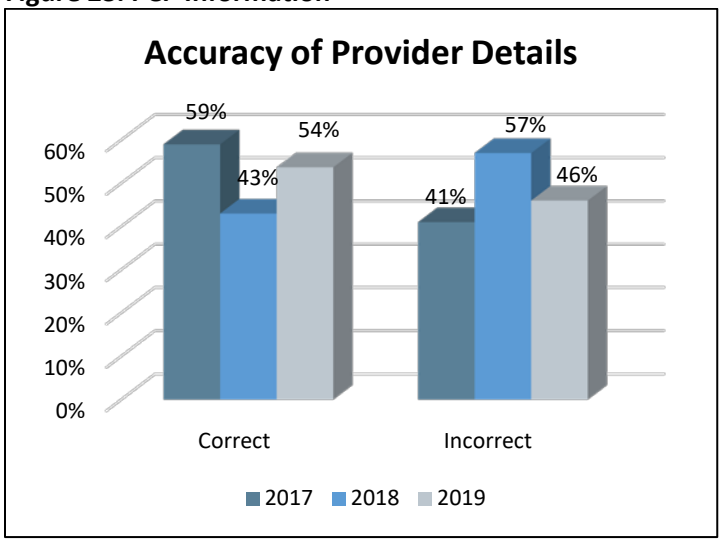
Survey scenarios mimic real barriers to members attempting to contact their PCP to obtain primary care services with the exception of respondents who refused to participate. Data regarding unsuccessful surveys due to "PCP Response" was collected for the first year in CY 2018, apart from respondents' refusal to participate. In CY 2017, 11 PCP offices refused to participate in the surveys, in CY 2018, 25 PCP offices refused, and in CY 2019, 16 offices refused to participate. Year over year, refusal to participate has remained consistent at 2%.

The largest category for unsuccessful surveys was "Wrong Location Listed for Provider." This misinformation may create a significant challenge for members attempting to locate PCPs in their desired area. It could also create network adequacy assessment issues, considering MDH relies on accurate location data to determine appropriate PCP coverage. These barriers can result in members seeking care from urgent care facilities or emergency departments, or delaying annual preventative care visits, if unable to locate the PCP of their choice to schedule an appointment.

Accuracy of PCP Information

Qlarant conducted telephonic surveys from June to July 2019 based on the PCP information provided by the MCOs. Telephonic surveys verified the accuracy of the PCP information used to populate each MCO's online provider directory. Results of the telephonic survey for all HealthChoice MCOs are presented in Figure 23.

Figure 23. PCP Information



PCP Information

- Correct PCP telephone numbers and addresses were found in 1,094 (54%) of the 2,037 attempted surveys.
- Of the 1,139 successful calls, a total of 1,055 (93%) of PCPs had accurate contact information or details (phone number or address).
- The accuracy of PCP information remained consistent from CY 2018 to CY 2019 at 93%.

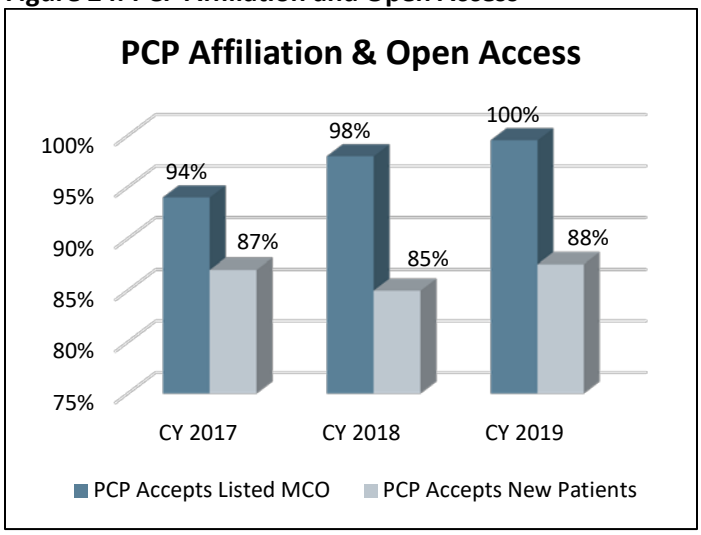
The MCOs provided sample PCP data in both CY 2018 and CY 2019. Survey results demonstrate that the accuracy of the PCP information provided by the MCOs improved in CY 2019 by 14 percentage points over CY 2018. Survey results exhibited that:

- There was a 1 percentage point decrease in CY 2019 (78 or 4%) for incorrect PCP telephone numbers over CY 2018 (105 or 5%) results.
- There was a 4 percentage point increase in CY 2019 (84 or 7%) for incorrect PCP addresses over CY 2018 (61 or 3%) results.
- There was a 6 percentage point decrease in CY 2019 (259 or 13%) of PCPs identified as no longer with the practice or at the location provided over CY 2018 (374 or 19%) results.

Members who cannot contact their PCPs due to no answer and changes in practice designations and/or locations can create access issues and continuity of care concerns for both MDH and the MCOs. The CY 2019 results denotes the need for the MCOs to measure and monitor the accuracy of PCP directory information more closely.

The CY 2019 telephonic surveys validated that PCPs accepted the listed MCO and new Medicaid patients, as illustrated in Figure 24.

Figure 24. PCP Affiliation and Open Access



PCP Affiliation & Open Access

- In CY 2019, less than 1% (5) of PCPs surveyed were unable to confirm acceptance of the listed MCO.*
- The majority of PCPs surveyed (88%) report accepting new patients in CY 2019.

* Due to rounding, graph reflects 100%.

Survey results demonstrated that by CY 2019, 100% of PCPs surveyed stated that they were affiliated with the listed MCO. Additionally, the majority of PCPs surveyed in CY 2019 (88%) stated that they accepted new Medicaid patients. The number of PCPs accepting new Medicaid patients decreased by 2 percentage points in CY 2018 and increased by 3 percentage points in CY 2019. It should be noted that beginning in CY 2018, the methodology changed whereby the surveyors specifically asked if the PCP accepted "new Medicaid patients," whereas in past years, surveyors simply asked if the PCP accepted "new patients."

Although the rate of 88% of PCPs accepting new Medicaid patients seems satisfactory, note only 56% of the PCPs were successfully contacted by surveyors, due to continued inaccurate information provided by the MCOs. Therefore, further analysis into open panels may warrant further MCO oversight.

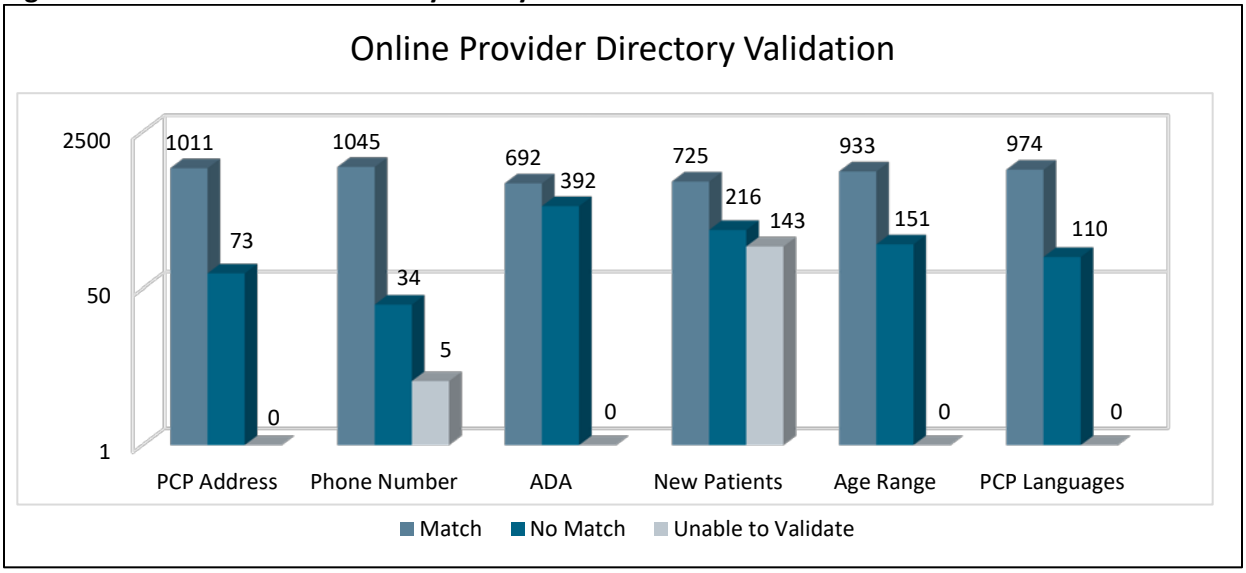
Validation of MCO Online Provider Directories

Qlarant validated the information in the MCO's online provider directory for each PCP that completed the telephone survey. The online directory was reviewed for the following information:

- **PCP Address:** Accuracy of the information presented in the online directory such as the PCP's name, address, and practice location(s).
- **PCP Phone Number:** Accuracy of the telephone number presented in the online directory.
- **ADA (Practice Accommodations for Physical Disabilities):** An indication in the online directory for the PCP as to whether the practice location has accommodations for individuals with disabilities.
- **New Patients:** An indication in the online directory for the PCP as to whether the PCP is accepting new patients.
- **Age Range:** An indication in the online directory for the PCP as to what ages the PCP serves.
- **PCP Languages:** An indication in the online directory of the languages spoken by the PCP.

Results of the online provider directory survey validation are presented in Figure 25.

Figure 25. Online Provider Directory Survey Validation Results



In CY 2019, 1,139 PCPs reported that they were active with an MCO; however, 55 PCPs were not found in the MCO's online provider directory. CY 2018 results were similar with 58 PCPs not found in the MCO's online provider directory from the 928 successful survey calls. CY 2019 directory validation included PCP address, phone number, ADA accessibility, accepting new patients, identified service age ranges, and languages spoken. Previously, directory validation included completion of cultural competency training and has been removed for CY 2019. Therefore, 1,084 PCPs were validated against the MCO's online provider directories for compliance with the regulations. Online provider directory results indicate that:

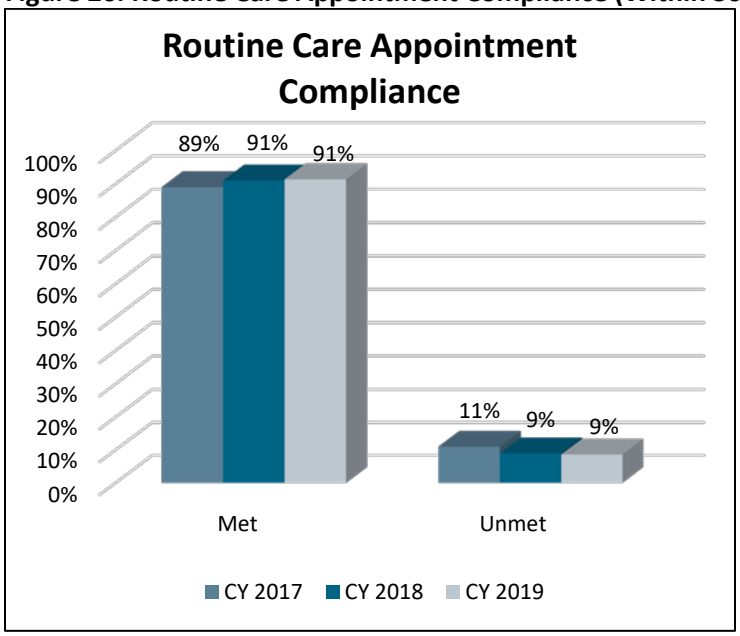
- Almost all PCP directory entries validated matched the address (1,011 or 93%) or telephone number (1,045 or 96%) responses provided in the telephone surveys, which is consistent with CY 2018 data (92% for PCP address accuracy and 97% for phone number accuracy).
- Over half of PCP directory entries (725 or 67%) validated that PCPs accepted new Medicaid patients compared to responses during the telephone survey, a significant decrease of 20 percentage points from CY 2018 (87%). Just over 13% (143) of the PCP directory entries did not confirm or deny acceptance of new Medicaid patients.
- The majority of PCP directory entries (933 or 86%) listed age ranges of patients served, a significant increase of 20 percentage points over CY 2018.
- The majority of the PCP directories (974 or 90%) specified the languages spoken by the PCP, a significant increase of 38 percentage points over CY 2018. The remaining directories did not specify languages spoken.

More than half of PCP directory entries (692 or 64%) specified practice accommodations for patients with disabilities, a slight improvement over CY 2018 (53%). All PCP offices are required to be ADA accessible.

Compliance with Routine Appointment Requirements

Routine appointments are required to be scheduled within 30 days of the enrollee's request. Survey results of PCP compliance with routine appointment requirements are presented in Figure 26.

Figure 26. Routine Care Appointment Compliance (Within 30 Days of Request)



Routine Care Appointment Compliance

- Of the 1,139 PCPs successfully surveyed, 85% (972) provided routine care appointment availability.
- 91% of PCPs that provided routine care appointment availability (888) met compliance with the routine care appointment time frame.
- CY 2019 routine care appointment compliance results remained consistent with CY 2018 results.

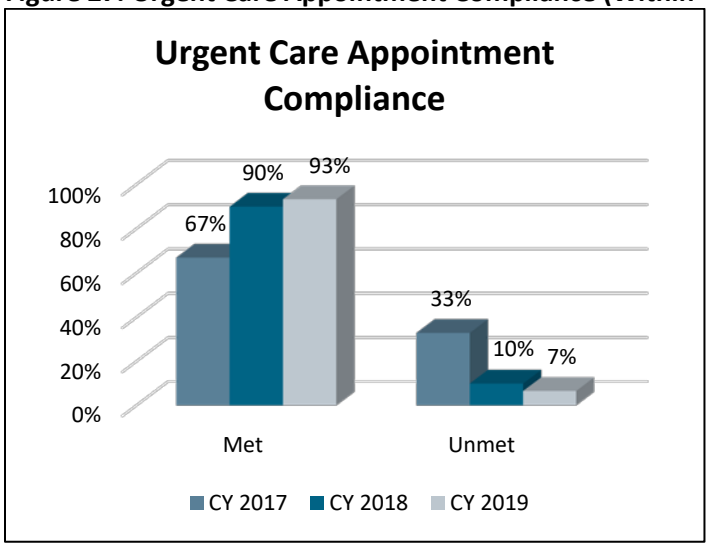
The methodology for CY 2019 remained consistent in obtaining appointment availability where surveyors were instructed to ask respondents if they could schedule appointments. As learned in previous surveys, some PCP offices and MCOs utilize separate staff or scheduling centers to provide support in booking appointments for PCPs. If the respondent stated that there was a separate number to contact in order to schedule appointments, the surveyor requested to be transferred or hung up and contacted the new number to obtain appointment availability.

The number of PCPs that provided routine care appointment availability to surveyors decreased by 14 percentage points, from 99% in CY 2018 to 85% in CY 2019. Nevertheless, compliance with the 30-day appointment time frame remained consistent with CY 2018 results at 91% for those PCPs that provided appointment availability.

Compliance with Urgent Care Appointment Requirements

Urgent care appointments are required to be scheduled within 48 hours of the enrollee's request. Survey results for PCP compliance with urgent care appointments are presented in Figure 27.

Figure 27. Urgent Care Appointment Compliance (Within 48 Hours of Request)



Urgent Care Appointment Compliance

- Of the 1,139 PCPs surveyed, the majority of PCPs provided and met the 48-hour urgent care timeframes (93% - 1,059). Compliance timeframes were achieved by offering appointments with another provider in the same practice (22% - 250).
- Results for urgent care appointment compliance in CY 2019 were significantly higher than CY 2018.

Based on feedback from the MCOs, the survey was revised in CY 2018 regarding urgent care appointments. Surveyors asked providers if the practice could provide an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the urgent care time frame. Additionally, data was collected on alternative options offered by the practice, such as referring the member to urgent care services, referring the member to the emergency room, or to another option. Due to this change in methodology, results for Urgent Care Appointment Compliance increased significantly since CY 2017. The number of PCPs that provided urgent care appointment availability increased from 67% in CY 2017 to 90% in CY 2018, and again in CY 2019 to 93%. This demonstrates an increase of 3 percentage points over CY 2018 and an increase of 26 percentage points over CY 2017.

A review of the results revealed that 71% of surveyed PCPs offered an urgent care appointment within the required 48-hour time frame; an additional 22% of PCPs offered an appointment within the required time frame with another provider in the same practice. Of the 7% (75) surveyed PCPs not meeting the appointment compliance timeframes, 88% (66) directed enrollees to an urgent care clinic or an emergency department, and 12% (9) did not provide any guidance. The option of directing the enrollee to an urgent care clinic appears to be a standard practice among PCPs when an urgent care appointment cannot be made upon request. Investigation of member complaints or grievances may provide MDH further insight into whether enrollees are accessing urgent care services because of PCP referrals to urgent care centers.

MCO-Specific Results for Successful Contacts

Table 66 presents MCO-specific results of successful calls, including the total number of PCP calls attempted, the total number of calls successfully completed, the call attempt on which the call was successfully completed, and the percentage of successfully completed calls.

Table 66. CY 2019 MCO Results of Successful Contacts

CY 2019 MCO Successful Contacts						
MCO	**Number of Call Attempts**	**1st Call Attempt**	**2nd Call Attempt**	**3rd Call Attempt**	**Total Successfully Completed Calls**	**Percent of Successfully Completed Calls**
ABH	213	103 (81%)	17 (13%)	8 (6%)	128	60%
ACC	247	131 (80%)	28 (17%)	4 (3%)	163	66%
JMS	181	77 (77%)	17 (17%)	6 (6%)	100	55%
KPMAS	163	110 (97%)	4 (3%)	0 (0%)	114	70%
MPC	259	55 (75%)	16 (22%)	2 (3%)	73	28%
MSFC	243	90 (76%)	21 (18%)	7 (6%)	118	49%
PPMCO	253	133 (92%)	8 (6%)	3 (2%)	144	57%
UHC	238	130 (86%)	16 (11%)	5 (3%)	151	63%
UMHP	240	122 (82%)	16 (11%)	10 (7%)	148	62%
TOTAL	**2,037**	**951 (83%)**	**143 (13%)**	**45 (4%)**	**1,139**	**56%**

Of the 2,037 PCP surveys attempted in CY 2019, there were 1,139 successful PCP surveys completed, thus yielding a response rate of 56%. MCO-specific results demonstrated that KPMAS had the highest percent of successful calls with 70%, and MPC had the lowest with 28%. By far, the majority of all calls were completed on the first call attempt.

MCO-Specific Results for Unsuccessful Contacts

Of the 2,037 PCP surveys attempted in CY 2019, there were 898 unsuccessful PCP surveys. The reasons for unsuccessful surveys were divided into two categories, “No Contact” or “PCP Response.”

Unsuccessful surveys categorized as “No Contact” were calls in which the surveyor could not reach the PCP, such as a “Hold Time Exceeding 5 Minutes” or “No Answer.” Unsuccessful survey calls identified as “Wrong Number,” “Office Closed,” and “Provider Not With Practice” were recategorized to “Number Did Not Reach Intended Provider” for 2019. Data from CY 2017 could not be matched and data from CY 2018 was restructured to align with the new reporting. Unsuccessful surveys categorized as “PCP Response” were calls that ended after initial contact with a live respondent. In these circumstances, the respondent may have refused to participate or noted that the provider was not a PCP.

A total of 592 (66%) telephonic surveys were unsuccessful due to “No Contact” and a total of 306 (34%) were due to “PCP Response.” Tables 67 and 68 present the MCO-specific results of unsuccessful contacts due to “No Contact” and “PCP Response.”

Table 67. CY 2019 MCO Result of Unsuccessful Contacts Due to "No Contact"

CY 2019 MCO Unsuccessful Contacts Due to "No Contact"						
MCO	**Did Not Reach Intended Provider**	**No Answer**	**Reached Voicemail**	**Hold Time > 5 min**	**Other**	**MCO Total**
ABH	37	6	15	3	0	**61 (10%)**
ACC	41	8	5	7	0	**61 (10%)**
JMS	23	13	6	0	0	**42 (7%)**
KPMAS	12	6	0	0	0	**18 (3%)**
MPC	78	46	15	7	0	**146 (25%)**
MSFC	50	12	20	2	0	**84 (14%)**
PPMCO	39	13	8	0	0	**60 (10%)**
UHC	37	13	12	0	0	**62 (11%)**
UMHP	28	13	8	9	0	**58 (10%)**
Total	**345 (58%)**	**130 (22%)**	**89 (15%)**	**28 (5%)**	**0 (0%)**	**592**

MCO results demonstrate that 345 or 38% of the telephone numbers provided by the MCOs did not reach the intended provider, and 130 or 14% of the telephone numbers were unanswered. These two categories contributed to the majority of unsuccessful contacts due to "No Contact." MPC had the highest number of unsuccessful calls (78) due to the number of calls that did not reach the intended provider, followed by MSFC with 50 calls. MPC also had the highest number of calls that were unanswered at 46, followed by JMS, PPMCO, UHC and UMHP each having 13 unanswered calls. MSFC had the highest number of calls reaching a voicemail (20).

Table 68. CY 2019 MCO Result of Unsuccessful Contacts Due to "PCP Response"

CY 2019 MCO Unsuccessful Contacts Due to "PCP Response"					
MCO	**Wrong Location Listed for Provider**	**Not a PCP**	**Does Not Accept Insurance**	**Refused to Participate**	**MCO Total**
ABH	8	0	13	3	**24 (8%)**
ACC	12	1	8	2	**23 (8%)**
JMS	26	0	12	1	**39 (13%)**
KPMAS	2	0	29	0	**31 (10%)**
MPC	30	0	2	8	**40 (13%)**
MSFC	35	0	6	0	**41 (13%)**
PPMCO	33	0	15	1	**49 (16%)**
UHC	11	1	13	0	**25 (8%)**
UMHP	26	0	7	1	**34 (11%)**
Total	**183 (60%)**	**2 (0%)**	**105 (35%)**	**16 (5%)**	**306**

MCO results demonstrate that the majority (183 or 20%) of unsuccessful contacts due to "PCP Response" were because the wrong location was listed for the provider. An additional 105 contacts, or 12% of the unsuccessful contacts, were because the PCP did not accept the insurance. PPMCO had the

highest number of total unsuccessful calls (49) due to the wrong location being listed for the provider along with provider not accepting the insurance. MSFC had 41 unsuccessful calls, with the majority (35) identified as wrong location listed for the provider, followed closely by MPC (30) and UMHP (26).

MCO-Specific Results for Accuracy of PCP Information

MCO-specific results from the successful contacts for the accuracy of PCP information are presented in Table 69.

Table 69. CY 2019 MCO Results from Successful Contacts for Accuracy of PCP Information

CY 2019 MCO Successful Contacts for Accuracy of PCP Information				
MCO	**Successful Contacts**	**Accurate PCP Information Provided**	**Accepts Listed MCO**	**Accepts New Medicaid Patients**
ABH	128	117 (91%)	128 (100%)	122 (95%)
ACC	163	149 (91%)	162 (99%)	138 (85%)
JMS	100	93 (93%)	100 (100%)	80 (80%)
KPMAS	114	114 (100%)	114 (100%)	110 (96%)
MPC	73	62 (85%)	72 (99%)	64 (88%)
MSFC	118	105 (89%)	118 (100%)	101 (86%)
PPMCO	144	133 (92%)	142 (99%)	123 (85%)
UHC	151	144 (95%)	151 (100%)	131 (87%)
UMHP	148	138 (93%)	147 (99%)	128 (86%)
TOTAL	**1,139**	**1,055 (93%)**	**1,134 (100%)**	**997 (88%)**

Results demonstrated that the accuracy of PCP information, such as name, address, and telephone numbers for successful contacts ranged between 85% and 100%. One MCO (KPMAS) had an accuracy rate of 100%. PCPs reporting that they accepted the listed MCO ranged from 99% to 100%, with five MCOs (ABH, JMS, KPMAS, MSFC, and UHC) results at 100%. PCPs that reported accepting new Medicaid patients ranged from 80% (JMS) to 96% (KPMAS).

MCO-Specific Results for Compliance with Appointment Requirements

MCO-specific results for compliance with routine and urgent care appointment time frame requirements are presented in Table 70.

Table 70. CY 2019 MCO Results for Compliance with Appointment Requirements

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Compliance with Routine Care Appointment Time Frame (within 30 Days)										
Compliant with Time Frame	100%	100%	80%	98%	93%	92%	83%	78%	100%	91%
# of Wait Days (Average)	7	7	17	4	11	11	18	18	8	12
# of Wait Days (Range)	0-28	0-30	0-95	0-45	0-56	0-70	0-135	0-131	0-30	0-135
Compliance with Urgent Care Appointment Time Frame (within 48 Hours)										
Appointment Available w/ Requested PCP At Same Location w/48 hours	81%	66%	74%	75%	71%	64%	72%	63%	76%	71%
Appointment Available w/ Another PCP At Same Location w/48 hours	18%	29%	22%	19%	22%	25%	17%	21%	22%	22%
COMPLIANCE W/ URGENT CARE APPOINTMENT	**99%**	**96%**	**96%**	**94%**	**93%**	**90%**	**89%**	**84%**	**98%**	**93%**

*Underline denotes that the minimum compliance score of 80% set by MDH is unmet.

Results for compliance with routine care appointments within 30 days ranged from 78% (UHC) to 100% (ABH, ACC, and UMHP). The average wait time for a routine care appointment ranged from 4 days (KPMAS) to 18 days (PPMCO and UHC). UHC's compliance score for routine appointments within 30 days was below the minimum compliance score set by MDH at 80%. A corrective action plan (CAP) is required to improve compliance with routine care appointment time frames.

Results for compliance with urgent care appointments within 48 hours with the PCP surveyed or another PCP at the same location ranged from 84% (UHC) to 99% (ABH).

Results for PCPs that provided an alternative option when urgent care appointments were not available with the PCP surveyed or another PCP at the same location ranged from 1% (ABH) to 31% (UHC). Four MCOs (ABH, ACC, JMS, and UMHP) had PCPs that did not provide any options when urgent care appointments were unavailable.

MCO-Specific Results for Validation of Online Provider Directories

MCO-specific results for the validation of Online Provider Directories are presented in Table 71.

Table 71. CY 2019 MCO Results for Validation of Online Provider Directories

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
PCP Listed in Online Directory	94%	93%	98%	99%	78%	97%	99%	95%	97%	**95%**
PCP's Practice Location Matched Survey Response	81%	85%	94%	91%	64%	91%	99%	90%	94%	**89%**
PCP's Practice Telephone Number Matched Survey Response	89%	89%	96%	99%	62%	97%	98%	95%	91%	**92%**
Specifies that PCP Accepts New Medicaid Patients and Matches Survey Response	84%	79%	74%	72%	68%	89%	47%	2%	74%	**64%**
Specifies Age of Patients Seen	94%	93%	98%	99%	78%	100%	99%	95%	0%	**95%**
Specifies Languages Spoken By PCP	94%	93%	98%	99%	78%	100%	99%	94%	24%	**77%**
Specifies Practice Accommodations for Patients with Disabilities	70%	93%	9%	99%	78%	97%	13%	92%	0%	**61%**

*Underline denotes that the minimum compliance score is unmet.

Validation of the MCO online provider directories demonstrates:

- Rates for PCPs being listed in the online provider directories ranged from 78% (MPC) to 99% (KPMAS and PPMCO).
- Rates for the PCP's practice location matching the survey response ranged from 64% (MPC) to 99% (PPMCO).
- Rates for the PCP's telephone number matching the survey response ranged from 62% (MPC) to 99% (KPMAS).
- Rates for the directories specifying that the PCP accepts new Medicaid patients ranged from 2% (UHC) to 89% (MSFC).
- Rates for the directories specifying the ages seen by the PCP ranged from 0% (UMHP) to 100% (MSFC).
- Rates for the directories specifying the languages spoken by the PCP ranged from 24% (UMHP) to 100% (MSFC).
- Rates for the directories specifying the practice has accommodations for patients with disabilities ranged from 0% (UMHP) to 99% (KPMAS).

The minimum compliance score is 80% for the validation of online directories. Based on the CY 2019 results, eight MCOs are required to submit CAPs to Qlarant to correct PCP details noted in the online provider directory.

Conclusion

Significant CY 2019 survey process improvements facilitated an easier and less burdensome call to the provider. The changes allowed for a streamlined data collection process with reporting categories that produced an efficient and accurate data analysis.
Several barriers to network adequacy have been identified through conducting the surveys. Primarily, the inaccuracy of PCP contact information does not allow for members to easily access PCPs. Once a PCP is identified, it is difficult for members to contact their PCP for appointments. Additionally, staff at provider offices and online provider directories are not accurately communicating or reflecting whether or not they are accepting new Medicaid patients, which prevents enrollees from scheduling appointments with their preferred PCP. Considering MDH relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, these barriers warrant further investigation to determine if they impact network adequacy determinations. Such barriers may cause members who are unable to contact their PCP to seek care from urgent care facilities or emergency departments. Furthermore, members may delay annual preventative care visits for themselves or their children if they are unable to contact a PCP and/or obtain an appointment.

MDH set a minimum compliance score of 80% for the Network Adequacy Assessment. Based on the CY 2019 results, eight of the MCOs are required to submit CAPs to Qlarant to correct PCP details noted in the online provider directory. Additionally, UHC is required to complete a CAP to improve compliance with routine care appointment time frames.

Recommendations

The following recommendations are resultant of the CY 2019 surveys.

MCO Recommendations

- **Provide complete and accurate PCP information** and current URLs to online provider directories.
- **Notify PCPs of the NAV survey time frame** and promote participation one month before the surveys begin.
- **Refrain from completing MCO-specific provider surveys** within the same time frame as the MD NAV surveys to optimize PCP participation.
- **Frequently inspect online provider directories** to ensure the status of accepting new Medicaid patients is accurate and communicate this information with provider office staff.
- **Ensure that MCO's online provider directory specifies the following information** for each PCP:
  - Whether they accept new Medicaid patients
  - The ages of patients served
  - All languages spoken by the PCP
  - That the practice location has accommodations for patients with disabilities, including offices, exam room(s), and equipment.
- **Clearly indicate appointment call center telephone numbers** in online directory webpages so members know what number to contact to schedule appointments for those MCOs with centralized scheduling processes.
- **Add the customer service department's telephone number on the bottom of each directory page** for member reference.

- **Share how current the information is in the online directory** by adding a date at the bottom of each page.

MDH Recommendations

- **Promote standards/best practices** for MCOs' online provider directory information, including:
  - Use of consistent lexicon for provider detail information
  - Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks
  - List all languages spoken by providers, including English
  - List age ranges of patients served. Members, especially parents of children or adolescents, rely on this information when searching for PCPs.
  - Update online directories identifying accommodations for patients with disabilities, including offices, exam room(s), and equipment in a manner that is easily accessible.
  - Require all directories to state the date the information was last updated for easy monitoring
- **Continue to monitor MCO complaints** regarding the use of urgent care and emergency department services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.
- **Review and revise COMAR 10.67.05.07(A)(3)(iii)** to specify which provider types are required to schedule patients within 48 hours of an appointment request.

Healthcare Effectiveness Data and Information Set (HEDIS)[7]

Introduction

Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result calculation to promote a high degree of standardization of HEDIS measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit™. To ensure audit consistency, only NCQA-licensed organizations using NCQA-certified Auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

Maryland Department of Health (MDH) contracted with MetaStar, Inc. (MetaStar), a NCQA-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results. For HEDIS 2019, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2018 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to MDH's priorities and goals.

Accreditation

All managed care organizations participating in the HealthChoice program as of January 1, 2013, were required to be accredited by the NCQA no later than January 1, 2015, to comply with COMAR 10.67.03.08.

Accreditation is based on a combination of adherence to accreditation standards with a comprehensive evaluation and analysis of clinical performance and consumer experience. A total of 100 points is possible with 50 points based on standards and 50 points on performance and consumer experience. The accreditation levels are used to rate the quality of care provided by health plans to their members. Based on the total number of points achieved, NCQA assigns a level of accreditation, as described in Table 72.

Table 72. NCQA Accreditation Levels*

Level	Description
Excellent	NCQA awards its highest status of Excellent to organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS/CAHPS results are in the highest range of national performance.
Commendable	NCQA awards an accreditation status of Commendable for service and clinical quality that meet NCQA's rigorous requirements for consumer protection and quality improvement.

[7] Information in Section X is provided by MDH's contractor, MetaStar, Inc.'s reports: *Statewide Executive Summary Report HealthChoice Participating Organizations HEDIS 2019 Results* and *Statewide Analysis Report HealthChoice Participating Organizations HEDIS 2019 Results.*

Level	Description
Accredited	NCQA awards an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protections and quality improvement.
Provisional	NCQA awards an accreditation status of Provisional to organizations with programs for service and clinical quality that meet some basic requirements for consumer protection and quality improvement.
Interim	NCQA awards an accreditation status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a new review within 18 months to demonstrate they have executed those processes effectively.
Denied	NCQA awards a status of Denied Accreditation to organizations whose programs for service and clinical quality do not meet NCQA requirements.

* Source: https://reportcards.ncqa.org

Current accreditation status for all HealthChoice organizations is listed below in Table 73.

Table 73. HealthChoice MCO NCQA Accreditation Status

HealthChoice Organization Name	Accreditation Status
Aetna Better Health of Maryland (ABH)*	Interim
AMERIGROUP Community Care (ACC)	Commendable
Jai Medical Systems (JMS)	Excellent
Kaiser Permanente of the Mid-Atlantic States (KPMAS)	Excellent
Maryland Physicians Care (MPC)	Accredited
MedStar Family Choice (MSFC)	Commendable
Priority Partners (PPMCO)	Commendable
UnitedHealthcare (UHC)	Commendable
University of Maryland Health Partners (UMHP)	Accredited

*ABH joined HealthChoice in October 2017.

Recent accreditation reviews resulted in two of the HealthChoice MCOs (JMS and KPMAS) receiving NCQA's highest accreditation rating of excellent, and three of the MCOs (ACC, MSFC, and PPMCO) receiving the second highest rating of commendable. JMS and KPMAS are the only two health plans in the nation with the top rating of 5.0.

Measures Designated for Reporting

Annually, MDH determines the set of measures required for HEDIS reporting. MDH selects these measures because they provide meaningful MCO comparative information and they measure performance pertinent to MDH's priorities and goals.

Measures Selected by MDH for HealthChoice Reporting

MDH required HealthChoice managed care organizations to report 45 HEDIS measures for services rendered in CY 2018. The required set includes a first year HEDIS measure: Risk of Continued Opioid Use (COU).

Table 74. Measures Selected by MDH for HealthChoice Reporting

NCQA Domains	HEDIS Measures
Effectiveness of Care (EOC) - 29 Measures	• Childhood Immunization Status (CIS) • Immunizations for Adolescents (IMA) • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) • Comprehensive Diabetes Care (CDC), all indicators except HbA1c Control (<7.0%) • Statin Therapy for Patients with Diabetes (SPD) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) • Appropriate Testing for Children with Pharyngitis (CWP) • Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) • Chlamydia Screening in Women (CHL) • Use of Imaging Studies for Low Back Pain (LBP) • Annual Monitoring for Patients on Persistent Medications (MPM) • Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) • Medication Management for People with Asthma (MMA) • Controlling High Blood Pressure (CBP) • Adult BMI Assessment (ABA) • Asthma Medication Ratio (AMR) • Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) • Pharmacotherapy Management of COPD Exacerbation (PCE) • Persistence of Beta Blocker Treatment after a Heart Attack (PBH) • Statin Therapy for Patients with Cardiovascular Disease (SPC) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) • Lead Screening in Children (LSC) • Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

NCQA Domains	HEDIS Measures
	• Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) • Use of Opioids at High Dosage (UOD) • Use of Opioids from Multiple Providers (UOP) • Risk of Continued Opioid Use (COU)*
Access/Availability of Care (AAC) - 3 Measures	• Adults' Access to Preventive/Ambulatory Health Services (AAP) • Children and Adolescents' Access to Primary Care Practitioners (CAP) • Prenatal and Postpartum Care (PPC)
Utilization and Risk Adjusted Utilization (URR) - 8 Measures	• Well-Child Visits in the First 15 Months of Life (W15) • Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Ambulatory Care: Total (AMBA) o Report Only "a" Level of Measure (Total) • Frequency of Selected Procedures (FSP) • Inpatient Utilization- Total (IPUA) o Report Only "a" Level of Measure (Total) • Antibiotic Utilization (ABXA) o Report Only "a" Level of Measure (Total) • Plan All-Cause Readmissions (PCR)
Health Plan Descriptive Information - 6 Measures	• Board Certification (BCR) • Enrollment by Product Line: Total (ENPA) o Report Only "a" Level of Measure (Total) • Enrollment by State (EBS) • Language Diversity of Membership (LDM) • Race/ Ethnicity Diversity of Membership (RDM) • Total Membership (TLM)

* First year measure, not publicly reported for HEDIS 2019.

In addition to the measures identified, two rates were collected from the Adults CAHPS Survey:

- Flu Vaccinations for Adults Ages 18 - 64 (FVA)
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC) (Advising Smokers and Tobacco Users to Quit Rate Only)

No Benefit (NB) Measure Designations

The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and MCOs do not have access to the data. So that MCOs are not penalized, NCQA allows the MCOs to report these measures with a NB designation. The following 14

measures are reported with an NB designation and do not appear in the measure specific findings of this report.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Follow-up Care after Hospitalization for Mental Illness (FUH)
- Follow-up After Emergency Department (ED) Visit for Metal Illness (FUM)
- Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA)
- Mental Health Utilization (MPT)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services: Total (IADA)

HEDIS Methodology

MetaStar follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2019 Volume 2: Technical Specifications.*

Data collection. The health plan pulls together all data sources to include administrative data, supplemental data, and medical record data, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. The three data sources that may be utilized are defined below:

Administrative Data. Administrative data refers to data that is collected, processed, and stored in automated information systems. Administrative data includes enrollment or eligibility information, claims information, and managed care encounters. Examples of services captured on claims and encounters include hospital and other facility services, professional services, prescription drug services, and laboratory services. Administrative data are readily available, are inexpensive to acquire, are computer readable, and typically encompass large populations.

Supplemental Data. NCQA defines supplemental data as atypical administrative data, (i.e., not claims or encounters). Sources include immunization registry files, laboratory results files, case management databases, and electronic health record databases. There are two distinct categories of supplemental data with varying requirements for proof-of-service. The most stable form is Standard Supplemental Data which is from a database with a constant form that does not change over time. Non-standard Supplemental Data is in a less stable form and may be manipulated by human intervention and interaction. Non-standard Supplemental Data must be substantiated by proof-of-service documentation and is subject to primary source verification yearly.

Medical Record Data. Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid methodology. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records is needed. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by MDH for HEDIS reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

Table 75 shows actual HEDIS 2019 measures collected by use of the administrative or hybrid method. A HealthChoice organization chooses the administrative versus hybrid method based on available resources, as the hybrid method takes significant resources to perform.

Table 75. MCO Use of Administrative or Hybrid Method

Measure List	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
ABA – Adult BMI Assessment	H	H	H	H	H	H	H	H	H
AWC – Adolescent Well-Care Visits	H	H	H	H	H	H	H	H	H
CBP – Controlling High Blood Pressure	H	H	H	H	H	H	H	H	H
CCS – Cervical Cancer Screening	H	H	H	H	H	H	H	H	H
CDC – Comprehensive Diabetes Care	H	H	H	H	H	H	H	H	H
CIS – Childhood Immunization Status	H	H	H	H	H	H	H	H	A
IMA– Immunizations for Adolescents	H	H	H	H	H	H	H	H	H
LSC – Lead Screening in Children	H	A	H	H	H	H	A	A	H
PPC – Prenatal and Postpartum Care	H	H	H	H	H	H	H	H	H
W15 – Well-Child Visits in the First 15 Months of Life	H	H	H	H	H	H	A	H	H
W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	H	H	H	H	H	H	H	H	H
WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	H	H	H	H	H	H	H	H	H

H—Hybrid; A—Administrative

HEDIS Audit Protocol

The HEDIS auditor follows *NCQA's HEDIS 2019 Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures*. The main components of the audit are described below.

Pre-Onsite Teleconference. A conference call is held two to four weeks prior to the onsite visit to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS.

HEDIS Roadmap Review. The HEDIS "Roadmap" is an acronym representing the HEDIS Record of Administration, Data Management, and Processes. The Roadmap is a comprehensive instrument designed by NCQA to collect information from each HealthChoice plan regarding structure, data collection and processing, and HEDIS reporting procedures. The health plan completes and submits the Roadmap to the auditing organization by January 31st of each reporting year. The auditor reviews the HEDIS Roadmap prior to the onsite audit in order to make preliminary assessments regarding Information Systems compliance and to identify areas requiring follow-up at the onsite audit.

Information Systems (IS) Standards. The onsite portion of the HEDIS Audit expands upon information gleaned from the HEDIS Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards measure how the organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data. IS standards describe the minimum requirements for information systems and processes used in HEDIS data collection and provides the foundation on which the auditor assesses the organization's ability to report HEDIS data accurately, completely, and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, to make a determination about the soundness and completeness of data to be used for HEDIS reporting.

HEDIS Measure Determination (HD) Standards. The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS Technical Specifications and report-production protocols. The auditor confirms the use of NCQA-certified measure software. The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS results for algorithmic compliance and performs benchmark comparison against NCQA-published means and percentiles.

Medical Record Review Validation (MRRV). The HEDIS audit includes a process to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a convenience sample of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS Compliance Audit. It ensures that medical records reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like-measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS hybrid specifications, (i.e., the member is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5

percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

Audit Designations. An NCQA audit results in audited rates or calculations at the measure or indicator level and indicates whether the measures can be publicly reported. All measures selected for reporting must have a final audited result. A measure selected for reporting or required by a state or federal program can receive an audit designation of biased rate (BR) if the auditor determines it is not reportable. The auditor approves the rate or result calculated by the HealthChoice organization for each measure included in the HEDIS report. Table 76 shows the audit designations of audit results, excerpted from *Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures.*

Table 76. HEDIS Audit Designations

Designation	Description
R	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
NB	Benefit Not Offered. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported. The organization chose not to report the measure. (An organization may exercise this option only for those measures not included in the measurement set required by MDH.)
NQ	Not Required. The organization was not required to report the measure.
BR	Biased Rate. The calculated was materially biased.
UN	Un-Audited. The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g. measured collected using electronic clinical data systems).

Note: The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and HealthChoice Organizations do not have access to the data. NCQA allows the MCOs to report these measures with a NB designation so that they are not penalized.

Bias Determination. Auditors perform a year-to-year rate change analysis using the NCQA means and percentiles to conduct reasonability assessment of the preliminary and final rates. The auditor assigns a biased rate to a measure whose rate has changed beyond the bias thresholds or is either well below or well above the mean rate, and the plan cannot justify the change. NCQA defines four bias determination rules, applied to specific measures. These are explained in Appendix 9 of *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

Final Audit Opinion. At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measure-specific rates/results and comments.

Measure Specific Findings Explanation

Three metrics are calculated to accompany the MCO–specific scores:

Maryland Average Reportable Rate (MARR). The MARR is an average of HealthChoice organizations' rates as reported to NCQA. In most cases, nine organizations contributed a rate to the average. Where

one or more organizations reported NA instead of a rate, the average consisted of fewer than nine component rates.

National HEDIS Mean (NHM) and NCQA Benchmarks. The NHM and Benchmarks are taken from NCQA's HEDIS Audit Means, Percentiles and Ratios—Medicaid, released each year to each reporting organization along with a data use license that outlines how this data can be used. The NCQA data set gives prior years' rates for each measure displayed as the mean rate and the benchmarked rate at the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles. NCQA averages the rates of all organizations submitting HEDIS results, regardless of the method of calculation (administrative or hybrid). NCQA's method is the same as that used for the MARR, but on a larger scale.

Year-to-year trending is possible when specifications remain consistent from year-to-year. (Expected updates to industry-wide coding systems are not considered specification changes.) For each measure, the tables display up to five years of results, where available.

When there are significant changes to the measure specifications so that data cannot be compared to the prior year, NCQA will determine there to be a break in trending. For HEDIS 2019, NCQA determined a trending break for CBP, UOD, and the UOP measures. The measures that have been impacted by a trending break are noted beneath each table.

Prior years' results are retained in the trending tables, regardless of specification changes. Text in italics notes when prior years' results fall under different specifications. Performance trends at the organization level are compared with the trends for the MARR and the NHM for the same measurement year. Rates are rounded to one decimal point from the rate/ratio reported to NCQA. This rounding corresponds to the rounding used by NCQA for the NHM.

Sources of Accompanying Information

Description. The source of the information is NCQA's *HEDIS 2019 Volume 2: Technical Specifications.*

Rationale. Sources for each rationale are identified at the end of each measure section in the full report.

Summary of Changes for HEDIS 2019. The source of the text is the *HEDIS 2019 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS 2019 Volume 2: October Technical Update.*

HEDIS Year 2019 Highlights

- HEDIS 2019 was ABH's first year reporting Maryland Medicaid data. Due to continuous enrollment criteria, thirty-seven measures and/or submeasures found in the Statewide Analysis Report had denominators of less than thirty and therefore are not included in the MARR.
- All MCOs that were able to report the rate for Chlamydia Screening (CHL), Childhood Immunization Status (CIS) Combo 2 & 3, Appropriate Testing for Children with Pharyngitis (CWP), Lead Screening in Children (LSC), and Timeliness of Prenatal Care (PPC) were above the national HEDIS mean.

- The Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) MARR decreased by more than 5% for measurement year 2018. Many MCOs had significant decreases in the reported rate with one MCO experiencing an 18.8% decline from the prior year. It should be noted, that the eligible populations are relatively small for each MCO, which can result in volatility of the reported rate.

Year-To-Year Changes

Table 77 shows the number of MCOs that experienced a lower or higher change in HEDIS rates from service year 2017 to 2018. The change in the MARR (2019 rate minus 2018 rate) and the change in the NHM (2018 rate minus 2017 rate) place Maryland HealthChoice organization trends in perspective. It should be considered when reviewing these figures that the NHM is retrospective while the MARR is for the current season. A comparison of change in the MARR vs. change in the NHM may be indicative of a specification change or reflect other lability considerations. For measures where a lower rate indicates better performance (single asterisk), the number of lower performing organizations appears in the higher column and the number of higher performing organizations appear in the lower column. New measures or indicators with no trendable history are not included in this analysis of change. HEDIS 2018 results of *NA* are not included in these results. Rates that stayed the same from last year and did not increase or decrease are not included in this table.

Table 77. Changes in HEDIS Rates from 2018 to 2019

HEDIS Measure	Lower	Higher	MARR change	NHM change
Adult BMI Assessment (ABA)	2	6	0.40%	3.80%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	1	7	1.70%	3.40%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	4	4	1.60%	-0.10%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	4	4	1.40%	-0.30%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	4	4	1.30%	0.30%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	4	4	2.60%	0.90%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	1	7	1.30%	2.00%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	4	4	2.40%	1.00%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	1	7	1.10%	2.20%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	3	5	2.10%	2.20%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	2	6	1.90%	2.10%

HEDIS Measure	Lower	Higher	MARR change	NHM change
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	1	7	2.10%	2.50%
Immunizations for Adolescents (IMA) – Combination 2 (Meningococcal, Tdap, HPV)	2	6	2.80%	11.90%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*	6	2	-0.90%	-0.20%
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)**	4	4	-1.10%	NA
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	5	3	-1.00%	0.80%
Adolescent Well-Care Visits (AWC)	3	5	-2.60%	2.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile - Total Rate	3	5	1.10%	3.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	3	4	0.10%	1.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	4	3	1.60%	3.00%
Appropriate Testing for Children with Pharyngitis (CWP)	2	6	-0.20%	4.20%
Lead Screening in Children (LSC)	0	8	5.10%	1.30%
Medication Management for People with Asthma (MMA) – Total 50% of treatment period	4	4	1.40%	1.70%
Medication Management for People with Asthma (MMA) – Total 75% of treatment period	4	4	0.80%	2.00%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	2	6	1.40%	0.50%
Asthma Medication Ratio (AMR)	5	3	-1.20%	0.30%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	6	1	-4.80%	0.00%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	5	3	-0.50%	2.30%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	2	6	2.00%	0.80%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	2	6	0.10%	-0.10%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	2	6	-0.10%	-0.50%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	6	2	-0.20%	0.10%

HEDIS Measure	Lower	Higher	MARR change	NHM change
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	4	4	0.00%	0.10%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	1	7	-0.90%	-0.50%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	3	5	-1.20%	-0.10%
Breast Cancer Screening (BCS)	4	4	-0.40%	-0.60%
Cervical Cancer Screening (CCS)	2	6	-0.30%	1.40%
Chlamydia Screening in Women (CHL) – Age 16 – 20 years	3	5	0.70%	0.30%
Chlamydia Screening in Women (CHL) – Age 21 – 24 years	4	4	-0.90%	0.50%
Chlamydia Screening in Women (CHL) – Total (16 – 24) years	3	5	-0.20%	0.30%
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	2	6	1.20%	-0.60%
Prenatal and Postpartum Care (PPC) – Postpartum Care	3	5	1.00%	0.60%
Controlling High Blood Pressure (CBP)***	NA	NA	NA	NA
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	4	2	-5.60%	-1.40%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	0	1	13.30%	0.70%
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Received Statin Therapy – Total	4	4	-0.10%	1.40%
Statin Therapy for Patients with Cardiovascular Disease (SPC) –Statin Adherence 80% - Total	2	6	2.30%	2.10%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	3	5	0.80%	0.90%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	3	5	0.00%	-2.80%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	5	3	-0.30%	2.30%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	5	3	-3.70%	2.30%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	3	5	0.80%	0.20%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	5	3	-1.40%	3.00%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	1	6	5.90%	0.70%
Statin Therapy for Patients with Diabetes (SPD) —Received Statin Therapy	1	7	1.00%	1.30%
Statin Therapy for Patients with Diabetes (SPD) – Statin Adherence 80%	1	7	3.40%	-0.30%
Use of Imaging Studies for Low Back Pain (LBP)	2	6	1.00%	1.20%

HEDIS Measure	Lower	Higher	MARR change	NHM change
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	4	4	2.70%	0.80%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	3	5	-0.10%	0.20%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics	2	6	-0.40%	0.40%
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	3	5	-0.20%	0.50%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	4	4	-14.50%	1.45%
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months 3	8	0	-3.30%	-3.00%
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 F	0	8	9.60%	0.00%
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 M	0	8	2.80%	1.00%
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 0-9 T	6	2	-6.30%	-2.00%
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 10-19 T	5	3	-1.80%	1.00%
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F	7	1	-4.40%	-6.00%
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45-64 F	5	3	-4.20%	-2.00%
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30-64 M	6	2	-0.80%	0.00%
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45-64 F	5	3	-1.50%	-1.00%
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30-64 M	6	2	0.30%	-1.00%
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45-64 F	7	1	-9.60%	-1.00%
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 F	3	5	4.60%	-1.00%
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45 - 64 M	6	2	-9.70%	-4.00%
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 15 - 44 F	3	5	0.40%	0.00%
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 45 - 64 F	4	4	2.00%	0.00%
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 15 - 44 F	4	4	0.70%	0.00%

HEDIS Measure	Lower	Higher	MARR change	NHM change
Frequency of Selected Procedures (FSP) – Lumpectomy/1000 MM 45 - 64 F	5	3	3.10%	-2.00%
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM	8	0	-45.50%	-14.00%
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay	3	5	21.90%	14.00%
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics	8	0	-5.10%	-4.00%
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script	5	3	2.00%	-10.00%
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern	8	0	-2.30%	-2.00%
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics	7	1	-0.30%	-1.40%

* A lower rate indicates better performance.
** Not a HEDIS sub-measure; MetaStar is calculating for MDH trending purposes.
***Break in trending for HEDIS 2019 due to revised specifications.
Rates that showed a decrease are identified in red. Rates that showed an increase are identified in green.

Three Year Trending

Table 78 shows MCOs that demonstrated incremental increases in performance scores over the past three years (2019 less 2017 for those plans that reported all three years). The analysis only shows a trend toward improvement. It does not indicate superior performance. For measures where a lower rate indicates better performance (single asterisk), the table shows organizations having a decrease in performance score over the past three years.

Table 78. HEDIS Measures Incremental Increases in Performance

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adult BMI Assessment (ABA)		X	X			X	X		X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)		X	X	X	X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 2				X					X
Childhood Immunization Status (CIS) – Combination 3				X					X
Childhood Immunization Status (CIS) – Combination 4				X					X
Childhood Immunization Status (CIS) – Combination 5				X					X

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Childhood Immunization Status (CIS) – Combination 6		X		X		X	X		X
Childhood Immunization Status (CIS) – Combination 7				X					X
Childhood Immunization Status (CIS) – Combination 8		X		X		X	X		X
Childhood Immunization Status (CIS) – Combination 9		X		X		X	X		X
Childhood Immunization Status (CIS) – Combination 10		X		X		X	X		X
Immunizations for Adolescents (IMA) – Combination 1		X	X	X		X	X	X	X
Immunizations for Adolescents (IMA) – Combination 2		X	X	X	X	X	X	X	X
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*							X	X	
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or more visits**			X	X	X				X
Well-Child Visits in the Third, Fourth, Fifth. and Sixth Years of Life (W34)			X	X				X	X
Adolescent Well-Care Visits (AWC)		X		X				X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile - Total Rate			X		X	X	X	X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate			X	X		X		X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate			X		X	X		X	X
Appropriate Testing for Children with Pharyngitis (CWP)		X	X	X	X	X	X	X	X
Lead Screening in Children (LSC)		X		X	X		X	X	X
Medication Management for People with Asthma (MMA) – Total 50% of treatment period		X		X		X	X	X	X
Medication Management for People with Asthma (MMA) – Total 75% of treatment period		X		X		X	X	X	X

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Appropriate Treatment for Children with Upper Respiratory Infection (URI)		X			X	X	X	X	X
Asthma Medication Ratio (AMR)			X	X					X
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)							X		
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate			X	X		X	X		
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate		X	X	X	X	X	X		
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12– 24 months			X	X	X	X	X	X	X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months – 6 years		X		X		X			X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7 – 11 years									X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12 – 19 years		X							
Adults' Access to Preventive/Ambulatory Health Services (AAP)– Age 20 – 44 years						X			X
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45 – 64 years				X		X			X
Breast Cancer Screening (BCS)		X	X			X	X		X
Cervical Cancer Screening (CCS)		X	X	X		X	X		X
Chlamydia Screening in Women (CHL) – Age 16 –2 0 years		X		X	X	X	X	X	X
Chlamydia Screening in Women (CHL) – Age 21 – 24 years		X		X		X		X	X
Chlamydia Screening in Women (CHL) – Total (16 – 24) years		X		X		X		X	X
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care			X			X			X
Prenatal and Postpartum Care (PPC) – Postpartum Care		X	X			X			X
Controlling High Blood Pressure (CBP)***									
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					X				

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)		X		X	X	X	X	X	
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy – Total		X	X		X		X	X	X
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Statin Adherence 80% - Total		X	X	X	X	X	X	X	X
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing		X	X	X					X
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)			X	X	X	X	X	X	
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)			X	X					X
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed		X		X		X		X	X
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy		X			X				X
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)		X	X			X			X
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		X	X		X	X		X	X
Statin Therapy for Patients with Diabetes (SPD) – Received Statin Therapy		X	X		X	X	X	X	X
Statin Therapy for Patients with Diabetes (SPD) – Statin Adherence 80%				X		X	X	X	X
Use of Imaging Studies for Low Back Pain (LBP)			X	X	X	X	X	X	X
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)			X		X	X	X	X	X
Annual Monitoring for Patients on Persistent Medications (MPM) – – Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)									X
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics						X			X
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate						X			X

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months									X
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months									
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery/1000 MM 45-64 F		X		X	X	X	X	X	X
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery/1000 MM 45-64 M		X		X	X	X	X	X	X
Frequency of Selected Procedures (FSP) – Tonsillectomy/000 MM 0-9 T			X			X			
Frequency of Selected Procedures (FSP) – Tonsillectomy/1000 MM 10 – 19 T		X							
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F									
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45 – 64 F		X	X				X		
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30 - 64 M			X						
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45 - 64 F				X			X		
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30 - 64 M			X						
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45 - 64 F				X					X
Frequency of Selected Procedures (FSP) – Back Surgery/1000 MM 45 - 64 F			X				X	X	X
Frequency of Selected Procedures (FSP)– Back Surgery/1000 MM 45-64 M									X
Frequency of Selected Procedures (FSP) – Mastectomy/1000 MM 15 - 44 F			X	X	X	X	X		X
Frequency of Selected Procedures (FSP) – Mastectomy/1000 MM 45-64 F			X		X	X	X		X
Frequency of Selected Procedures (FSP) – Lumpectomy/1000 MM 15 - 44 F		X	X			X			X
Frequency of Selected Procedures (FSP) –						X	X		X

HEDIS Measure	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Lumpectomy /1000 MM 45 - 64 F									
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges/1000 MM									X
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay		X	X		X	X	X	X	X
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics									
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script				X				X	
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern									
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics			X						
Totals	**0**	**38**	**38**	**44**	**26**	**48**	**39**	**33**	**64**

*A lower rate indicates better performance.
**Custom measure made up of 5 visits and 6 or more visits combined
***Break in trending for HEDIS 2019 due to revised specifications

Consumer Assessment of Healthcare Providers and Systems (CAHPS)[8]

Introduction

COMAR 10.67.04.03B(4) requires that all HealthChoice MCOs participate in the annual CAHPS Survey. MDH began contracting with the Center for the Study of Services (CSS), an NCQA–certified survey vendor, in 2017 to conduct its survey. CSS administers this survey to a random sample of eligible adult and child members enrolled in HealthChoice via mixed methodology (mail with telephone follow–up), per NCQA protocol. All nine MCOs participated in the HealthChoice CAHPS 2019 survey based on services provided in CY 2018.

2019 CAHPS 5.0H Medicaid Survey Overview

In 2019, the 5.0H version of the CAHPS Adult and Child Medicaid Satisfaction Surveys was used to survey the HealthChoice population about services provided in CY 2018. The survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow MDH to:

- Determine how well participating HealthChoice MCOs are meeting their members' expectations
- Provide feedback to the HealthChoice MCOs to improve quality of care
- Encourage HealthChoice MCO accountability
- Develop a HealthChoice MCO action plan to improve members' quality of care

Results from the CAHPS 5.0H survey summarize member satisfaction with their health care through ratings, composite measures, and question summary rates. In general, summary rates represent the percentage of respondents who chose the most positive response categories as specified by NCQA. Ratings and composite measures in the CAHPS 5.0H Adult and Child Medicaid Survey include:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision–Making

Five additional composite measures are calculated for the Children with Chronic Conditions (CCC) population:

- Access to Prescription Medicine
- Access to Specialized Services

[8] Information in Section XI is provided by MDH's contractor, Center for the Study of Services' report: *State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations Adult and Child Populations 2019 CAHPS 5.0H Member Experience Survey.*

- Getting Needed Information
- Personal Doctor Who Knows Child
- Coordination of Care for CCC

Survey Methodology

CSS administered the 2019 Health Plan CAHPS Survey in accordance with the NCQA methodology detailed in *HEDIS 2019, Volume 3: Specifications for Survey Measures* and *Quality Assurance Plan for HEDIS 2019 Survey Measures.* The NCQA-prescribed sample size consisted of 3,490 members for the Child Medicaid with CCC Measure version of the survey and 1,350 members for the Adult Medicaid version. Sample-eligible members were members who were 18 years of age or older (for the Adult version) or 17 years of age or younger (for the Child Medicaid with CCC Measure version) as of December 31, 2018; were currently enrolled; had been continuously enrolled for six months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid. The sample frame for the Child with CCC Measure survey included a pre-screen status code to identify children that were likely to have a chronic condition based on claim and encounter records. Using this code, a second sample was drawn from the child Medicaid CCC population, in addition to those members from the general child Medicaid population included in the initial sample.

Prior to sampling, CSS carefully inspected the member files and informed the MDH of any errors or irregularities found (such as missing address elements or subscriber numbers). Once the quality assurance process had been completed, CSS processed member addresses through the USPS National Change of Address service to ensure that the mailing addresses were up-to-date. The final sample was generated following the NCQA-specified methodology, with no more than one member per household selected to receive the survey. CSS assigned each sampled member a unique identification number, which was used to track their progress throughout the data collection process.

The appropriate health plan name and logo appeared on the materials that were sent to members. The outer envelope used for survey mailings was marked “RESPONSE NEEDED” or “FINAL REMINDER – PLEASE RESPOND,” depending on the mailing wave. Each survey package included a postage-paid return envelope. In addition to English, members had the option to complete the survey in Spanish using a telephone request line. All of the elements of the survey package were approved by NCQA prior to the initial mailing.

The MDH elected to use NCQA’s mixed survey administration methodology, which involved two survey mailings with telephone follow-up. Data collection closed on May 14, 2019. Survey results were submitted to NCQA on May 30, 2019.

Member Dispositions and Response Rates

A detailed breakdown of sample member dispositions is provided in Table 79 below. Tables 80 and 81 provide response rate information on each surveyed MCO by population type.

Table 79. Sample Dispositions Among Adult and Child Members

Disposition Group	Disposition Category	Adult	Child General Population
Ineligible	Deceased	4	3
	Does not meet eligibility criteria (1)	181	146
	Language barrier (3)	64	154
	Mentally/Physically incapacitated (4)	20	N/A
	Total Ineligible	**269**	**303**
Non–Response	Incomplete but eligible	174	255
	Refusal	374	724
	Maximum attempts made	8,820	9,866
	Added to Do Not Call (DNC) List (8)	70	84
	Total Non–Response	**9,438**	**10,929**

*Maximum attempts made include two survey mailings and a maximum of six call attempts

Table 80. Adult Survey Completes and Response Rate

HealthChoice MCO	Sample Size	Completes*	Response Rate
ABH	1,350	215	16.4%
ACC	1,350	258	19.6%
JMS	1,350	287	21.6%
KPMAS	1,350	274	20.9%
MPC	1,350	297	22.2%
MSFC	1,350	275	20.6%
PPMCO	1,350	293	22.1%
UHC	1,350	282	21.6%
UMHP	1,350	262	20.0%
Total HealthChoice MCOs	**12,150**	**2,443**	**20.6%**

*During the telephone follow–up, members had the option to complete the survey in either English or Spanish.

Table 81. Child Survey Completes and Response Rate

MCO	General Population	CCC Population	Sample Size Total	General Population Completes	CCC Population Completes	General Population Response Rate
ABH	1,650	53	1,703	346	51	21.8%
ACC	1,650	1,840	3,490	453	290	27.9%
JMS	1,650	849	2,499	286	136	17.5%
KPMAS	1,650	1,840	3,490	458	240	28.4%
MPC	1,650	1,840	3,490	417	369	25.7%

MCO	General Population	CCC Population	Sample Size Total	General Population Completes	CCC Population Completes	General Population Response Rate
MSFC	1,650	1,840	3,490	377	311	23.1%
PPMCO	1,650	1,840	3,490	444	394	27.6%
UHC	1,650	1,840	3,490	437	371	27.0%
UMHP	1,650	1,840	3,490	400	240	24.9%
Total	**14,850**	**13,782**	**28,632**	**3,618**	**2,402**	**24.9%**

*During the telephone follow-up, members had the option to complete the survey in either English or Spanish.

Survey Measures

Ratings

The CAHPS survey includes four global ***rating questions*** that ask respondents to rate the following items on a *0* to *10* scale:

- ***Rating of Personal Doctor*** (*0* = worst personal doctor possible; *10* = best personal doctor possible).
- ***Rating of Specialist Seen Most Often*** (*0* = worst specialist possible; *10* = best specialist possible)
- ***Rating of All Health Care*** (*0* = worst health care possible; *10* = best health care possible)
- ***Rating of Health Plan*** (*0* = worst health plan possible; *10* = best health plan possible)

Rating question results are reported as the proportion of members selecting one of the top three responses (*8*, *9*, or *10*).

Composites

Composite measures combine results from related survey questions into a single measure to summarize performance in specific areas. ***Composite Global Proportions*** express the proportion of respondents selecting the desired response option(s) from a given group of questions on the survey. A global proportion is calculated by first determining the proportion of respondents selecting the response(s) of interest on each survey question contributing to the composite and subsequently averaging these proportions across all items in the composite.

The following composites are reported for the Adult and General Child Medicaid populations:

- ***Getting Needed Care*** combines responses to two survey questions that address member access to care. Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Getting Care Quickly*** combines responses to two survey questions that address timely availability of urgent and routine care. Results are reported as the proportion of members responding *Always* or *Usually*.

- ***How Well Doctors Communicate*** combines responses to four survey questions that address physician communication. Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Customer Service*** combines responses to two survey questions about member experience with the health plan's customer service. Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Shared Decision Making*** combines responses to three survey questions that focus on decisions related to prescription medicines. Results are reported as the proportion of members responding *Yes*.

The following composite measures are calculated and reported for the Child CCC population:

- ***Access to Specialized Services*** combines responses to three survey questions addressing the child's access to special equipment or devices, therapies, treatments, or counseling. Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Personal Doctor Who Knows Child*** combines responses to three survey questions addressing the doctor's understanding of the child's health issues. Results are reported as the proportion of members responding *Yes*.
- ***Coordination of Care for Children with Chronic Conditions*** combines responses to two survey items addressing care coordination needs related to the child's chronic condition. Results are reported as the proportion of members responding *Yes*.
- ***Getting Needed Information*** (single item). Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Access to Prescription Medicines*** (single item). Results are reported as the proportion of members responding *Always* or *Usually*.

HealthChoice MCO Performance on CAHPS Survey Measures

The tables that follow show how the HealthChoice Aggregate and each of the individual MCOs performed over time. For each measure, the best performing plan is identified by an asterisk.

Overall Ratings – Adult Population

There were four Overall Ratings questions asked in the CAHPS 5.0H Adult Medicaid Survey that used a scale of "0 to 10," where a "0" represented the worst possible and a "10" represented the best possible. Table 82 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS 2017, 2018, and 2019. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 82. CAHPS Adult Population – Aggregate Rates of Overall Ratings Questions for 2017-2019

Overall Ratings	2019 (Summary Rate – *8,9,10*)	2018 (Summary Rate – *8,9,10*)	2017 (Summary Rate – *8,9,10*)
Specialist Seen Most Often	80.9%	80.4%	81.3%
Personal Doctor	82.2%	79.0%	79.8%

Overall Ratings	2019 (Summary Rate – *8,9,10*)	2018 (Summary Rate – *8,9,10*)	2017 (Summary Rate – *8,9,10*)
Health Care	74.1%	74.3%	73.6%
Health Plan	74.9%	75.9%	74.0%

HealthChoice members give their highest satisfaction ratings to their Personal Doctor (82.2%, up from 79.0% in 2018) and/or their Specialist (80.9%, up from 80.4% in 2018). Somewhat fewer HealthChoice members gave positive satisfaction ratings to their Health Care (74.1%, down from 74.3% in 2018) and/or Health Plan (74.9%, down from 75.9% in 2018) overall.

Table 83 shows health plan comparisons of the nine participating HealthChoice MCOs for the four Overall Ratings questions asked in the CAHPS 5.0H Adult Medicaid Survey. The HealthChoice MCO with the highest Summary Rate for a particular overall rating is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 83. CAHPS 2019 MCO Adult Population –- Summary Rates of Overall Rating Questions

MCOs	Overall Ratings (Summary Rate – *8,9,10*)			
	Specialist Seen Most Often	Personal Doctor	Health Care	Health Plan
HealthChoice Aggregate	**80.9%**	**82.2%**	**74.1%**	**74.9%**
ABH	76.9%	77.3%	70.8%	62.8%
ACC	84.4%	82.9%	**78.3%***	76.4%
JMS	79.3%	84.7%	70.1%	69.6%
KPMAS	84.4%	79.3%	77.8%	80.5%
MPC	80.3%	83.8%	75.0%	81.1%
MSFC	**85.1%***	**87.3%***	77.2%	**83.0%***
PPMCO	77.2%	80.6%	73.1%	76.0%
UHC	81.0%	83.6%	71.4%	69.2%
UMHP	79.1%	78.8%	72.8%	72.5%

*HealthChoice MCO with the highest Summary Rate

Composite Measure Results – Adult Population

Composite measures combine results from related survey questions into a single score to summarize health plan performance in a specific area of care or service. Table 84 shows the composite measure comparisons for Adult Summary Rates from CAHPS 2017 to 2019.

Table 84. CAHPS Adult Population – 2017-2019 Summary Rates for Composite Measure Results

Composite Measure	2019 (Summary Rate – *Always/Usually or Yes*)	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)
Getting Needed Care	83.1%	82.2%	82.2%
Getting Care Quickly	83.6%	81.6%	81.4%
How Well Doctors Communicate	92.2%	91.7%	91.7%
Customer Service	88.0%	88.4%	89.1%
Shared Decision-Making	78.3%	79.3%	81.0%

HealthChoice MCOs receive the highest ratings among their members on the "How Well Doctors Communicate" (92.2% Summary Rate – Always/Usually) and "Customer Service" (88.0% Summary Rate – Always/Usually) composite measures. On the other hand, the research shows that HealthChoice MCOs receive the lowest ratings among their members on the "Shared Decision-Making" composite measure (78.3% Summary Rate – Yes). The composite measures "Getting Care Quickly" increased from 2018 to 2019 (up from 81.6% to 83.6% Summary Rate – Always/Usually). The composite measure "Getting Needed Care" rating also increased from 2018 to 2019 (up from 82.2% to 83.1% (Summary Rate – Always/Usually).

Table 85 shows health plan comparisons of Adult Summary Rates for composite measures for the nine participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 85. CAHPS 2019 MCO Adult Population –- Summary Rates for Composite Measure Results

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision-Making
HealthChoice Aggregate	**83.1%**	**83.6%**	**92.2%**	**88.0%**	**78.3%**
ABH	71.5%	76.2%	87.1%	79.2%	74.2%
ACC	83.3%	85.3%	89.7%	90.0%	75.2%
JMS	80.1%	78.7%	95.0%	91.0%	77.3%
KPMAS	86.2%	83.3%	89.2%	88.2%	74.8%
MPC	82.8%	**86.3%***	94.0%	85.1%	79.7%
MSFC	**87.0%***	85.1%	**95.9%***	**94.0%***	**81.7%***
PPMCO	80.9%	84.6%	91.3%	90.3%	80.4%

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision-Making
HealthChoice Aggregate	**83.1%**	**83.6%**	**92.2%**	**88.0%**	**78.3%**
UHC	86.1%	83.8%	92.2%	85.1%	78.8%
UMHP	86.6%	85.8%	93.1%	89.0%	79.3%

*HealthChoice MCO with the highest Summary Rate

Overall Ratings – Child Population

The results from the four Overall Ratings questions asked in the CAHPS 5.0H Child Medicaid Survey are represented in Tables 86 and 87. The summary rate represents the percentage of members who rated the question an 8, 9, or 10. Rates are provided for 2017, 2018, and 2019.

Table 86. CAHPS Child Population – Summary Rates of Overall Rating Questions for 2017-2019

Overall Ratings	2019 (Summary Rate – *8,9,10*)	2018 (Summary Rate – *8,9,10*)	2017 (Summary Rate – *8,9,10*)
Personal Doctor	90.3%	91.1%	90.3%
Health Care	88.4%	89.0%	88.0%
Health Plan	85.2%	86.8%	86.7%
Specialist	84.8%	85.3%	85.4%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians regarding their child's Personal Doctor (90.3%), Health Care overall (88.4%), Health Plan overall (85.2%) and Specialist (84.8%). Results for Overall Rating questions for 2019 declined slightly over the prior year for each of the four questions.

The following table shows plan comparisons of Child Summary Ratings of the four Overall Rating questions for the nine participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular overall rating question is identified by an asterisk. Additionally, the table indicates the HealthChoice Aggregate for each question.

Table 87. CAHPS 2019 MCO Child Population – Summary Rates of Overall Rating Questions

MCOs	Overall Ratings (Summary Rate – *8,9,10*)			
	Personal Doctor	Specialist	Health Care	Health Plan
HealthChoice Aggregate	**90.3%**	**84.8%**	**88.4%**	**85.2%**
ABH	83.9%	83.8%	78.4%	74.8%
ACC	92.0%	83.1%	91.8%	**88.9%***
JMS	**95.3%***	82.9%	**93.1%***	84.5%
KPMAS	92.7%	84.8%	87.9%	87.5%
MPC	88.9%	**89.2%***	89.0%	86.1%
MSFC	89.0%	85.2%	88.3%	85.2%
PPMCO	90.4%	82.0%	90.3%	88.6%
UHC	89.9%	86.0%	86.9%	83.6%
UMHP	90.4%	84.9%	88.6%	85.2%

*HealthChoice MCO with the highest Summary Rate

Composite Measures Results – Child Population

Tables 88 and 89 show the child composite measure results from CAHPS 2017, 2018, and 2019.

Table 88. CAHPS Child Population – 2017-2019 Summary Rates for Composite Measure Results

Composite Measures	2019 (Summary Rate – *Always/Usually or Yes*)	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)
Getting Needed Care	82.1%	83.5%	83.0%
Getting Care Quickly	87.4%	88.7%	88.1%
How Well Doctors Communicate	93.5%	94.0%	94.0%
Customer Service	85.5%	88.5%	88.4%
Shared Decision-Making	78.4%	80.3%	77.0%

In 2019, HealthChoice MCOs received the highest ratings among their child members on the following composite measures:

- How Well Doctors Communicate (93.5% Summary Rate – Always/Usually);
- Getting Care Quickly (87.4% Summary Rate – Always/Usually);
- Customer Service (85.5% Summary Rate – Always/Usually).

Somewhat lower proportions of child members gave HealthChoice MCOs positive ratings for the "Getting Needed Care" (82.1% Summary Rate – Yes) and "Shared Decision-Making" (78.4% Summary Rate – Yes) composite measures.
Five additional composite measures are calculated for the CCC population. These results are listed in the table below.

Table 89. CAHPS Child – CCC Population – 2017-2019 Summary Rates for Additional Composite Measure Results

Additional CCC Composite Measures	2019 (Summary Rate – *Always/Usually or Yes*)	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)
Access to Prescription Medicine	90.0%	91.0%	90.8%
Access to Specialized Services	75.8%	78.7%	77.0%
Getting Needed Information	90.4%	92.7%	91.4%
Personal Doctor Who Knows Child	90.4%	92.1%	90.1%
Coordination of Care for Children with Chronic Conditions	72.8%	73.1%	73.6%

Table 90 and 91 show health plan comparisons of the nine participating HealthChoice MCOs among the Child Population. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk, and the HealthChoice Aggregate is included for each question.

Table 90. CAHPS 2019 MCO Child Population – Summary Rates for Composite Measure Results

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
HealthChoice Aggregate	**82.1%**	**87.4%**	**93.5%**	**85.5%**	**78.4%**
ABH	71.5%	83.0%	91.2%	80.0%	75.0%
ACC	82.4%	85.4%	90.9%	85.6%	77.8%
JMS	**87.8%***	**92.1%***	**95.8%***	**89.9%***	81.4%
KPMAS	83.1%	85.4%	95.3%	88.3%	78.8%
MPC	85.5%	89.6%	94.1%	86.0%	79.6%
MSFC	83.0%	87.6%	95.4%	88.2%	**81.6%***
PPMCO	79.2%	89.1%	95.3%	86.1%	79.5%

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
HealthChoice Aggregate	**82.1%**	**87.4%**	**93.5%**	**85.5%**	**78.4%**
UHC	85.0%	90.7%	92.0%	82.3%	77.3%
UMHP	80.8%	83.3%	92.1%	84.3%	74.6%

*HealthChoice MCO with the highest Summary Rate

Table 91. CAHPS 2019 MCO Child – CCC Population Summary Rates for Additional Composite Measure Results

MCOs	Additional CCC Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Access to Prescription Medicine	Access to Specialized Services	Getting Needed Information	Personal Doctor Who Knows Child	Coordination of Care for Children with Chronic Conditions
HealthChoice Aggregate	**90.0%**	**75.8%**	**90.4%**	**90.4%**	**72.8%**
ABH	78.1%	55.1%	73.8%	77.6%	65.0%
ACC	87.6%	73.7%	90.8%	91.3%	74.7%
JMS	93.3%	**80.2%***	92.7%	**94.3%***	66.7%
KPMAS	90.2%	74.2%	**93.6%***	85.6%	72.9%
MPC	92.0%	78.7%	93.4%	88.9%	**75.7%***
MSFC	**93.9%***	76.3%	87.7%	93.6%	70.8%
PPMCO	91.8%	78.3%	90.1%	91.9%	71.6%
UHC	86.1%	78.7%	91.2%	89.7%	74.8%
UMHP	87.2%	68.8%	87.5%	90.4%	72.3%

*HealthChoice MCO with the highest Summary Rate

Key Driver Analysis

Key Driver Analysis identifies those areas of health plan performance and aspects of member experience that shape members' overall assessment of their health plan. To the extent that these areas or experiences can be improved, the overall rating of the plan will reflect these gains. For each member population type, top five priorities for quality improvement with the greatest potential to affect the overall *Rating of Health Plan* score are identified below.

Key Drivers of Member Experience – Adult Medicaid

Ratings of the plan are strongly related to members' ability to get the care they need when they need it. Making appointments for routine care at a doctor's office or clinic may also be viewed as an indirect measure of access and availability of care. *Rating of Personal Doctor* may reflect the quality of the health plan's network and its ability to contract with better providers.

Priority	Key Driver	Interpretation	Recommended Action
1	Q14. Ease of getting needed care, tests, or treatment (percent *Always* or *Usually*)	The higher the proportion of plan members reporting that the necessary care, tests, or treatment were easy to get, the higher the overall plan score	Improve member access to care (ease of getting needed care, tests, or treatment)
2	Q23. Rating of Personal Doctor (percent 8, 9, or 10)	The higher the proportion of members rating their personal doctor as 8, 9, or 10, the higher the overall plan score	Improve the quality of physicians in health plan network (personal doctors)
3	Q29. Written materials or the Internet provided needed information (percent *Always* or *Usually*)	The higher the proportion of members reporting that they found the information they needed in the plan's written materials or the Internet, the higher the overall plan score	Improve saliency, availability, and clarity of information about how the health plan works in written materials or on the Internet
4	Q5. Made appointments for routine care at a doctor's office or clinic (percent *Yes*)	The higher the proportion of members who made appointments for check-up or routine care at a doctor's office or clinic during the past 6 months, the higher the overall plan score	Improve member access to care (scheduling appointments for routine care)
5	Q31. Health plan customer service provided needed information or help (percent *Always* or *Usually*)	The higher the proportion of members who were able to get the information or help they needed from customer service, the higher the overall plan score	Improve the ability of the health plan customer service to provide members with necessary information or help

Key Drivers of Member Experience – Child Medicaid

Ratings of the plan are strongly related to members' ability to get the care they need as soon as they need it. *Rating of Personal Doctor* may reflect the quality of the health plan's network and its ability to contract with better providers.

Priority	Key Driver	Interpretation	Recommended Action
1	Q15. Ease of getting needed care, tests, or treatment (percent *Always* or *Usually*)	The higher the proportion of respondents reporting that the necessary care, tests, or treatment were easy to get, the higher the overall plan score	Improve member access to care (ease of getting needed care, tests, or treatment)
2	Q51. Customer service treated member with courtesy and respect (percent Always or Usually)	The higher the proportion of respondents reporting that they were treated with courtesy and respect by customer service, the higher the overall plan score	Improve the ability of the health plan customer service to treat members with courtesy and respect
3	Q46. Got specialist appointment as soon as needed (percent Always or Usually)	The higher the proportion of respondents who were able to get a specialist appointment when they needed it, the higher the overall plan score	Improve member access to care (getting an appointment to see a specialist)
4	Q41. Rating of Personal Doctor (percent 8, 9, or 10)	The higher the proportion of members rating their child's personal doctor as 8, 9, or 10, the higher the overall plan score	Improve the quality of physicians in the plan's network (personal doctors)
5	Q30. Child has personal doctor (percent Yes)	The higher the proportion of respondents who report that their child has a personal doctor, the higher the overall plan score	Improve member access to care (having a personal doctor)

Review of Compliance with Quality Strategy

Quality Strategy Evaluation

Table 92 describes MBMA's progress against the Quality Strategy's goal.

Table 92. Quality Strategy Evaluation

Department's Quality Strategy Goal	Performance Against Goal	Met
Ensure compliance with changes in Federal/State law and regulation.	MDH consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs. For the CY 2018 Systems Performance Review MCOs were reviewed against new appeal and grievance standards consistent with the Code of Federal Regulation.	√
Improve performance over time.	MDH continually strives to improve performance, which is evident through the high standards it sets for the MCOs in the Annual Systems Performance Review, Value-Based Purchasing Initiative, Performance Improvement Projects, and other review activities. It continually monitors the progress of MCO performance in multiple areas as demonstrated throughout this report, and holds annual one-on-one Quality Meetings with each MCO to review results and discuss quality initiatives.	√
Allow comparisons to national and state benchmarks.	In almost every area of review, comparisons to national and state benchmarks can be found to mark progress and delineate performance against goals.	√
Reduce unnecessary administrative burden on MCOs.	MDH has attempted to reduce unnecessary administrative burden on the MCOs in any way possible. MDH has moved from an annual to a triennial Systems Review process with desktop reviews occurring in the intervening years. Based on feedback from the MCOs, the period for commenting on revised SPR standards and guidelines was shortened from 90 days to 60 days for comprehensive onsite reviews and 45 days for interim reviews to allow for more presite preparation time. Additionally, validation of each MCO's Outreach Plan was incorporated as a component of the SPR thereby eliminating a separate MCO activity. Furthermore, MDH has updated its Model Notices for Grievances, Appeals, and Preservice Denials as a result of opportunities identified during the Systems Performance Reviews and in quality meetings with the MCOs to assist MCOs in complying with new regulations. These model notices may be viewed as a best practice.	√

Department's Quality Strategy Goal	Performance Against Goal	Met
Assist MDH with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with a disability, and adults with chronic conditions.	The Medical Benefits Management Administration assisted MDH by: • Requiring NCQA accreditation and HEDIS performance measure reporting to monitor compliance with quality of care and access standards for participants. • Reporting Medicaid Adult and Child CORE Measures to CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive. • Revising the Value-Based Purchasing Initiative to incentivize measures that focus on health care outcomes rather than processes and include adults with disabilities and adults and children with chronic conditions. • CAHPS Developing and implementing a performance monitoring policy and financial sanction policy coupled with intermediate sanctions to hold MCOs accountable for quality improvement. • Evaluating the implementation of the Medicaid and CHIP Managed Care Final Rule, which set new operational standards for MCOs.	√

√ – Goal Met

EQRO Recommendations for MCOs

Each MCO is committed to delivering high quality care and services to its participants. However, opportunities exist for continued performance improvement. Based upon the evaluation of activities, Qlarant has developed several recommendations for all MCOs which are identified throughout the Annual Technical Report.

EQRO Recommendations for MBMA

Considering the results for measures of quality, access, and timeliness of care for the contracted MCOs, Qlarant developed the following recommendations for MBMA:

- Implement the MCO Performance Monitoring Policy and Financial Sanction Policy in response to continually underperforming MCOs.
- Continue to support, provide guidance, and work collaboratively with each MCO as they work to meet all requirements.
- Continue to review reports and provide recommendations as needed to each MCO.
- Consider reinstituting comprehensive onsite Systems Performance Reviews to ensure a consistently high level of MCO performance.

Conclusion

This report is a representation of all quality assurance activities that took place in calendar years 2018-2019 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted within each individual review activity.
Overall strengths for the HealthChoice program in the areas of quality, access, and timeliness of care and services are outlined in Table 93.

Table 93. HealthChoice Program Strengths for Quality, Access, and Timeliness

HealthChoice Program Strength	Q	A	T
Encounter Data Validation: Encounter data submitted by the HealthChoice MCOs for CY 2017 is considered accurate and reliable with an overall match rate of 94.8%.	√		√
EPSDT Medical Record Reviews: HealthChoice total scores continue to increase; scores increased by one percentage point (90% to 91%) from CY 2016 to CY 2017, and three percentage points (91% to 94%) from CY 2017 to CY 2018.	√	√	√
Quarterly Grievances, Appeals, and Pre-Service Denials: MCOs demonstrated fairly strong and consistent results in meeting regulatory requirements for grievances, appeals, and preservice denials.	√		√
Performance Improvement Projects: Validation of the Lead Screening PIPs determined levels of confidence or high levels of confidence for all eight participating MCOs*.	√	√	√

*ABH did not participate in Performance Improvement Projects as they were new to the HealthChoice Program

MDH sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality improvement. The CY 2018 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Acronym List

Acronym	Definition
ABH	Aetna Better Health of Maryland
ACC	AMERIGROUP Community Care
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act of 1990
AWC	Adolescent Well Care
BMI	Body Mass Index
BR	Biased Rate
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CARC	Claim Adjustment Reason Codes
CBP	Controlling High Blood Pressure
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CI	Confidence Interval
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CPT	Current Procedural Terminology
CY	Calendar Year
CSS	Center for the Study of Services
DBMS	Data Base Management System
DHQA	Division of HealthChoice Quality Assurance
EBS	Enrollment by State
ED	Emergency Department
EDI	Electronic Data Interchange
EDITPS	Electronic Data Interchange Translator Processing System
EDV	Encounter Data Validation
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EOB	Explanation of Benefit
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Fully Compliant
FFS	Fee-For-Service
FSP	Frequency of Selected Procedures
HEDIS	Healthcare Effectiveness Data and Information Set

Acronym	Definition
HCQIS	Healthcare Quality Improvement System for Medicaid Managed Care
HILLTOP	The Hilltop Institute of University of Maryland Baltimore County
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HRA	Health Risk Assessment
IS	Information System
JMS	Jai Medical Systems, Inc.
KPMAS	Kaiser Permanente of the Mid-Atlantic States, Inc.
MARR	Maryland Average Reportable Rate
MBMA	Medical Benefits Management Administration
MCO	Managed Care Organization
MDH	Maryland Department of Health
MPC	Maryland Physicians Care
MRR	Medical Record Review
MRRV	Medical Record Review Validation
MSFC	MedStar Family Choice, Inc.
NA	Not Applicable
NB	No Benefit
NCQA	National Committee for Quality Assurance
NHM	National HEDIS Mean
NV	Not Valid
OB/GYN	Obstetrician/Gynecology
PCP	Primary Care Physician
PIP	Performance Improvement Project
PM	Partially Met
PPMCO	Priority Partners
QA	Quality Assurance
QAP	Quality Assurance Program
QIO	Quality Improvement Organization
QOC	Quality of Care
RARC	Remittance Advice Remark Codes
ROADMAP	Record of Administration, Data Management and Processes
SC	Substantially Compliant
SFTP	Secure File Transfer Protocol
SPR	Systems Performance Review
STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
U	Unmet

Acronym	Definition
UHC	UnitedHealthcare Community Plan
UMHP	University of Maryland Health Partners
VBP	Value-Based Purchasing
VFC	Vaccine for Children
VIS	Vaccine Information Statement

CY 2019 Maryland MCO Systems Performance Standards and Guidelines

Standard	Description	Cite(s) and References
1.0	**Systematic Process of Quality Assessment and Improvement – The QAP objectively and systematically monitors and evaluates the QOC and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.**	
1.1	The QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population. a. The monitoring and evaluation of care reflects the population served by the MCO in terms of age, disease categories, and special risk status. b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.	42 CFR § 438.330 42 CFR § 438.330(b)(4) COMAR 10.09.65.03
1.2	The QAP's written guidelines for the MCO's QOC studies and related activities require the use of quality indicators. a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience. b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.	42 CFR § 438.330 42 CFR § 438.330(c) COMAR 10.09.65.03
1.3	The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines. a. Deleted in CY 2018. b. Clinical practice guidelines are based on evidence based practices or professional standards of practice and are developed or reviewed by MCO providers. c. The guidelines focus on the process and outcomes of health care delivery and access to care. d. A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs. e. The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted. f. There are guidelines to address preventive health services for children and adults. g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a. h. The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for UM decisions, enrollee education, and coverage of services.	42 CFR § 438.236
1.4	The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services.	42 CFR § 438.330

Standard	Description	Cite(s) and References
	a. The QAP has written guidelines to evaluate the QOC provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above.	
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include: a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).	HCQIS II.E.1-7 COMAR 10.09.65.03C
1.6	Deleted in CY 2017 SPR.	
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to enrollees.	42 CFR § 438.330
1.8	A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include: a. QA studies and other activities undertaken, results, and subsequent actions. b. Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results. c. Analysis of aggregate data on utilization and quality of services rendered. d. Demonstrated improvements in quality. e. Areas of deficiency. f. Recommendations for improvement to be included in the subsequent year's QA Work Plan. g. An evaluation of the overall effectiveness of the QAP.	42 CFR § 438.330(b)(2)
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	42 CFR § 438.330
1.10	The MCO must have a Disaster Recovery Plan that is updated on an annual basis.	COMAR 10.09.65.15

Standard	Description	Cite(s) and References
2.0	**Accountability to the Governing Body – The governing body of the MCO is the BOD or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.** **This standard will be reviewed until the MCO attains 100% compliance.**	
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.	HCQIS III.A
2.2	The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide oversight as a committee.	HCQIS III.B
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	HCQIS III.C
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	HCQIS III.D
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate review of findings and issues of concern within the MCO.	HCQIS III.E
2.6	Deleted in CY 2019.	
2.7	The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of: a. UM activities and findings, and b. Evaluation of UM progress.	HCQIS XIII
3.0	**Oversight of Delegated Entities and Subcontractors – The MCO remains accountable for all functions, even if certain functions are delegated to other entities.**	
3.1	The MCO must ensure that delegates have detailed agreements and are notified of the grievance and appeal system. a. The MCO must ensure that there is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. b. The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	HCQIS VIIL A COMAR 10.09.65.17.A
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the QOC being provided.	HCQIS VIIL B COMAR 10.09.65.17.D
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: a. Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc. b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.	HCQIS VI.C 42 CFR § 438.230 (a & b) COMAR 10.09.65.17.D COMAR 31.10.11 COMAR 31.10.23.01

Standard	Description	Cite(s) and References
	c. Review and approval of claims payment activities at least semi-annually, where applicable. d. Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. e. Review and approval of over and under utilization reports, at least semi-annually, where applicable.	Ins. Art. § 15-1004 Ins. Art. § 15-1005
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.	COMAR 10.09.65.17B(5)
4.0	**Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.** **This standard will be reviewed until the MCO attains 100% compliance.**	
4.1	The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process. b. The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions. c. The Credentialing Plan must identify the practitioners who fall under its scope of authority and action. d. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d).	HCQIS IX A-D Ins. Art. § 15-112 (a)(4)(ii)(9) Ins. Art. § 15-112 (d) COMAR 10.09.65.02M COMAR 10.09.65.17
4.2	There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes: a. Written policies and procedures for the suspension, reduction, or termination of practitioner privileges. b. A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. Deleted in CY 2019.	HCQIS IX H-J
4.3	If the MCO delegates credentialing/ recredentialing activities, the following must be present: a. A written description of the delegated activities. b. A description of the delegate's accountability for designated activities. c. Evidence that the delegate accomplished the credentialing activities.	HCQIS IX G
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include: a. A review of a current valid license to practice. b. A review of a valid DEA or CDS certificate, if applicable. c. A review of graduation from medical/ancillary (NP, PT, OT, SLP etc.) school and completed residency or	HCQIS IX E.1-7 42 CFR § 438.214 (c-e) COMAR 10.09.65.02.N

Standard	Description	Cite(s) and References
	post-graduate training, as applicable. d. A review of work history. e. A review of a professional and liability claims history. f. A review of current adequate malpractice insurance according to the MCO's policy. g. Deleted as of the CY 2017 SPR. h. A review of EPSDT certification. i. Adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements. j. Adherence to the time frames set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d).	Ins. Art. § 15-112 (a)(4)(ii)(9) Ins. Art. § 15-112 (d)
4.5	The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include: a. Any revocation or suspension of a State license or a DEA/BNDD number. b. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records). c. Any sanctions imposed by Medicare and/or Medicaid. d. Information about the practitioner from the NPDB and the MBP.	HCQIS IX E.8-12
4.6	The credentialing application includes the following: a. The use of illegal drugs. b. Any history of loss of license. c. Any history of loss or limitation of privileges or disciplinary activity. d. Attestation to the correctness and completeness of the application.	HCQIS IX E.13.a-e COMAR 31.10.26.03
4.7	There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.	HCQIS IX E.14 COMAR 10.09.65.02 H (1) 28 CFR Chapter 1, Part 36
4.8	There is evidence that recredentialing is performed at least every three years and: a. Includes a review of information from the NPDB. b. Deleted in CY 2019. c. Includes all items contained in element 4.4 a–h, except 4.4 d (work history). d. Includes all items contained in 4.6 a–d. e. Meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.	HCQIS IX F.1-2 COMAR 10.09.65.02.N Ins. Art. § 15-112 (d)
4.9	There is evidence that the recredentialing process includes a review of the following: a. Enrollee complaints/grievances. b. Results of quality reviews. c. Deleted in CY 2018. d. Office site compliance with ADA standards, if applicable.	HCQIS IX F.3 a-e

Standard	Description	Cite(s) and References
4.10	The MCO must have policies and procedures regarding the selection and retention of providers. a. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. b. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program	42 CFR § 438.214 42 CFR § 438.207
4.11	The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP. a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired. b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.	COMAR 10.09.66.05
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	COMAR 10.09.65.17B
5.0	**Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.**	
5.1	The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.09.71.02 and 10.09.71.04. a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.09.71. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in CY 2018. f. There is complete documentation of the substance of the grievances and steps taken in the case record. g. The MCO adheres to regulatory time frames for written acknowledgment and written resolution of all grievances, even if the resolution was previously provided verbally. h. The MCO ensures that written resolution letters describe the grievance and the resolution in easy to understand language.	HCQIS X.E.1-5 COMAR 10.09.71.02 COMAR 10.09.71.04 COMAR 10.09.71.05 42 CFR § 438.402 (a & b) 42 CFR § 438.406 (a & b) 42 CFR § 438.408 (a-f)
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.09.66.01C.	COMAR 10.09.65.02.H COMAR 10.09.66.01 42 CFR § 438.10 42 CFR § 438.206 (c)(2)

Standard	Description	Cite(s) and References
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: a. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data. b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. c. Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.	HCQIS X.1 42 CFR § 438.100 (d) 42 CFR § 438.224 HIPAA Health-General §§ 4-301
5.4	The MCO has written policies regarding the appropriate treatment of minors.	HCQIS X.J Health General 20-102
5.5	As a result of the enrollee satisfaction surveys, the MCO: a. Identifies and investigates sources of dissatisfaction. b. Implements steps to follow up on the findings. c. Informs practitioners and providers of assessment results. d. Reevaluates the effects of b. above at least quarterly.	HCQIS X.K.3 a-c HCQIS X.K.4 42 CFR § 438.206 (c)
5.6	The MCO has systems in place to assure that new enrollees receive required information within established time frames. a. Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. d. The MCO includes the Continuity of Health Care Notice in the new enrollee packet. e. The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	COMAR 10.09.66.02 COMAR 10.09.65.02.G (3) COMAR 10.09.63.02 Ins. Art. § 15-140 42 CFR 438.10
5.7	The MCO must have an active Consumer Advisory Board (CAB). a. The MCO's CAB membership must reflect the special needs population requirements.	COMAR 10.09.65.12

Standard	Description	Cite(s) and References
	b. The CAB must meet at least six times a year. c. The MCO must have a mechanism for tracking enrollee feedback from the meetings.	
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. a. Materials distributed by the MCO to the enrollee will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland. b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page. c. Notices and Taglines must be posted in significant communications and publications. d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. e. MCO's electronic information provided to members must meet requirements set forth in COMAR.	45 CFR § 92.7 45 CFR § 92.8 42 CFR § 438.10 COMAR 10.09.66.01
5.9	The MCO must maintain written policies and procedures for advance directives. a. The MCO must educate staff regarding advance directives policies and procedures. b. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). c. The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	42 CFR § 422.128 42 CFR § 438.3(j)(1) 42 CFR § 489.100 Hlth Gen Art §5-601-618 COMAR 10.09.65.02
5.10	MCO must comply with the marketing requirements of COMAR 10.09.65.23. a. An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient. b. An MCO cannot engage in marketing activities without prior approval of the Department. c. Deleted in CY 2018.	42 CFR § 438.104 COMAR 10.09.65.23
6.0	**Availability and Accessibility – The MCO has established measurable standards for access and availability.**	
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. a. The MCO has developed and disseminated written access and availability standards. b. The MCO has processes in place to monitor performance against its access and availability standards at least quarterly. c. The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance. d. The MCO has documented review of the Enrollee Services Call Center performance.	HCQIS XI COMAR 10.09.66.03-08 42 CFR §438.206(c)(1) 42 CFR §438.210 COMAR 10.09.66.07.B(2) 42 CFR §438.68(c)(1)(vii) 42 CFR §438.68(c)(1)(viii) 42 CFR § 438.206(c)(2)

Standard	Description	Cite(s) and References
		42 CFR § 438.206(c)(3) CMS's Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population. b. At the time of enrollment, enrollees are provided with information about the MCO's providers. c. The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities. d. The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.	HCQIS XI COMAR 10.09.66.02.C COMAR 10.09.66.05.B COMAR 10.09.66.06.B-D COMAR 10.09.66.01.A (3) 42 CFR § 438.10 (f) (2-6) 42 CFR § 438.206 (b) 42 CFR § 438.207 42 CFR § 438.10 (h) (1) (i-viii)
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services. a. Deleted in CY 2019. b. Deleted in CY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	HCQIS XI COMAR 10.09.64.06 COMAR 10.09.66.03 COMAR 10.09.66.07
7.0	**Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.**	
7.1	There is a comprehensive written UR Plan. a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the	HCQIS XIII A 42 CFR § 438.236

Standard	Description	Cite(s) and References
	process used to review and approve the provision of medical services. b. The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services. c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.	
7.2	The UR Plan specifies criteria for UR/UM decisions. a. The criteria used to make UR/UM decisions must be based on acceptable medical practice. b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria. c. The UR Plan must describe the involvement of participating providers in the review and updating of criteria. d. There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures. e. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines. f. There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria on at least an annual basis.	HCQIS XIII A COMAR 10.09.65.11 S 2
7.3	The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. a. Services provided must be reviewed for over and under utilization. b. UR reports must provide the ability to identify problems and take the appropriate corrective action. c. Corrective measures implemented must be monitored.	HCQIS XIII 42 CFR § 438.330 (b)
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation. a. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. b. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. c. Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	HCQIS XIII.C 1-7 COMAR 10.09.71.04 42 CFR § 438.210 (c & d)
7.5	Adverse determination letters include a description of how to file an appeal. a. All adverse determination letters are written in easy to understand language. b. Adverse determination letters include all required components.	HCQIS XIII.C 1-7 COMAR 10.09.71.02 COMAR 10.09.71.04F 42 CFR § 438.404 45 CFR § 92.7 45 CFR § 92.8

Standard	Description	Cite(s) and References
7.6	The MCO must be compliant with the requirements of COMAR 10.09.71.04 pursuant to notification requirements for preauthorization denials. a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State. b. The MCO demonstrates compliance with adverse determination notification time frames in response to preauthorization requests as specified by the State.	HCQIS XIII.C 1-7 COMAR 10.09.71.04 42 CFR § 438.10 (f & g)
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals. a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.09.71.02 and COMAR 10.09.71.05. b. The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals. c. The MCO must adhere to appeal timeframes. d. The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process. e. Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request. f. Written notifications to enrollees include appeal decisions that are documented in easy to understand language.	HCQIS XIII.C 1-7 COMAR 10.09.71.02 COMAR 10.09.71.05 42 CFR § 438.404 (b) 42 CFR § 438.406 (a & b) 42 CFR § 438.408 (a-f)
7.8	The MCO must have written policies and procedures pertaining to provider appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.09.71.03. b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	HCQIS XIII.C 1-7 COMAR 10.09.71.03 42 CFR § 438.236
7.9 *Formerly 7.6*	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	COMAR 10.09.65.03
7.10 *Formerly 7.7*	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between	COMAR 10.09.86.00

Standard	Description	Cite(s) and References
	the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.	
7.11 *Formerly 7.8*	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. a. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in in regulation. b. The MCOs must provide evidence of implementation of the corrective managed care plan.	COMAR 10.09.75.02
7.12	Deleted in CY 2019.	
8.0	**Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management.**	
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.	HCQIS XIV COMAR 10.09.64.06 COMAR 10.09.65.04-11 42 CFR §438.208(c)(1,2)
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	COMAR 10.09.63.03
8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health programs, and other frequently involved community based organizations (CBOs).	HCQIS XIV
8.4	The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).	HCQIS XI
8.5	The MCO must monitor the effectiveness of the CM Program.	HCQIS XIV COMAR 10.09.64.06 COMAR 10.09.65.04-11
8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.	COMAR 10.09.65.14E
8.7	The MCO must comply with providing the Continuity of Health Care Notice to members and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by members.	Ins. Art. §15-140(f)

Standard	Description	Cite(s) and References
9.0	**Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population.** **This standard will be reviewed until the MCO attains 100% compliance.**	
9.1	The MCO has a comprehensive written HEP, which must include: a. The education plan's purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying enrollees and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and enrollees.	COMAR 10.09.65.03
9.2	The HEP incorporates activities that address needs identified through the analysis of enrollee data.	COMAR 10.09.65.03
9.3	The MCO's HEP must: a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. c. Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals.	COMAR 10.09.65.03
9.4	The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.	COMAR 10.09.65.03
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide: a. Samples of notifications, brochures, and mailings. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	COMAR 10.09.65.03
10.0	**Outreach Plan – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.**	

Standard	Description	Cite(s) and References
10.1	The MCO has developed a written OP that describes the following: a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. b. MCO's organizational capacity to provide both broad-based and enrollee-specific outreach. c. Unique features of the MCO's enrollee outreach initiatives. d. Community partnerships. e. Role of the MCO's provider network in performing outreach. f. MCO's relationship with each of the LHDs and ACCUs.	COMAR 10.09.65.02
10.2	The MCO has implemented policies and procedures for: a. The provision of outreach services for new and existing enrollees for wellness/preventive health services. b. Deleted in CY 2019. c. The provision of outreach via telephone, written materials, and face-to-face contact. d. Monitoring of all outreach activities, including those delegated or subcontracted to other entities.	COMAR 10.09.66.05
10.3	The MCO has implemented strategies: a. Deleted in CY 2019. b. Deleted in CY 2019. c. To promote the provision of EPSDT services and respond to no shows and non-compliant behavior related to children in need of EPSDT services. d. To bring enrollees into care who are difficult to reach or who miss appointments.	COMAR 10.09.66.05
11.0	**Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.**	
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include: a. Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. b. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers.	42 CFR § 438.608 COMAR 10.09.68 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

Standard	Description	Cite(s) and References
	e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.	
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse. d. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. e. A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal. g. A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal. h. A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.	42 CFR § 438.608 COMAR 10.09.68 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"
11.3	The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include: a. A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report. b. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse is investigated.	42 CFR § 438.608 COMAR 10.09.68 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

Standard	Description	Cite(s) and References
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. c. Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	42 CFR § 438.608 COMAR 10.09.68 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"
11.5 *Formerly 2.8*	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies. b. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity. c. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with an employment, consulting or other arrangement with the MCO. d. An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM. e. An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.	42 CFR § 438.610(a) 42 CFR § 438.610(b) 42 CFR § 438.610(c) COMAR 10.09.64.03 42 CFR § 455.436 COMAR 10.09.68.03G

HEDIS Results

Table A3-1. HealthChoice Organizations HEDIS® [1] 2019 Results

HEDIS 2019 Results, (Page 1 of 4)	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2019
HealthChoice Organizations	**ABH***			**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Adult BMI Assessment (ABA)	NA	NA	NA[1]	91.0%	92.0%	94.2%	98.0%	98.5%	99.0%	98.0%	98.1%	98.0%	89.3%	87.8%	88.8%	90.6%	96.2%	100.0%	89.6%	91.2%	94.4%	90.3%	93.7%	84.9%	88.6%	92.9%	94.2%	94.2%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	NA	NA	NA[1]	30.0%	31.8%	32.6%	37.0%	43.6%	49.7%	57.1%	71.2%	65.2%	21.3%	26.5%	26.9%	20.7%	30.0%	33.4%	25.5%	30.0%	33.8%	25.9%	31.2%	36.3%	25.0%	33.2%	33.3%	38.9%
Childhood Immunization Status (CIS)– Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	NA	NA	NA[1]	85.0%	85.2%	82.0%	91.0%	85.4%	83.4%	73.1%	72.5%	81.5%	79.9%	66.2%	73.2%	84.4%	84.2%	81.5%	83.5%	79.8%	76.4%	79.8%	74.5%	74.9%	80.8%	76.6%	84.7%	79.7%
Childhood Immunization Status (CIS)– Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	NA	NA	NA[1]	83.0%	82.5%	79.6%	88.0%	83.7%	80.5%	70.0%	70.3%	79.6%	78.5%	64.5%	69.6%	81.8%	82.7%	78.6%	82.6%	77.9%	75.2%	77.9%	70.8%	72.7%	79.3%	75.2%	83.1%	77.4%
Childhood Immunization Status (CIS)– Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	NA	NA	NA[1]	80.0%	80.1%	76.6%	88.0%	83.3%	79.3%	69.5%	70.1%	79.3%	75.7%	62.5%	66.7%	79.3%	81.3%	76.4%	80.9%	76.4%	74.2%	74.7%	67.4%	71.0%	76.6%	73.7%	82.0%	75.7%
Childhood Immunization Status (CIS)– Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	NA	NA	NA[1]	70.0%	69.8%	67.6%	73.0%	71.2%	67.2%	55.0%	62.3%	73.5%	59.5%	52.6%	58.2%	67.9%	67.9%	66.4%	69.5%	68.1%	66.9%	65.2%	57.4%	63.7%	60.6%	58.6%	64.8%	66.1%
Childhood Immunization Status (CIS)– Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	NA	NA	NA[1]	42.0%	48.7%	49.4%	57.0%	64.4%	56.4%	46.3%	55.7%	66.7%	42.4%	34.1%	37.0%	49.6%	47.7%	49.6%	48.8%	50.9%	51.6%	44.8%	41.6%	41.8%	41.4%	46.7%	47.4%	50.0%
Childhood Immunization Status (CIS)– Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	NA	NA	NA[1]	68.0%	67.9%	66.7%	73.0%	71.2%	66.4%	55.0%	62.0%	73.2%	57.9%	51.3%	56.0%	66.2%	67.2%	64.7%	68.4%	67.4%	66.2%	63.5%	55.5%	62.8%	59.6%	57.9%	64.3%	65.0%
Childhood Immunization Status (CIS)– Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	NA	NA	NA[1]	42.0%	47.7%	48.9%	57.0%	64.4%	55.6%	46.0%	55.7%	66.4%	41.4%	33.1%	35.5%	48.2%	47.5%	48.4%	48.4%	50.9%	51.1%	43.1%	40.4%	41.4%	40.6%	45.7%	47.0%	49.3%
Childhood Immunization Status (CIS)– Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	NA	NA	NA[1]	37.0%	44.3%	44.3%	49.0%	55.8%	49.0%	37.5%	49.9%	61.6%	32.9%	27.7%	31.6%	43.8%	41.1%	44.5%	42.6%	46.5%	46.5%	39.7%	36.7%	39.2%	34.1%	37.2%	39.1%	44.5%
Childhood Immunization Status (CIS)– Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	NA	NA	NA[1]	36.0%	43.3%	43.8%	49.0%	55.8%	48.5%	37.5%	49.9%	61.3%	32.2%	27.0%	30.2%	42.3%	40.9%	43.6%	42.3%	46.5%	46.0%	38.7%	35.8%	38.7%	38.8%	36.7%	38.9%	43.9%
Immunizations for Adolescents (IMA)– Combination 1 (Meningococcal, Tdap/Td)	NA	NA	NA[1]	88.0%	89.1%	90.3%	89.0%	89.7%	91.7%	80.5%	83.7%	83.0%	88.2%	84.7%	87.6%	84.2%	88.6%	89.8%	89.1%	87.1%	91.5%	86.7%	87.4%	90.8%	80.5%	87.5%	89.5%	89.3%
Immunizations for Adolescents (IMA)–Combination 2 (Meningococcal, Tdap, HPV)	NA	NA	NA[1]	28.9%	48.9%	49.4%	52.7%	72.2%	65.9%	26.7%	47.5%	51.6%	21.3%	37.7%	40.9%	24.1%	35.5%	43.3%	26.9%	38.4%	51.6%	22.9%	36.5%	38.2%	17.4%	30.4%	28.5%	46.2%
Well-Child Visits in the First 15 months of Life (W15)– No well-child visits[2]	NA	NA	NA[1]	1.0%	0.5%	0.6%	5.0%	0.5%	1.0%	3.6%	2.0%	0.3%	1.4%	2.0%	0.6%	3.2%	2.0%	1.2%	1.5%	5.0%	2.4%	0.3%	2.4%	1.5%	8.5%	2.0%	1.9%	1.2%
Well-Child Visits in the First 15 months of Life (W15)– MDH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	NA	NA	NA[1]	88.7%	88.8%	84.2%	80.7%	85.9%	80.8%	78.4%	86.9%	89.6%	83.6%	84.2%	84.8%	82.7%	86.5%	80.8%	82.0%	76.5%	81.2%	87.1%	87.6%	85.2%	74.2%	81.0%	82.0%	83.6%
Well-Child Visits in the First 15 months of Life (W15)– MDH Six or more visits	NA	NA	NA[1]	NA[1]	72.0%	70.45%	NA[1]	75.0%	67.68%	NA[1]	75.4%	81.3%	NA[1]	70.8%	68.7%	NA[1]	73.3%	67.7%	NA	56.8%	62.8%	NA[1]	72.5%	69.1%	NA[1]	67.6%	66.4%	69.3%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	NA	NA	64.0%	88.0%	88.8%	87.5%	90.0%	91.3%	90.5%	79.6%	77.6%	85.0%	79.9%	76.6%	71.8%	79.5%	77.1%	76.7%	81.0%	85.6%	80.3%	82.6%	81.5%	83.7%	69.8%	70.3%	81.9%	80.1%
Adolescent Well-Care Visits (AWC)	NA	NA	43.8%	69.0%	73.0%	73.7%	84.0%	80.7%	77.4%	56.0%	59.1%	64.8%	72.7%	54.7%	57.2%	55.8%	59.7%	53.5%	64.4%	65.7%	57.4%	62.6%	63.8%	65.0%	52.6%	56.7%	61.7%	61.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)– BMI Percentile- Total Rate	NA	NA	65.6%	73.0%	73.2%	71.8%	92.0%	95.9%	96.4%	100.0%	100.0%	99.0%	60.8%	53.0%	62.0%	74.7%	81.1%	88.9%	68.5%	76.4%	72.3%	76.5%	75.7%	76.6%	54.5%	68.1%	78.9%	79.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)– Counseling for Nutrition – Total Rate	NA	NA	75.0%	79.0%	75.7%	77.6%	95.0%	97.6%	95.1%	94.3%	100.0%	100.0%	64.0%	62.3%	63.2%	71.9%	85.3%	82.6%	73.4%	73.7%	69.6%	76.0%	77.1%	77.4%	63.8%	67.6%	79.1%	80.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)– Counseling for Physical Activity – Total Rate	NA	NA	71.9%	72.0%	68.1%	70.6%	91.0%	96.6%	94.6%	100.0%	100.0%	100.0%	56.8%	53.0%	60.2%	69.9%	80.2%	78.1%	67.4%	66.2%	65.0%	70.9%	71.8%	71.3%	53.8%	62.0%	75.0%	76.3%
Appropriate Testing for Children with Pharyngitis (CWP)	NA	NA	80.0%	81.0%	79.6%	86.2%	83.0%	92.2%	84.9%	93.4%	91.9%	96.1%	88.3%	87.7%	89.0%	92.2%	93.7%	95.1%	86.0%	86.2%	88.4%	87.8%	89.3%	89.6%	84.0%	86.7%	84.0%	88.2%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3]Trending break for HEDIS 2019 due to measure specification changes. HEDIS 2019 results cannot be compared to the prior year benchmarks.

ABH: Aetna Better Health of Maryland
ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems, Inc.
KPMAS: Kaiser Permanente of the Mid-Atlantic States, Inc.
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice, Inc.
PPMCO: Priority Partners
UHC: UnitedHealthcare Community Plan
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

[1] HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS 2019 Results, (Page 2 of 4)	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2019
HealthChoice Organizations	**ABH***			**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Lead Screening in Children (LSC)	NA	NA	NA[1]	80.0%	80.0%	82.0%	91.0%	88.6%	90.9%	66.1%	68.5%	83.5%	72.2%	74.7%	80.1%	84.8%	83.0%	84.4%	78.6%	80.1%	80.5%	73.0%	72.0%	76.7%	70.6%	74.5%	83.9%	82.8%
Medication Management for People With Asthma (MMA)– Total 50% of treatment period	NA	NA	NA[1]	47.0%	50.0%	54.7%	77.0%	75.0%	74.1%	50.5%	61.5%	56.4%	64.4%	60.5%	57.4%	50.1%	53.7%	53.4%	48.1%	49.6%	51.8%	53.6%	55.7%	57.1%	55.9%	59.9%	71.6%	59.6%
Medication Management for People With Asthma (MMA)– Total 75% of treatment period	NA	NA	NA[1]	21.0%	23.8%	26.2%	52.0%	51.0%	47.1%	28.4%	33.3%	30.3%	38.3%	34.1%	33.8%	25.2%	29.4%	29.2%	24.5%	25.2%	27.7%	28.4%	31.5%	33.1%	31.2%	34.8%	41.9%	33.7%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	NA	NA	NA[1]	91.0%	92.0%	93.9%	97.0%	98.0%	96.7%	97.2%	98.1%	96.8%	88.7%	88.6%	89.6%	92.2%	91.5%	93.6%	90.8%	92.0%	93.9%	89.6%	90.1%	92.5%	88.0%	87.7%	92.2%	93.7%
Asthma Medication Ratio (AMR)	NA	NA	NA[1]	67.0%	63.2%	65.5%	70.0%	70.7%	73.0%	72.6%	77.9%	74.0%	63.6%	63.1%	58.0%	67.9%	64.6%	61.8%	62.2%	58.9%	60.2%	63.6%	62.7%	62.4%	47.3%	60.1%	57.1%	64.0%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	NA	NA	NA[1]	30.0%	30.5%	28.8%	32.0%	40.7%	14.4%	50.0%	NA[1]	29.5%	31.5%	32.0%	30.6%	40.7%	38.9%	38.5%	29.9%	31.1%	31.8%	32.9%	32.2%	31.4%	37.5%	36.9%	33.3%	29.8%
Pharmacotherapy Management of COPD Exacerbation (PCE)– Systemic Corticosteroid Rate	NA	NA	NA[1]	68.0%	68.2%	66.1%	65.0%	68.4%	67.6%	55.2%	78.6%	83.8%	73.9%	70.8%	71.9%	71.6%	74.8%	72.1%	66.7%	61.8%	71.2%	65.0%	69.0%	61.6%	80.7%	78.2%	71.0%	70.7%
Pharmacotherapy Management of COPD Exacerbation (PCE)– Bronchodilator Rate	NA	NA	NA[1]	81.0%	82.3%	83.5%	86.0%	87.9%	88.3%	75.9%	83.3%	94.6%	86.9%	85.8%	87.2%	87.3%	88.7%	89.0%	81.5%	80.9%	84.8%	81.5%	80.4%	79.0%	89.3%	88.7%	88.2%	86.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP)– Age 12–24 months	NA	NA	87.2%	98.0%	97.5%	97.3%	93.0%	92.5%	94.3%	92.5%	95.7%	96.4%	96.4%	96.1%	97.4%	94.3%	95.5%	95.7%	97.0%	93.6%	97.0%	96.2%	96.8%	96.7%	89.2%	94.0%	96.0%	95.3%
Children and Adolescents' Access to Primary Care Practitioners (CAP)– Age 25 months–6 years	NA	NA	75.9%	93.0%	93.5%	93.9%	92.0%	91.8%	91.1%	87.5%	86.3%	91.4%	90.8%	88.7%	89.8%	87.6%	86.9%	88.3%	93.1%	89.5%	91.2%	92.0%	90.5%	90.3%	83.5%	83.4%	86.7%	88.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP)– Age 7–11 years	NA	NA	NA[1]	96.0%	96.0%	95.8%	94.0%	94.3%	92.1%	92.5%	91.7%	91.9%	94.0%	92.4%	92.3%	92.8%	91.9%	91.6%	95.4%	90.9%	93.1%	94.8%	93.9%	93.3%	83.5%	84.3%	83.6%	91.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP)– Age 12–19 years	NA	NA	NA[1]	94.0%	93.6%	94.0%	95.0%	93.8%	92.6%	91.5%	90.4%	90.0%	91.8%	89.9%	89.8%	90.7%	89.2%	89.5%	94.1%	89.6%	91.2%	93.4%	92.1%	90.9%	85.0%	83.5%	84.2%	90.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP)– Age 20–44 years	NA	NA	56.5%	76.0%	74.3%	74.7%	68.0%	64.4%	64.4%	75.3%	73.7%	74.7%	79.9%	75.7%	76.0%	72.5%	71.1%	72.8%	80.4%	76.5%	78.4%	76.7%	75.1%	75.5%	65.4%	65.6%	67.8%	71.2%
Adults' Access to Preventive/Ambulatory Health Services (AAP)– Age 45–64 years	NA	NA	68.4%	86.0%	84.6%	84.5%	86.0%	83.7%	83.0%	82.1%	81.5%	82.9%	87.3%	85.1%	84.7%	83.2%	81.9%	83.5%	88.4%	86.0%	87.0%	86.7%	86.1%	86.3%	77.5%	77.9%	79.1%	82.2%
Breast Cancer Screening (BCS)	NA	NA	NA[1]	66.0%	69.2%	69.2%	74.0%	77.5%	75.8%	87.9%	81.5%	79.7%	68.2%	59.2%	55.6%	65.5%	67.1%	69.0%	69.2%	68.5%	69.5%	60.2%	59.9%	59.4%	67.3%	74.9%	76.3%	69.3%
Cervical Cancer Screening (CCS)	NA	NA	29.9%	66.0%	62.5%	67.9%	73.0%	76.8%	74.3%	79.2%	80.4%	88.0%	66.3%	56.7%	63.5%	55.9%	54.3%	60.9%	64.7%	64.0%	66.9%	68.6%	59.6%	58.9%	45.3%	45.3%	49.9%	62.2%
Chlamydia Screening in Women (CHL)– Age 16–20 years	NA	NA	65.4%	62.0%	63.9%	65.0%	89.0%	91.0%	87.6%	69.8%	71.3%	74.5%	57.6%	56.4%	57.8%	56.0%	59.1%	61.0%	60.0%	60.7%	60.2%	56.0%	57.4%	59.4%	50.1%	55.1%	54.6%	65.1%
Chlamydia Screening in Women (CHL)– Age 21–24 years	NA	NA	63.0%	70.0%	71.8%	71.8%	85.0%	81.7%	80.8%	82.1%	80.2%	83.5%	68.7%	66.0%	66.5%	66.3%	68.2%	69.3%	68.0%	68.0%	67.8%	65.4%	67.2%	65.9%	60.4%	67.6%	65.3%	70.4%
Chlamydia Screening in Women (CHL)– Total (16–24) years	NA	NA	64.2%	66.0%	67.4%	67.9%	87.0%	86.6%	84.4%	77.5%	77.0%	80.0%	62.8%	61.1%	61.9%	61.3%	64.0%	65.3%	63.6%	64.0%	63.6%	60.0%	61.6%	62.2%	56.3%	62.5%	60.9%	67.8%
Prenatal and Postpartum Care (PPC)– Timeliness of Prenatal Care	NA	NA	85.0%	89.0%	87.4%	83.5%	79.0%	78.3%	81.1%	96.7%	93.7%	94.1%	89.5%	82.7%	87.0%	83.6%	78.9%	85.1%	89.3%	84.4%	87.1%	87.6%	85.2%	83.5%	86.4%	88.3%	88.4%	86.1%
Prenatal and Postpartum Care (PPC)– Postpartum Care	NA	NA	64.0%	73.7%	72.0%	77.9%	81.3%	83.6%	90.4%	84.1%	85.2%	84.0%	67.1%	69.1%	66.9%	71.2%	74.0%	77.7%	71.3%	69.1%	70.8%	70.6%	66.4%	65.9%	71.0%	74.0%	79.0%	75.2%
Controlling High Blood Pressure (CBP)	NA	NA	51.0%	63.0%	62.0%	58.6%	72.0%	74.9%	72.6%	84.4%	85.2%	79.9%	68.7%	46.2%	46.2%	72.8%	72.8%	59.6%	51.1%	53.3%	49.9%	64.9%	64.7%	57.4%	NA	52.3%	65.5%	60.1%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	NA[1]	NA[1]	65.2%	69.5%	87.0%	NA[1]	69.0%	90.5%	NA[1]	72.4%	83.2%	81.6%	84.0%	80.5%	80.8%	62.0%	75.0%	72.3%	71.9%	81.0%	77.6%	71.2%	81.0%	70.0%	56.7%	69.2%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA[1]	77.0%	NA[1]	NA[1]	NA[1]	NA[1]	NA[1]	53.9%	NA[1]	NA[1]	76.9%	NA[1]	NA[1]	75.0%	NA[1]	NA1	57.1%	66.7%	80.0%	70.8%	NA[1]	NA[1]	NA[1]	1.0%	NA[1]	80.0%
Statin Therapy for Patients With Cardiovascular Disease (SPC) – –Received Statin Therapy – Total	NA	NA	NA[1]	70.1%	68.3%	72.1%	80.8%	82.1%	82.0%	89.5%	93.0%	86.7%	75.4%	75.1%	76.2%	80.2%	78.6%	75.5%	72.1%	75.7%	76.9%	73.5%	73.8%	73.5%	71.9%	74.5%	77.3%	77.5%
Statin Therapy for Patients With Cardiovascular Disease (SPC) – –Statin Adherence 80% - Total	NA	NA	NA[1]	48.7%	53.6%	53.8%	54.6%	53.7%	55.6%	44.1%	46.3%	54.7%	64.6%	64.3%	65.2%	44.4%	50.0%	54.5%	50.2%	52.6%	50.8%	48.0%	55.4%	54.1%	56.5%	55.9%	61.5%	56.3%
Comprehensive Diabetes (CDC)– Hemoglobin A1c (HbA1c) Testing	NA	NA	93.0%	85.0%	90.5%	85.9%	95.0%	94.9%	95.2%	92.7%	91.6%	93.3%	88.7%	80.8%	81.3%	91.7%	90.0%	90.4%	89.3%	88.1%	87.3%	86.1%	85.9%	84.4%	82.5%f	81.8%	88.8%	88.8%
Comprehensive Diabetes (CDC)– HbA1c Poor Control (>9.0%) [2]	NA	NA	40.4%	40.0%	34.1%	38.2%	27.0%	29.9%	28.1%	27.8%	28.0%	28.0%	34.4%	47.9%	48.4%	29.5%	31.4%	33.3%	34.0%	38.9%	42.6%	35.6%	35.5%	40.4%	42.1%	49.2%	32.6%	36.9%
Comprehensive Diabetes (CDC)– HbA1c Control (< 8.0%)	NA	NA	52.6%	52.0%	59.4%	51.8%	63.0%	61.1%	63.8%	60.0%	60.9%	61.1%	56.5%	46.0%	42.6%	58.1%	56.7%	54.3%	53.5%	49.6%	47.7%	51.1%	54.5%	49.1%	48.7%	42.6%	59.4%	53.6%
Comprehensive Diabetes (CDC)– Eye Exam (Retinal) Performed	NA	NA	21.1%	49.9%	55.7%	54.7%	74.0%	75.7%	71.9%	87.8%	84.5%	88.1%	51.9%	42.8%	39.9%	49.8%	63.7%	57.0%	55.7%	38.4%	50.6%	56.9%	62.3%	57.9%	31.2%	39.2%	45.5%	54.1%
Comprehensive Diabetes (CDC)– Medical Attention for Nephropathy	NA	NA	93.0%	87.0%	90.5%	87.1%	94.0%	94.2%	93.4%	94.2%	92.2%	94.0%	87.9%	86.4%	89.1%	92.4%	91.0%	92.1%	99.8%	86.9%	89.8%	90.3%	89.8%	89.1%	85.6%	88.1%	88.6%	90.7%
Comprehensive Diabetes (CDC)– Blood Pressure Control (<140/90 mm Hg)	NA	NA	54.4%	64.0%	64.7%	64.5%	78.0%	76.5%	78.3%	84.5%	82.3%	82.0%	55.6%	49.9%	54.7%	62.9%	69.8%	65.4%	55.5%	56.7%	54.0%	59.9%	65.2%	59.6%	41.6%	58.6%	63.5%	64.1%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3]Trending break for HEDIS 2019 due to measure specification changes. HEDIS 2019 results cannot be compared to the prior year benchmarks.

ABH: Aetna Better Health of Maryland
ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems, Inc.
KPMAS: Kaiser Permanente of the Mid-Atlantic States, Inc.
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice, Inc.
PPMCO: Priority Partners
UHC: UnitedHealthcare Community Plan
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2019 Results, (Page 3 of 4)	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2019
HealthChoice Organizations	**ABH***			**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	NA	NA	NA[1]	74.0%	66.7%	75.7%	77.0%	82.9%	81.8%	NA[1]	NA[1]	NA[1]	62.7%	60.1%	74.5%	58.6%	66.0%	77.2%	70.2%	65.0%	66.0%	75.4%	76.3%	79.4%	57.7%	59.5%	63.2%	74.0%
Statin Therapy for Patients With Diabetes (SPD) —Received Statin Therapy	NA	NA	NA[1]	59.4%	60.0%	61.5%	63.3%	65.3%	66.6%	84.4%	78.9%	80.6%	59.2%	59.1%	60.6%	59.5%	62.9%	63.7%	58.6%	59.2%	60.6%	58.2%	60.3%	59.0%	53.8%	57.8%	58.2%	63.9%
Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%	NA	NA	NA[1]	49.2%	44.9%	48.5%	50.7%	43.7%	50.3%	50.3%	52.1%	51.7%	59.7%	58.6%	59.2%	48.8%	47.4%	49.0%	48.9%	46.1%	50.1%	48.7%	48.7%	49.3%	57.9%	55.7%	66.7%	53.1%
Use of Imaging Studies for Low Back Pain (LBP)	NA	NA	NA[1]	76.0%	76.7%	75.7%	69.0%	79.9%	76.7%	76.9%	77.1%	82.0%	72.7%	75.0%	76.7%	66.1%	72.7%	73.0%	77.8%	77.7%	79.8%	73.3%	75.4%	76.5%	70.4%	70.4%	72.5%	76.6%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	NA	NA	NA[1]	80.0%	74.7%	77.9%	73.0%	69.7%	77.4%	93.6%	87.8%	84.1%	69.3%	70.1%	69.9%	78.9%	82.5%	80.4%	77.6%	78.3%	77.9%	72.1%	69.9%	73.1%	73.5%	62.8%	77.1%	77.2%
Annual Monitoring for Patients on Persistent Medications (MPM)– –Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	NA	NA	83.3%	90.0%	88.9%	88.7%	97.0%	94.7%	95.8%	92.0%	90.3%	91.7%	88.5%	86.2%	87.7%	89.3%	90.0%	89.0%	88.4%	88.1%	88.3%	89.4%	89.3%	88.3%	85.6%	85.2%	87.9%	89.0%
Annual Monitoring for Patients on Persistent Medications (MPM)– Members on diuretics	NA	NA	80.4%	89.0%	88.0%	88.3%	95.0%	93.7%	94.9%	90.5%	88.6%	88.9%	88.0%	86.0%	86.8%	87.5%	88.3%	88.4%	88.2%	88.3%	87.8%	88.8%	88.0%	87.1%	86.6%	84.9%	87.9%	87.8%
Annual Monitoring for Patients on Persistent Medications (MPM)– Total rate	NA	NA	82.2%	89.9%	88.5%	88.5%	96.0%	94.2%	95.4%	91.4%	89.6%	90.6%	88.1%	86.1%	87.4%	88.4%	89.3%	88.7%	88.1%	88.2%	88.1%	88.9%	88.7%	87.8%	85.9%	85.1%	87.9%	88.5%
Ambulatory Care (AMB)– Outpatient visits per 1,000 member months	NA	NA	257.4	366.9	354.3	346.5	350.6	328.7	335.4	336.6	315.9	276.9	420.4	397.5	400.7	359.8	356.2	354.6	NA	390.3	394.9	367.5	345.1	336.1	247.3	332.2	339.2	338.0
Ambulatory Care (AMB)– Emergency department (ED) visits per 1,000 member months 3	NA	NA	50.1	53.4	50.6	47.1	93.6	83.0	78.1	26.3	26.6	23.8	68.5	61.9	59.1	55.6	53.5	52.1	NA	58.0	55.0	56.8	51.7	48.6	86.4	60.7	58.2	52.5
Frequency of Selected Procedures (FSP)– Bariatric weight loss surgery /1000 MM 45-64 F	NA	NA	0.12	0.05	0.07	0.12	0.59	0.02	0.02	0.05	0.07	0.13	0.04	0.04	0.14	0.07	0.05	0.27	0.03	0.05	0.17	0.05	0.04	0.15	0.07	0.02	0.14	0.14
Frequency of Selected Procedures (FSP)– Bariatric weight loss surgery /1000 MM 45-64 M	NA	NA	0.00	0.01	0.00	0.03	0.02	0.00	0.02	0.00	0.00	0.04	0.01	0.00	0.02	0.01	0.00	0.05	0.00	0.00	0.03	0.01	0.00	0.02	0.00	0.00	0.05	0.03
Frequency of Selected Procedures (FSP)– Tonsillectomy /1000 MM 0-9 T	NA	NA	0.00	0.48	0.53	0.46	0.21	0.10	0.30	0.23	0.26	0.21	0.62	0.58	0.56	0.48	0.48	0.49	0.58	0.58	0.49	0.51	0.50	0.49	0.37	0.36	0.26	0.36
Frequency of Selected Procedures (FSP)– Tonsillectomy /1000 MM 10-19 T	NA	NA	0.06	0.14	0.16	0.17	0.17	0.05	0.16	0.20	0.14	0.11	0.26	0.20	0.24	0.24	0.17	0.16	0.24	0.23	0.20	0.20	0.21	0.17	0.34	0.22	0.10	0.15
Frequency of Selected Procedures (FSP)– Hysterectomy, abdominal /1000 MM 45-64 F	NA	NA	0.47	0.27	0.28	0.25	0.31	0.16	0.12	0.26	0.25	0.15	0.27	0.24	0.15	0.27	0.27	0.22	0.26	0.31	0.24	0.28	0.20	0.21	0.32	0.36	0.12	0.21
Frequency of Selected Procedures (FSP)– Hysterectomy, vaginal /1000 MM 45-64 F	NA	NA	0.00	0.15	0.11	0.16	0.02	0.00	0.02	0.20	0.23	0.05	0.19	0.11	0.15	0.27	0.17	0.13	0.17	0.20	0.17	0.17	0.12	0.11	0.17	0.15	0.06	0.09
Frequency of Selected Procedures (FSP)– Cholecystectomy, open /1000 MM 30-64 M	NA	NA	0.00	0.04	0.02	0.04	0.02	0.05	0.02	0.03	0.02	0.01	0.07	0.04	0.02	0.06	0.03	0.01	0.04	0.03	0.02	0.04	0.03	0.02	0.05	0.00	0.02	0.02
Frequency of Selected Procedures (FSP)– Cholecystectomy, open /1000 MM 45-64 F	NA	NA	0.00	0.51	0.04	0.02	0.05	0.02	0.02	0.02	0.00	0.02	0.08	0.04	0.02	0.04	0.03	0.01	0.03	0.04	0.04	0.04	0.03	0.03	0.05	0.09	0.02	0.02
Frequency of Selected Procedures (FSP)– Laparoscopic/1000 MM 30-64 M	NA	NA	0.44	0.19	0.20	0.14	0.06	0.04	0.09	0.12	0.07	0.08	0.29	0.24	0.17	0.15	0.14	0.13	0.23	0.21	0.20	0.22	0.19	0.13	0.18	0.19	0.10	0.16
Frequency of Selected Procedures (FSP)– Laparoscopic/1000 MM 45-64 F	NA	NA	0.23	0.51	0.49	0.41	0.19	0.30	0.07	0.24	0.38	0.25	0.55	0.53	0.43	0.56	0.27	0.43	0.51	0.53	0.43	0.42	0.36	0.33	0.32	0.60	0.45	0.34
Frequency of Selected Procedures (FSP)– Back Surgery /1000 MM 45-64 F	NA	NA	0.23	0.53	0.50	0.40	0.59	0.33	0.69	0.14	0.05	0.12	0.86	0.72	0.65	0.58	0.46	0.54	0.62	0.69	0.67	0.54	0.55	0.61	0.39	0.54	0.82	0.53
Frequency of Selected Procedures (FSP)– Back Surgery /1000 MM 45-64 M	NA	NA	0.34	0.42	0.50	0.36	0.50	0.56	0.45	0.16	0.15	0.16	0.84	0.72	0.66	0.68	0.71	0.57	0.82	0.77	0.65	0.70	0.63	0.54	0.39	0.47	0.47	0.47
Frequency of Selected Procedures (FSP)– Mastectomy /1000 MM 15-44 F	NA	NA	0.00	0.03	0.04	0.03	0.00	0.00	0.01	0.00	0.00	0.02	0.02	0.04	0.04	0.04	0.05	0.07	0.02	0.04	0.03	0.03	0.03	0.02	0.04	0.00	0.05	0.03
Frequency of Selected Procedures (FSP)– Mastectomy /1000 MM 45-64 F	NA	NA	0.23	0.18	0.12	0.09	0.02	0.02	0.05	0.15	0.09	0.09	0.08	0.10	0.13	0.06	0.11	0.14	0.11	0.12	0.11	0.13	0.10	0.07	0.07	0.10	0.13	0.11
Frequency of Selected Procedures (FSP)– Lumpectomy /1000 MM 15-44 F	NA	NA	0.08	0.09	0.10	0.10	0.05	0.06	0.12	0.60	0.04	0.09	0.12	0.10	0.09	0.12	0.13	0.12	0.12	0.13	0.12	0.11	0.10	0.08	0.08	0.08	0.10	0.10
Frequency of Selected Procedures (FSP)– Lumpectomy /1000 MM 45-64 F	NA	NA	0.59	0.33	0.34	0.30	0.19	0.14	0.12	0.41	0.28	0.33	0.37	0.26	0.25	0.36	0.45	0.59	0.32	0.35	0.32	0.29	0.33	0.20	0.37	0.31	0.37	0.34
Inpatient Utilization - General Hospital Acute Care (IPU)– Total Inpatient: Total Discharges /1000 MM	NA	NA	6.01	5.23	5.05	4.58	9.53	9.19	8.83	5.33	5.62	5.27	6.58	6.46	6.44	6.83	6.56	6.35	6.49	6.81	6.20	4.91	5.58	4.21	6.91	7.20	7.03	6.10
Inpatient Utilization - General Hospital Acute Care (IPU)– Total Inpatient: Total Average Length of Stay	NA	NA	4.22	4.17	4.21	4.34	4.47	4.64	4.80	3.36	3.45	3.31	3.87	2.53	4.54	4.18	4.78	4.22	4.09	4.44	4.21	4.44	4.4	4.68	3.51	3.54	3.62	4.22

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3]Trending break for HEDIS 2019 due to measure specification changes. HEDIS 2019 results cannot be compared to the prior year benchmarks.

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MARR: Maryland Average Reportable Rate

HEDIS 2019 Results, (Page 4 of 4)	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2017	2018	2019	2019
HealthChoice Organizations	**ABH***			**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Antibiotic Utilization (ABX)– Average Scrips PMPY for Antibiotics	NA	NA	0.62	0.84	0.79	0.76	0.79	0.80	0.74	0.58	0.60	0.57	1.09	1.01	1.00	0.90	0.86	0.84	0.98	0.93	0.90	0.91	0.85	0.80	0.86	0.81	0.80	0.78
Antibiotic Utilization (ABX)– Average Days Supplied per Antibiotic Scrip	NA	NA	8.54	9.28	9.26	9.25	8.67	7.74	8.51	9.29	9.28	9.36	9.30	9.24	9.19	8.94	8.86	8.90	9.32	9.34	9.31	9.09	9.25	9.21	9.32	9.22	9.13	9.04
Antibiotic Utilization (ABX)– Average Scrips PMPY for Antibiotics of Concern	NA	NA	0.26	0.34	0.31	0.28	0.26	0.26	0.25	0.22	0.22	0.20	0.45	0.41	0.40	0.36	0.33	0.32	0.40	0.37	0.35	0.40	0.35	0.33	0.38	0.34	0.32	0.30
Antibiotic Utilization (ABX)– Percentage of Antibiotics of Concern of all Antibiotic	NA	NA	41.2%	40.4%	38.8%	37.6%	33.1%	32.5%	33.5%	38.2%	35.9%	35.8%	41.3%	40.4%	40.1%	40.5%	39.0%	37.6%	41.5%	39.3%	38.9%	43.7%	41.6%	40.9%	44.3%	42.2%	40.4%	38.4%
Use of Opioids at High Dosage (UOD)	NA	NA	NA[1]	NA	76.0	5.5%	NA	38.6	3.5%	NA	22.4	2.7%	NA	119.9	9.8%	NA	76.2	7.0%	NA	105.1	9.9%	NA	72.2	4.9%	NA	135.3	11.7%	6.9%
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers [2]	NA	NA	23.8%	NA	313.3	28.4%	NA	267.5	22.1%	NA	262.8	25.7%	NA	195.7	19.6%	NA	387.5	41.6%	NA	329.4	31.0%	NA	250	27.8%	NA	321.1	30.4%	27.8%
Use of Opioids From Multiple Providers (UOP) - Multiple Pharmacies [2]	NA	NA	14.3%	NA	109.1	7.1%	NA	126.8	9.3%	NA	69.6	5.0%	NA	0	0%	NA	105.9	9.3%	NA	129.3	11.0%	NA	62.3	6.8%	NA	124.7	10.1%	8.1%
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers and Multiple Pharmacies [2]	NA	NA	7.1%	NA	69.4	4.3%	NA	93.9	6.3%	NA	39.0	3.7%	NA	0	0%	NA	80.0	7.4%	NA	88.4	7.2%	NA	35.4	4.0%	NA	89.4	6.4%	5.2%
Observed Readmission Rate Total (PCR)	NA	NA	0.0%	NA	NA	14.5%	NA	NA	13.0%	NA	NA	11.3%	NA	NA	16.2%	NA	NA	14.0%	NA	NA	13.6%	NA	NA	10.9%	NA	NA	17.4%	12.3%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) [2]	NA	NA	0.0%	3.0%	2.1%	1.0%	2.0%	2.0%	0.9%	0.1%	0.0%	0.0%	1.8%	1.4%	1.2%	1.3%	1.1%	0.4%	2.0%	1.4%	1.1%	3.0%	2.5%	1.4%	1.9%	1.3%	1.5%	0.84%

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Health Plan Descriptive Information

	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Language Diversity **(LDM)** – Spoken - English Number	0	16	0	66776	250453	0	0	53392	0
Language Diversity **(LDM)** – Spoken - English Percent	0.00%	0.00%	0.00%	84.86%	96.45%	0.00%	0.00%	29.35%	0.00%
Language Diversity **(LDM)** – Spoken - Non-English Number	0	16066	0	10059	3403	0	0	4373	0
Language Diversity **(LDM)** – Spoken - Non-English Percent	0.00%	4.98%	0.00%	12.78%	1.31%	0.00%	0.00%	2.40%	0.00%
Language Diversity **(LDM)** – Spoken - Unknown Number	21966	306678	33369	1828	5810	115528	356354	124146	63089
Language Diversity **(LDM)** – Spoken - Unknown Percent	100.00%	95.02%	100.00%	2.32%	2.24%	100.00%	100.00%	68.25%	100.00%
Language Diversity **(LDM)** – Spoken - Declined Number	0	0	0	26	0	0	0	0	0
Language Diversity **(LDM)** – Spoken - Declined Percent	0.00%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – White / Total	4758	54593	0	14682	83509	28646	105129	56653	17595
Race/Ethnicity Diversity **(RDM)** – White / Percent	21.66%	16.91%	0.00%	18.66%	32.16%	24.80%	29.50%	31.14%	27.89%
Race/Ethnicity Diversity **(RDM)** – Black / Total	7174	119104	0	41764	92864	46644	122305	75244	21271
Race/Ethnicity Diversity **(RDM)** – Black / Percent	32.66%	36.90%	0.00%	53.07%	35.76%	40.37%	34.32%	41.36%	33.72%
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Total	0	0	0	185	0	0	2	0	0
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Percent	0.00%	0.00%	0.00%	0.24%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – Asian / Total	1503	14475	0	6643	9759	6249	0	10920	2962
Race/Ethnicity Diversity **(RDM)** – Asian / Percent	6.84%	4.48%	0.00%	8.44%	3.76%	5.41%	0.00%	6.00%	4.69%
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Total	44	440	0	69	344	0	14216	337	143
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Percent	0.20%	0.14%	0.00%	0.09%	0.13%	0.00%	3.99%	0.19%	0.23%
Race/Ethnicity Diversity **(RDM)** – Other / Total	0	0	0	2030	870	1075	0	0	0
Race/Ethnicity Diversity **(RDM)** – Other / Percent	0.00%	0.00%	0.00%	2.58%	0.34%	0.93%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Total	0	0	0	451	0	0	0	0	0
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Percent	0.00%	0.00%	0.00%	0.57%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – Unknown / Total	720	134148	33369	12675	72320	32607	2188	38757	625
Race/Ethnicity Diversity **(RDM)** – Unknown / Percent	3.28%	41.56%	100.00%	16.11%	27.85%	28.22%	0.61%	21.31%	0.99%
Race/Ethnicity Diversity **(RDM)** – Declined / Total	7767	0	0	190	0	307	112514	0	20493
Race/Ethnicity Diversity **(RDM)** – Declined / Percent	35.36%	0.00%	0.00%	0.24%	0.00%	0.27%	31.57%	0.00%	32.48%
Total Membership – Total membership numbers for each plan	21966	322760	33369	78689	259666	115528	356354	181911	63089

	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Board Certification **(BCR)** – Family Medicine: Number of Physicians	315	935	80	222	579	320	625	1985	744
Board Certification **(BCR)** – Family Medicine: Number Board Certified	209	546	65	205	460	234	568	1432	565
Board Certification **(BCR)** – Family Medicine: Percent Board Certified	66.35%	58.40%	81.25%	92.34%	79.45%	73.13%	90.88%	72.14%	75.94%
Board Certification **(BCR)** – Internal Medicine: Number of Physicians	512	3271	616	351	1446	492	990	4455	893
Board Certification **(BCR)** – Internal Medicine: Number Board Certified	376	2278	534	317	1172	358	824	3284	711
Board Certification **(BCR)** – Internal Medicine: Percent Board Certified	73.44%	69.64%	86.69%	90.31%	81.05%	72.76%	83.23%	73.71%	79.62%
Board Certification **(BCR)** – OB/GYN: Number of Physicians	379	761	163	182	580	158	838	1235	670
Board Certification **(BCR)** – OB/GYN: Number Board Certified	272	610	163	160	472	85	791	1030	454
Board Certification **(BCR)** – OB/GYN: Percent Board Certified	71.77%	80.16%	100.00%	87.91%	81.38%	53.80%	94.39%	83.40%	67.76%
Board Certification **(BCR)** – Pediatrician: Number of Physicians	297	1690	217	110	1128	330	880	2028	658
Board Certification **(BCR)** – Pediatrician: Number Board Certified	224	1364	197	98	949	225	849	1650	499
Board Certification **(BCR)** – Pediatrician: Percent Board Certified	75.42%	80.71%	90.78%	89.09%	84.13%	68.18%	96.48%	81.36%	75.84%
Board Certification **(BCR)** – Geriatricians: Number of Physicians	30	134	39	4	34	8	59	168	37
Board Certification **(BCR)** – Geriatricians: Number Board Certified	24	85	35	4	30	7	52	98	27
Board Certification **(BCR)** – Geriatricians: Percent Board Certified	80.00%	63.43%	89.74%	100.00%	88.24%	87.50%	88.14%	58.33%	72.97%
Board Certification **(BCR)** – Other Specialists: Number of Physicians	1324	5697	1935	1112	5477	2255	13066	9665	4410
Board Certification **(BCR)** – Other Specialists: Number Board Certified	1073	4469	1705	1046	4768	1556	12407	7502	2515
Board Certification **(BCR)** – Other Specialists: Percent Board Certified	81.04%	78.44%	88.11%	94.06%	87.05%	69.00%	94.96%	77.62%	57.03%
Enrollment by Product Line **(ENP)** – Shows only total member months for Female	48208	1760498	145883	418574	1410508	584457	1958070	957583	262781
Enrollment by Product Line **(ENP)** – Shows only total member months for Male	47970	1514373	168069	361498	1159165	497732	1594966	836493	273952
Enrollment by Product Line **(ENP)** – Shows only total member months Total	96178	3274871	313952	780072	2569673	1082189	3553036	1794076	536733
Enrollment by State **(EBS)** – Maryland Only	16656	272034	26833	63670	214656	91452	299480	146338	48131

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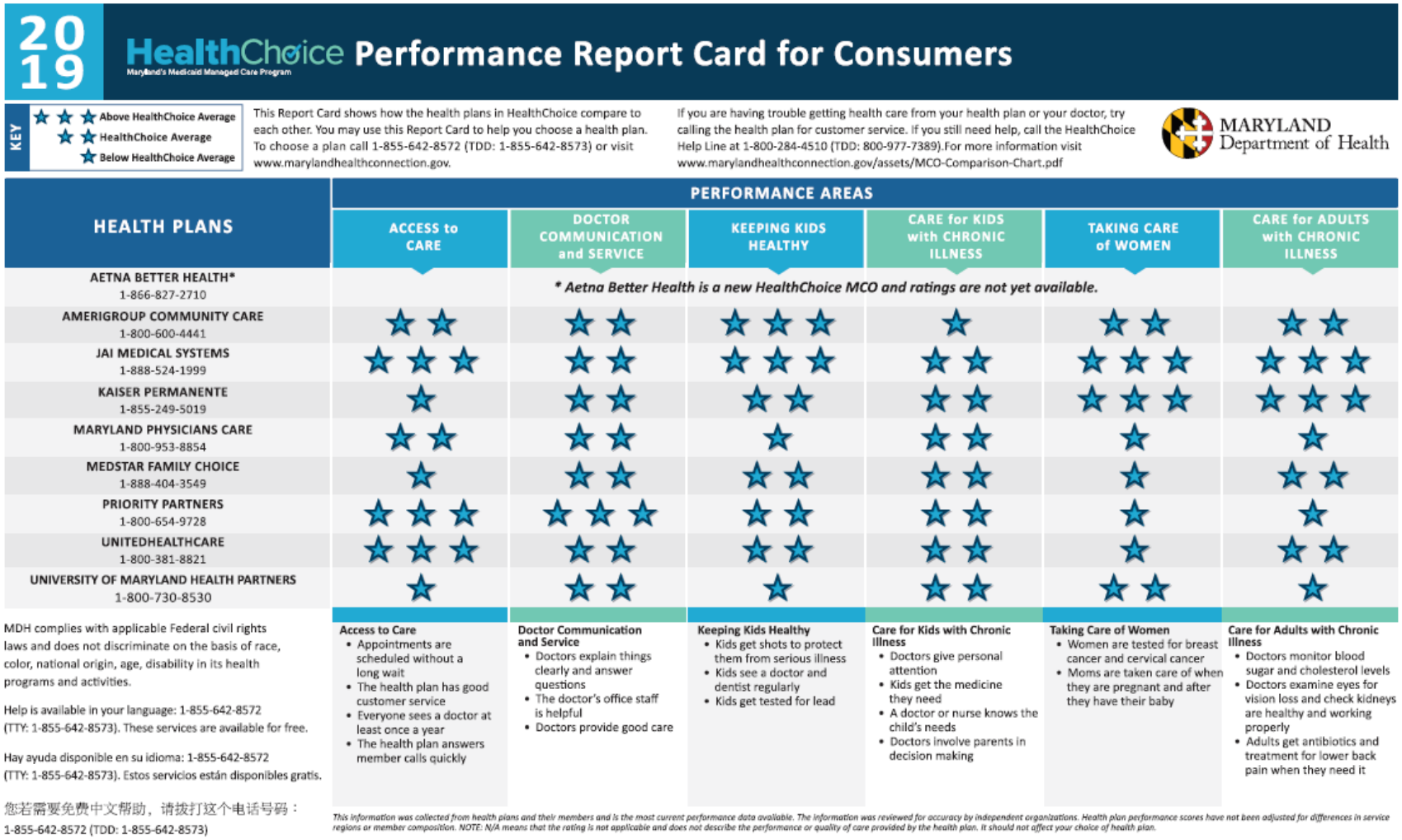
CY 2019 MD HealthChoice Performance Report Card

English Version



2019 HealthChoice Performance Report Card for Consumers

Maryland's Medicaid Managed Care Program

KEY
★★★ Above HealthChoice Average
★★ HealthChoice Average
★ Below HealthChoice Average

This Report Card shows how the health plans in HealthChoice compare to each other. You may use this Report Card to help you choose a health plan. To choose a plan call 1-855-642-8572 (TDD: 1-855-642-8573) or visit www.marylandhealthconnection.gov.

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service. If you still need help, call the HealthChoice Help Line at 1-800-284-4510 (TDD: 800-977-7389).For more information visit www.marylandhealthconnection.gov/assets/MCO-Comparison-Chart.pdf

MARYLAND Department of Health

HEALTH PLANS	PERFORMANCE AREAS					
	ACCESS to CARE	DOCTOR COMMUNICATION and SERVICE	KEEPING KIDS HEALTHY	CARE for KIDS with CHRONIC ILLNESS	TAKING CARE of WOMEN	CARE for ADULTS with CHRONIC ILLNESS
AETNA BETTER HEALTH* 1-866-827-2710		* Aetna Better Health is a new HealthChoice MCO and ratings are not yet available.				
AMERIGROUP COMMUNITY CARE 1-800-600-4441	★★	★★	★★★	★	★★	★★
JAI MEDICAL SYSTEMS 1-888-524-1999	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE 1-855-249-5019	★	★★	★★	★★	★★★	★★★
MARYLAND PHYSICIANS CARE 1-800-953-8854	★★	★★	★	★★	★	★
MEDSTAR FAMILY CHOICE 1-888-404-3549	★	★★	★★	★★	★	★★
PRIORITY PARTNERS 1-800-654-9728	★★★	★★★	★★	★★	★	★
UNITEDHEALTHCARE 1-800-381-8821	★★★	★★	★★	★★	★	★★
UNIVERSITY OF MARYLAND HEALTH PARTNERS 1-800-730-8530	★	★★	★	★★	★★	★

MDH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability in its health programs and activities.

Help is available in your language: 1-855-642-8572 (TTY: 1-855-642-8573). These services are available for free.

Hay ayuda disponible en su idioma: 1-855-642-8572 (TTY: 1-855-642-8573). Estos servicios están disponibles gratis.

您若需要免费中文帮助，请拨打这个电话号码：1-855-642-8572 (TDD: 1-855-642-8573)

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

Care for Kids with Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

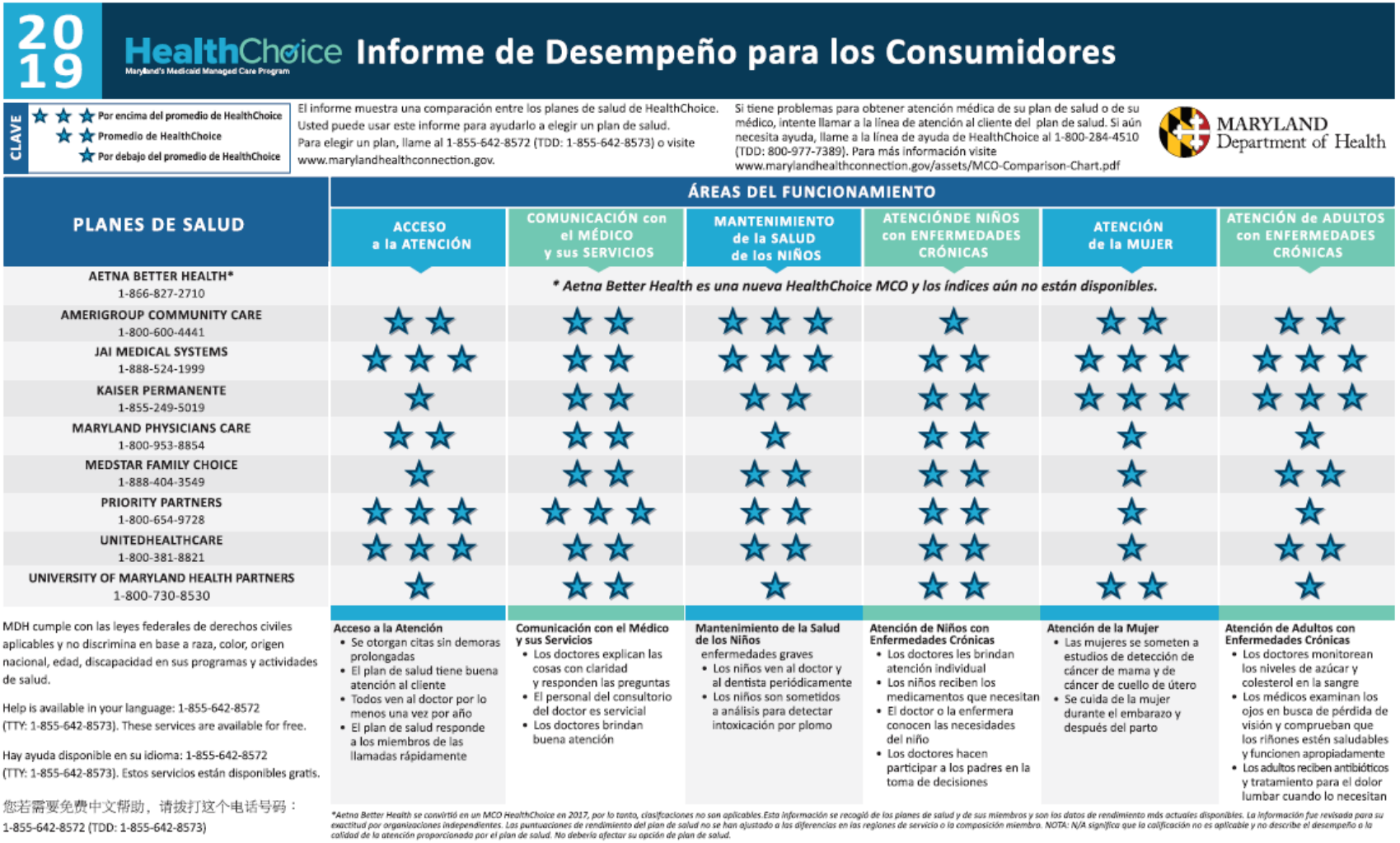
Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

Care for Adults with Chronic Illness
- Doctors monitor blood sugar and cholesterol levels
- Doctors examine eyes for vision loss and check kidneys are healthy and working properly
- Adults get antibiotics and treatment for lower back pain when they need it

This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition. NOTE: N/A means that the rating is not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.

CY 2019 MD HealthChoice Performance Report Card

Spanish Version



2019 HealthChoice Maryland's Medicaid Managed Care Program

Informe de Desempeño para los Consumidores

CLAVE
★★★ Por encima del promedio de HealthChoice
★★ Promedio de HealthChoice
★ Por debajo del promedio de HealthChoice

El informe muestra una comparación entre los planes de salud de HealthChoice. Usted puede usar este informe para ayudarlo a elegir un plan de salud.
Para elegir un plan, llame al 1-855-642-8572 (TDD: 1-855-642-8573) o visite www.marylandhealthconnection.gov.

Si tiene problemas para obtener atención médica de su plan de salud o de su médico, intente llamar a la línea de atención al cliente del plan de salud. Si aún necesita ayuda, llame a la línea de ayuda de HealthChoice al 1-800-284-4510 (TDD: 800-977-7389). Para más información visite www.marylandhealthconnection.gov/assets/MCO-Comparison-Chart.pdf

MARYLAND Department of Health

PLANES DE SALUD	ÁREAS DEL FUNCIONAMIENTO					
	ACCESO a la ATENCIÓN	COMUNICACIÓN con el MÉDICO y sus SERVICIOS	MANTENIMIENTO de la SALUD de los NIÑOS	ATENCIÓNDE NIÑOS con ENFERMEDADES CRÓNICAS	ATENCIÓN de la MUJER	ATENCIÓN de ADULTOS con ENFERMEDADES CRÓNICAS
AETNA BETTER HEALTH* 1-866-827-2710	* Aetna Better Health es una nueva HealthChoice MCO y los índices aún no están disponibles.					
AMERIGROUP COMMUNITY CARE 1-800-600-4441	★★	★★	★★★	★	★★	★★
JAI MEDICAL SYSTEMS 1-888-524-1999	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE 1-855-249-5019	★	★★	★★	★★	★★★	★★★
MARYLAND PHYSICIANS CARE 1-800-953-8854	★★	★★	★	★★	★	★
MEDSTAR FAMILY CHOICE 1-888-404-3549	★	★★	★★	★★	★	★★
PRIORITY PARTNERS 1-800-654-9728	★★★	★★★	★★	★★	★	★
UNITEDHEALTHCARE 1-800-381-8821	★★★	★★	★★	★★	★	★★
UNIVERSITY OF MARYLAND HEALTH PARTNERS 1-800-730-8530	★	★★	★	★★	★★	★

MDH cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad en sus programas y actividades de salud.

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Acceso a la Atención
- Se otorgan citas sin demoras prolongadas
- El plan de salud tiene buena atención al cliente
- Todos ven al doctor por lo menos una vez por año
- El plan de salud responde a los miembros de las llamadas rápidamente

Comunicación con el Médico y sus Servicios
- Los doctores explican las cosas con claridad y responden las preguntas
- El personal del consultorio del doctor es servicial
- Los doctores brindan buena atención

Mantenimiento de la Salud de los Niños
enfermedades graves
- Los niños ven al doctor y al dentista periódicamente
- Los niños son sometidos a análisis para detectar intoxicación por plomo

Atención de Niños con Enfermedades Crónicas
- Los doctores les brindan atención individual
- Los niños reciben los medicamentos que necesitan
- El doctor o la enfermera conocen las necesidades del niño
- Los doctores hacen participar a los padres en la toma de decisiones

Atención de la Mujer
- Las mujeres se someten a estudios de detección de cáncer de mama y de cáncer de cuello de útero
- Se cuida de la mujer durante el embarazo y después del parto

Atención de Adultos con Enfermedades Crónicas
- Los doctores monitorean los niveles de azúcar y colesterol en la sangre
- Los médicos examinan los ojos en busca de pérdida de visión y comprueban que los riñones estén saludables y funcionen apropiadamente
- Los adultos reciben antibióticos y tratamiento para el dolor lumbar cuando lo necesitan

Aetna Better Health se convirtió en un MCO HealthChoice en 2017, por lo tanto, clasificaciones no son aplicables. Esta información se recogió de los planes de salud y de sus miembros y son los datos de rendimiento más actuales disponibles. La información fue revisada para su exactitud por organizaciones independientes. Las puntuaciones de rendimiento del plan de salud no se han ajustado a las diferencias en las regiones de servicio o la composición miembro. NOTA: N/A significa que la calificación no es aplicable y no describe el desempeño o la calidad de la atención proporcionado por el plan de salud. No debería afectar su opción de plan de salud.

Qlarant