Medicaid Managed Care Organization

Maryland
DEPARTMENT OF HEALTH

HealthChoice
Maryland's Medicaid Managed Care Program

EPSDT Medical Record Review

Executive Summary Report

Calendar Year 2018

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Qlarant

CY 2018 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review Executive Summary Report

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 Omnibus Budget Reconciliation Act (OBRA) 1989]. Each State determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

The Program's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. The foundation of this philosophy is based on providing a "medical home" for each enrollee, by connecting each enrollee with a primary care provider (PCP) who is responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary preventive care for the enrollee. The Program emphasizes health promotion and disease prevention, and requires that participants be provided health education and outreach services.

As the Maryland Department of Health's (MDH's) contracted External Quality Review Organization (EQRO), Qlarant annually completes an EPSDT medical record review. The medical record review findings assist MDH evaluate the degree to which HealthChoice children and adolescents 0 through 20 years of age receive timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

This report summarizes the findings from the EPSDT medical record review for Calendar Year (CY) 2018. Approximately 642,271 children were enrolled in the HealthChoice Program during this period. The nine Managed Care Organizations (MCOs) evaluated for CY 2018 were:

- AMERIGROUP Community Care (ACC)
- Aetna Better Health of Maryland (ABH)
- 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)

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.
- 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 recipients through 20 years of age as of the last day of the measurement year.
- Sample includes EPSDT recipients enrolled on last day of the measurement year, and for at least 320 days in the same MCO.
  Exception – If the recipient'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 recipients 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 recipients 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, and
- 12 through 20 years of age.

The following scores were provided to the specific elements within each age group based on medical record documentation:

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 Corrective Action Plan (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 recipients 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 (IRR) 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 1 displays the MCO results for CY 2018.

Table 1. 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%
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%**

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 2. 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%**

Underlined element scores denote scores below the 80% minimum compliance requirement.
[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.

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 Body Mass Index (BMI) beginning at 2 years of age.

Table 3. CY 2018 Comprehensive Physical Examination Element Results

CY 2018 Comprhensive 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%
Component Score	**97%**	**95%**	**100%**	**98%**	**96%**	**98%**	**98%**	**97%**	**97%**	**97%**

Underlined element scores denote scores below the 80% minimum compliance 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 sexually transmitted infection/human immunodeficiency virus (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 4. 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%
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%**

Underlined element scores denote scores below the 80% minimum compliance requirement.
[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.

Laboratory/At-Risk Screening Results

- All MCO component scores except for one (ACC) exceeded the minimum compliance score of 80% in CY 2018. ACC submited 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 Advisory Committee of Immunization Practices (ACIP) and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients through 18 years of age must participate in the Department'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 the table below.

Table 5. 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%**

Underlined element scores denote scores below the 80% minimum compliance requirement.
[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)

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 6. 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%**

Underlined element scores denote scores below the 80% minimum compliance requirement.

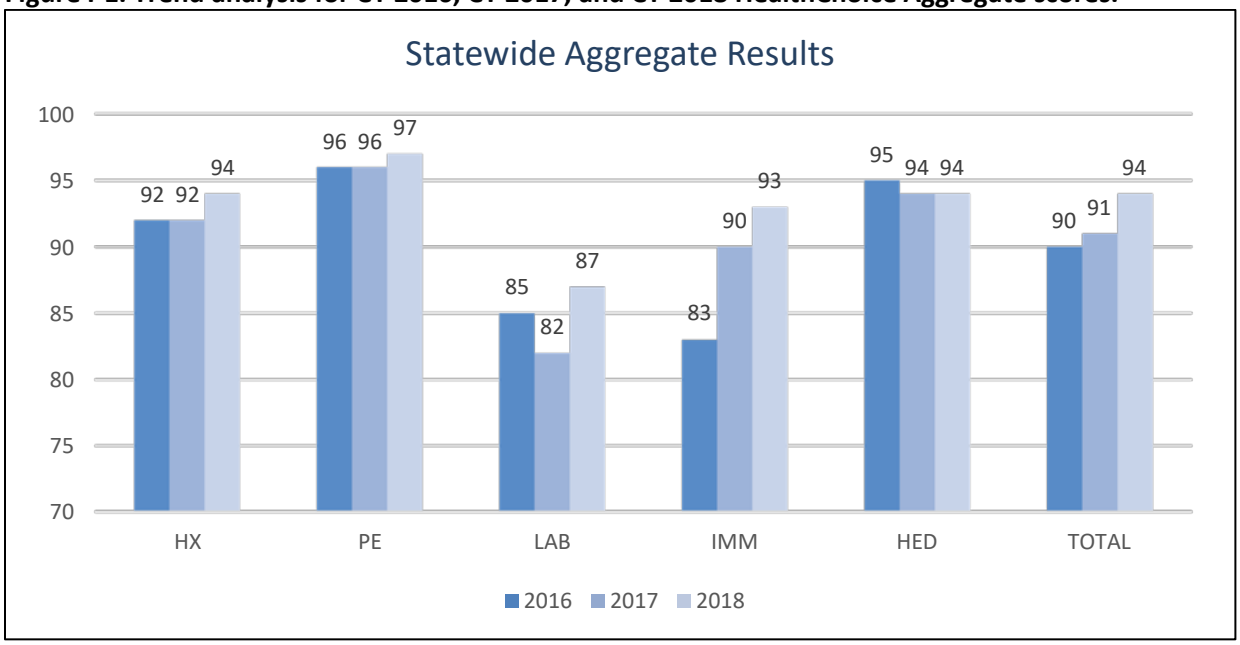
Health Education/Anticipatory Guidance Results

- 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 a 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 I-1. 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 HED (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 Healthy Kids/EPSDT Program. In the event the minimum compliance score is not met, MCOs are required to submit a CAP. The CAPs are evaluated by Qlarant to determine whether the plans are acceptable. 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.

Conclusions

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.

The MCO results of the EPSDT review demonstrate strong compliance with the timely screening and preventive care requirements of the Healthy Kids/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 follows the Maryland Schedule of Preventive Health Care.