HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

Performance Improvement Project Annual Report

Calendar Year 2018

Qlarant

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Medicaid Managed Care Organization Performance Improvement Projects Annual Report 2018

Introduction

The Maryland Department of Health (MDH) is responsible for the evaluation of the quality of care provided to Medical Assistance recipients in the HealthChoice program. MDH contracts with Qlarant as the External Quality Review Organization (EQRO). Qlarant is responsible for evaluating the Performance Improvement Projects (PIPs) submitted by the Managed Care Organizations (MCOs) according to Centers for Medicare and Medicaid Services' (CMS') *External Quality Review Protocol 3: Validating Performance Improvement Projects.*

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio PIP. The Lead Screening PIP replaced the Controlling High Blood Pressure PIP in 2018. This report summarizes the findings from the validation of both PIPs. The MCOs who conducted PIPs in 2018 are identified below. Aetna Better Health (ABH) did not conduct any PIPs for the CY 2017 measurement period since they commenced operations in October 2017.

- 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)

PIP 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

MDH initiated the Asthma Medication Ratio PIP in February 2017 using HEDIS® 2017 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2017. The 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. Maryland's Asthma Control Program and its partners have demonstrated success through an evidence-based, public health approach to asthma control by focusing on communities with the greatest needs.

MDH initiated the Lead Screening PIP in March 2018 using HEDIS® 2018 and CY 2017 Maryland encounter data measure rates as the baseline measurements for MCOs in developing interventions due September 30, 2018. The HEDIS® 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 from birth to age 6 while their neurological systems are developing. Exposure to lead can cause long-term neurological damage that may be associated with learning and behavioral problems and with 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.

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, as well as 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 the Department.

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 1.

Table 1. 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.

Validation Steps	Qlarant's Validation Process
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. Table 2 describes the criteria for reaching a determination in the scoring methodology.

Table 2. 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.

Beginning with the Lead Screening PIP, all new PIPs will be using the new Rapid Cycle PIP Process 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.

Qlarant assists the MCOs in the Rapid Cycle PIP process and breaks down the process into manageable steps based on the PIP development and implementation requirements:

1. **Develop an appropriate project rational** 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.

The Rapid Cycle PIP approach is continuous and allows the PIPs to monitor their improvement efforts over short time periods (monthly or quarterly). Frequent monitoring allows for quick intervention, when necessary. The ultimate goal is for MCOs to improve performance in a short amount of time and sustain improvement resulting in a positive impact on member health outcomes.

Implementing a quarterly schedule to guide MCO's activities facilitates a meaningful Rapid Cycle PIP process, particularly in the first year of deployment.

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 3 represents the CY 2018 Validation Results for all Asthma Medication Ratio PIPs.

Table 3. Asthma Medication PIP Validation Results for CY 2018

Step/Description	CY 2018 Asthma Medication Ratio PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	NA	NA	NA	NA	NA	NA	NA	NA
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Met	Met	Met
7. Assess Improvement Strategies	PM	Met	Met	Met	PM	PM	PM	PM
8. Review Data Analysis & Interpretation of Study Results	PM	Met	Met	Met	Met	PM	PM	PM
9. Assess Whether Improvement is Real Improvement	PM	PM	PM	PM	PM	PM	PM	Met
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

PM – Partially Met; NA – Not Applicable

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

Five MCOs (ACC, MSFC, PPMCO, UHC, and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies) because member interventions did not address cultural differences. Additionally, PPMCO's interventions were not robust enough or responsive to the identified system-wide barriers, based upon an analysis of the MCO's data.

Four MCOs (ACC, PPMCO, UHC, and UMHP) 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 data analysis plan in their data analysis.

All MCOs, with the exception of UMHP, received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement) because there was no documented quantitative improvement in the rate compared to the previous measurement year.

All MCOs received a rating of "N/A" for Step 10 (Assess Sustained Improvement) because two remeasurements are required before sustained improvement can be determined.

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 were identified as follows.

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:

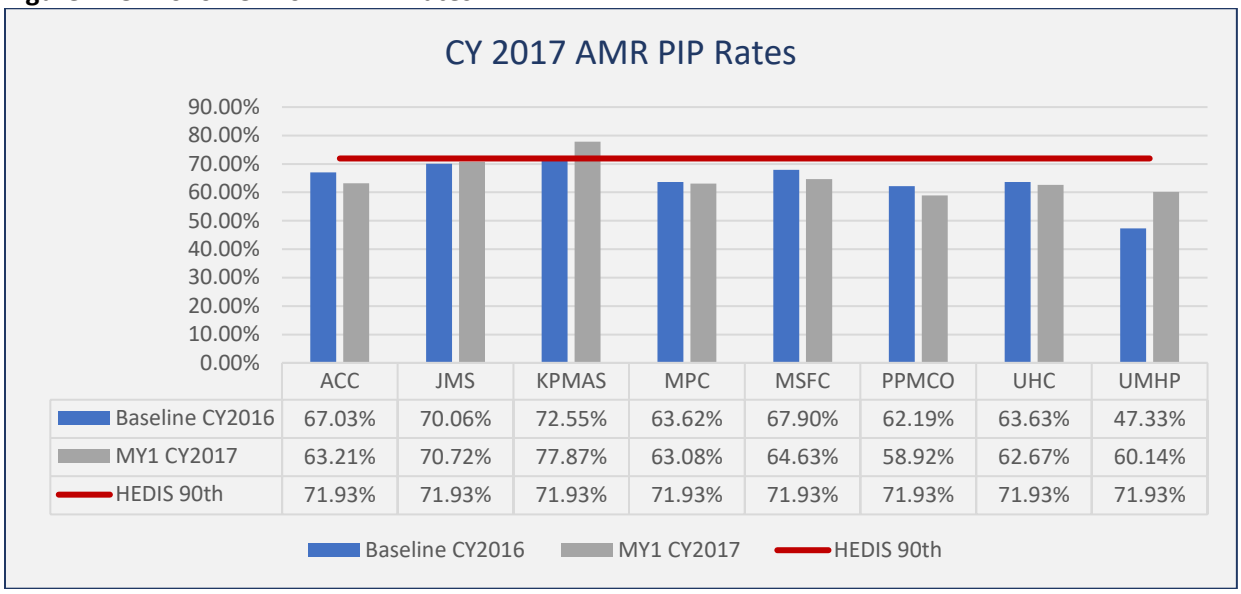
- Member education and outreach, including targeting members who meet specific criteria.
- Use of CRISP (Chesapeake Regional Information System) data by MCOs and providers to identify and target members with ED usage.
- Disease/case management.
- Health coaches.
- Provider education.
- Provider care 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.

Asthma Medication Ratio Indicator Results

CY 2017 is the first 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 2017 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%
MY1 CY2017	63.21%	70.72%	77.87%	63.08%	64.63%	58.92%	62.67%	60.14%
HEDIS 90th	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%

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

Three MCOs demonstrated improvement in performance rates over their baseline measurements:

- JMS' rate increased by 0.66 percentage points.
- KPMAS' rate increased by 5.32 percentage points.
- UMHP's rate increased by 12.81 percentage points, which was statistically significant.

The remaining five MCOs experienced a decline in performance over their baseline measurements:

- ACC's rate declined by 3.82 percentage points, which was statistically significant.
- MPC's rate declined by 0.54 percentage points.
- MSFC's rate declined by 3.27 percentage points.
- PPMCO's rate declined by 3.27 percentage points, which was statistically significant.
- UHC's rate declined by 0.96 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 4 represents the CY 2018 Validation Results for all Lead Screening PIPs.

Table 4. Lead Screening PIP Validation Results for CY 2018

Step/Description	CY 2018 Lead Screening PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	NA	NA	Met	Met	Met	NA	NA	Met
6. Review Data Collection Procedures	Met	Met	Met	PM	Met	Met	Met	PM
7. Assess Improvement Strategies	PM	Met	Met	PM	Met	PM	Met	PM
8. Review Data Analysis & Interpretation of Study Results	Met	Met	Met	PM	Met	PM	Met	PM
9. Assess Whether Improvement Is Real Improvement	NA	NA	NA	NA	NA	NA	NA	NA
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

PM – Partially Met; NA – Not Applicable

Two MCOs (MPC and UMHP) received a rating of "Partially Met" for Step 6 (Review Data Collection Procedures) because they did not identify the qualifications and relevant experience of the staff that collect the data.

Four MCOs (ACC, MPC, PPMCO, and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). MPC, PPMCO and UMHP did not implement sufficient interventions to address system-wide barriers in a meaningful way. Additionally, ACC, PPMCO, and UMHP did not demonstrate implementation of targeted interventions in response to any cultural barriers identified among its population subgroups.

Three MCOs (MPC, PPMCO and UMHP) received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results). MPC did not accurately report indicator results, while PPMCO and UMHP did not provide an analysis of their data consistent with their data analysis plan.

All MCOs received a rating of "N/A" for Steps 9 (Assess Whether Improvement is Real Improvement) and 10 (Assess Sustained Improvement) as CY 2017 was the baseline measurement year. Indicator improvement and sustained improvement will be assessed in subsequent years.

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

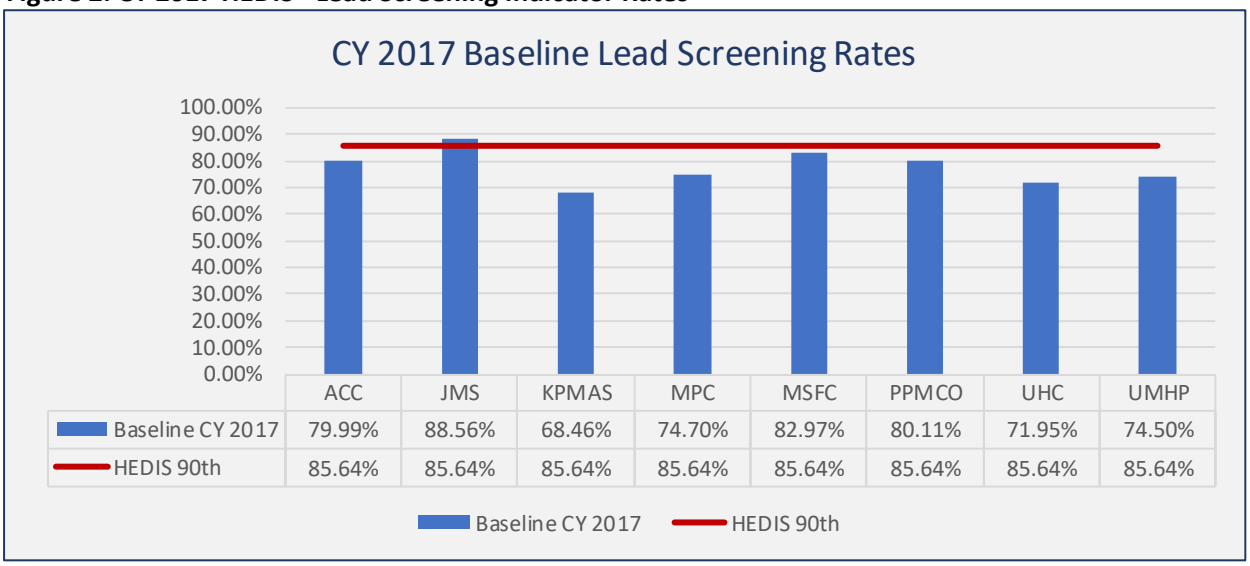
Below are examples of interventions implemented by the HealthChoice MCOs for Lead Screening PIPs:

- 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 on-site 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.
- Provider feedback on lead screening performance.

Lead Screening Indicator Results

CY 2017 is the baseline measurement year for the Lead Screening PIP. Figure 2 represents the HEDIS® indicator rates for the eight MCOs participating in this PIP.

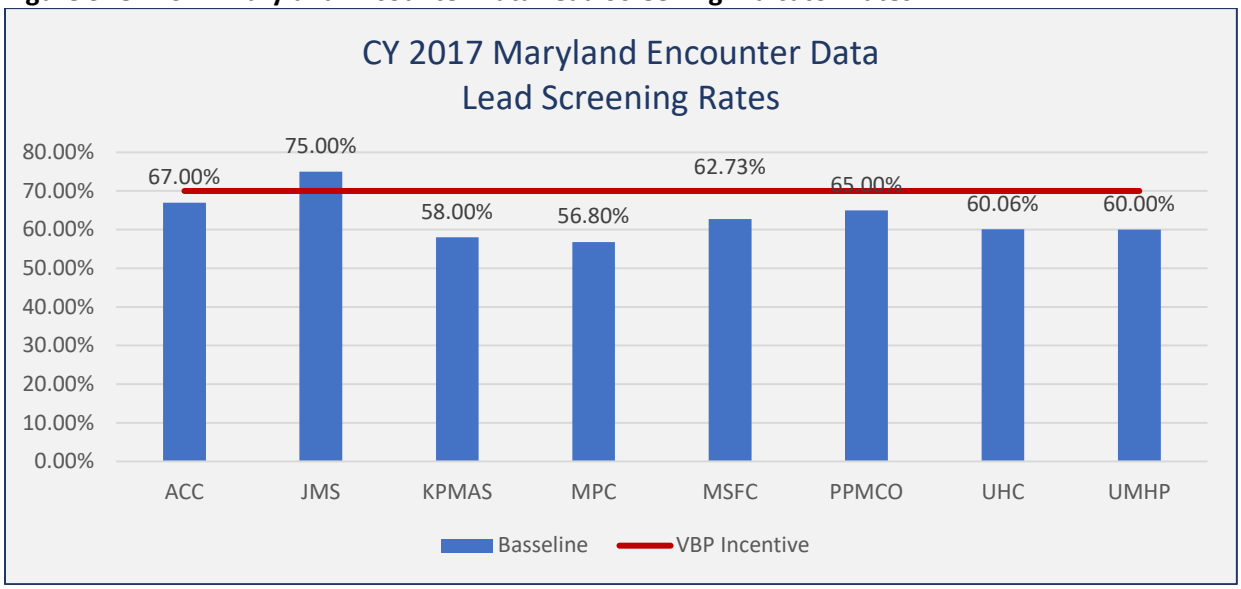
Figure 2. CY 2017 HEDIS® Lead Screening Indicator Rates



There is wide variation among the MCOs in the baseline rates relative to the 2018 HEDIS® Medicaid 90th Percentile benchmark. JMS exceeds the 90th percentile benchmark for the Lead Screening rate. Three MCOs (ACC, MSFC and PPMCO) are performing close to or above the 75th percentile for this measure. Baseline rates for MPC, UHC, and UMHP are performing close to or above the 50th percentile. KPMAS is performing mid-range between the 25th and 50th percentiles.

Figure 3 represents the Maryland encounter data indicator rates.

Figure 3. CY 2017 Maryland Encounter Data Lead Screening Indicator Rates



JMS is the only MCO with Maryland encounter data rates for lead screening that are in the incentive benchmark range of ≥ 70% for Maryland's Value Based Purchasing Initiative. Two MCOs (ACC and PPMCO) have rates within the VBP neutral benchmarks (64%-69%). The remaining five MCOs (KPMAS, MPC, MSFC, UHC, and UMHP) have rates within the VBP disincentive benchmark (≤ 63%).

PIP Recommendations

Qlarant recommends that the HealthChoice MCOs concentrate efforts on:

- **Completing annual in-depth barrier analysis** to identify root causes of suboptimal performance, which will direct where limited resources can be most effectively used to drive improvement. Barrier analysis continues to be conducted at a high-level by many MCOs, resulting in little or no improvement in indicator rates.
- **Developing robust, system–level interventions** responsive to identified barriers, which 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.
- **Ensuring 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.
- **Assessing interventions for their effectiveness**, and initiating 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.
- **Ensuring that data analysis is consistent with the data analysis plan**, both quantitative and qualitative.

Conclusions

All MCOs are required to participate in two PIPs, Asthma Medication Ratio and Lead Screening. CY 2017 results were submitted in September 2018, representing the first remeasurement year for the Asthma Medication Ratio PIP and the baseline measurement year for the Lead Screening PIP. Eight of the nine HealthChoice MCOs participated in both PIPs. ABH's participation was not required since the MCO did not initiate operations until October 2017. A separate HEDIS® audit of all PIP indicator results was conducted by an independent NCQA-certified organization. Maryland encounter data rates were also validated by Qlarant.

An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS® and Maryland encounter data measure findings and conclusions for the selected indicators. Tables 5 and 6 identify the level of confidence Qlarant has assigned to each MCO's Asthma Medication Ratio and Lead Screening PIPs for CY 2018.

Table 5. CY 2018 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	X	X				
Confidence	X				X		X	X
Low Confidence						X		
Reported PIP Results Not Credible								

A low confidence level was assigned to PPMCO's Asthma Medication Ratio PIP as their interventions were not robust enough, not always linked to an identified barrier, and the MCO did not assess the interventions for their impact. A level of confidence was assigned to PIPs submitted by ACC, UHC, and UMHP due to inconsistencies with their data analysis based on their data analysis plan. MSFC's PIP was assigned a level of confidence due to the lack of robust, timely interventions not implemented as planned. Additionally, all MCOs that were assigned a level of low confidence or confidence did not demonstrate implementation of targeted interventions in response to identified cultural or linguistic barriers.

Table 6. CY 2018 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	X		X		X	
Confidence				X		X		X
Low Confidence								
Reported PIP Results Not Credible								

The Lead Screening PIP submitted by MPC was assigned a level of confidence because it did not evidence sufficient interventions to improve outcomes in a meaningful way, describe the qualifications and experience of individuals that collect the data, and report accurate indicator rates. PPMCO's PIP was assigned a level of confidence since it did not implement more than one new intervention or address system-wide barriers, and there was no evidence that this intervention was assessed for effectiveness. Reported results for UMHP's PIP were assigned a level of confidence due to the absence of stated qualifications and experience of individuals used to collect medical record data, lack of interventions to address provider and member cultural/linguistic barriers, and data analysis inconsistencies with data analysis plan.