

The Qlarant logo features the word "Qlarant" in a white, sans-serif font, followed by a stylized graphic of four yellow squares arranged in a 2x2 grid.

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MARYLAND  
Department of Health

**HealthChoice**  
Maryland's Medicaid Managed Care Program

Medicaid Managed Care  
Organization

Performance Improvement  
Project Annual Report

Calendar Year 2019

Submitted November 2019

# Medicaid Managed Care Organization Performance Improvement Projects Annual Report 2019

## 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 2019 are identified below. Aetna Better Health (ABH) did not conduct any PIPs for the CY 2018 measurement period since they joined the HealthChoice program 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 rates as the baseline measurement for MCOs. 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.

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. 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 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.

## 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 1.

**Table 1. 10–Step Validation Methodology to PIP Validation**

Validation Steps	Qlarant’s Validation Process
<p><b>Step 1.</b> The <b>study topic</b> selected must be appropriate and relevant to the MCO’s population.</p>	<p>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.</p>

Validation Steps	Qlarant’s Validation Process
<b>Step 2.</b> The <b>study question(s)</b> must be clear, simple, and answerable.	Identify a study question that addresses the topic and relates to the indicators.
<b>Step 3.</b> The <b>study indicator(s)</b> 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.
<b>Step 4.</b> The <b>study population</b> 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.
<b>Step 5.</b> The <b>sampling method</b> must be valid and protect against bias.	Assess the techniques used to provide valid and reliable information.
<b>Step 6.</b> The <b>data collection procedures</b> 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.
<b>Step 7.</b> The <b>improvement strategies</b> , 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.
<b>Step 8.</b> The <b>study findings</b> , 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.
<b>Step 9.</b> Project results must be assessed as <b>real improvement</b> .	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.
<b>Step 10.</b> <b>Sustained improvement</b> 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 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.

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 2019 Validation Results for all Asthma Medication Ratio PIPs.

**Table 3. 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	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	PM	PM	PM	PM	PM	PM
8. Review Data Analysis & Interpretation of Study Results	PM	Met	PM	PM	PM	PM	PM	PM
9. Assess Whether Improvement is Real Improvement	Met	PM	PM	PM	PM	PM	PM	PM
10. Assess Sustained Improvement	Unmet	Met	Unmet	Unmet	Unmet	Unmet	Unmet	Unmet

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.

Seven MCOs 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 with the exception of 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, with the exception of 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 of the 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, with the exception of 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 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:

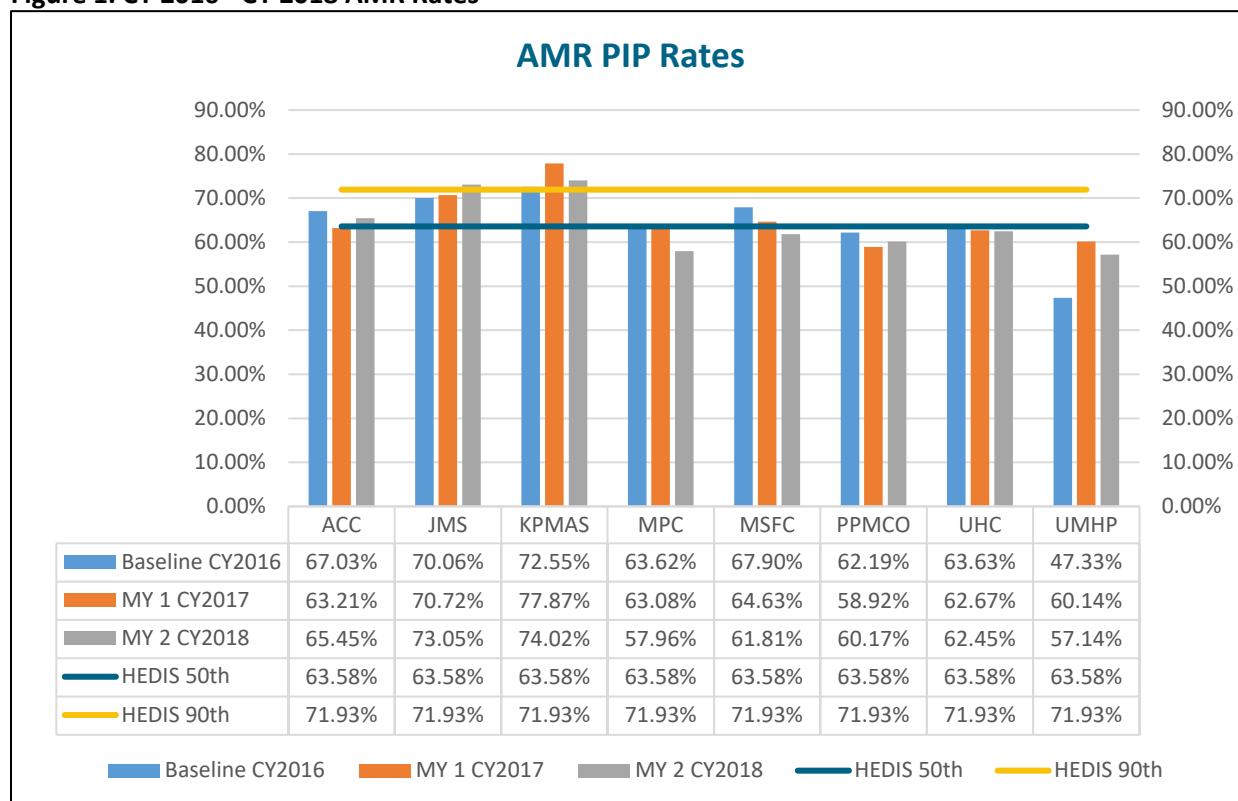
- Member education and outreach, including targeting members who meet specific criteria.
- Use of CRISP (Chesapeake Regional Information System for our Patients) data by MCOs and providers to identify and target members with ED usage.
- Disease/case management.
- Health coaches.
- Provider education.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



Note: Measurement Year (MY)

There is wide variation among the MCOs in their performance relative to the HEDIS® 2018 (MY 2017) Medicaid 90<sup>th</sup> Percentile benchmark. JMS and KPMA are performing above the 90<sup>th</sup> percentile. ACC is



performing above the 50<sup>th</sup> percentile. MPC, MSFC, PPMCO, UHC, and UMHP are performing below the 50<sup>th</sup> 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 4 represents the CY 2019 Validation Results for all Lead Screening PIPs.

**Table 4. 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	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	Met	Met	Met	Met	Met
7. Assess Improvement Strategies	PM	Met	PM	PM	Met	PM	Met	Met
8. Review Data Analysis & Interpretation of Study Results	PM	Met	PM	PM	PM	Met	PM	PM
9. Assess Whether Improvement Is Real Improvement	PM	PM	Met	PM	PM	PM	PM	Met

Step/Description	CY 2019 Lead Screening PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

PM – Partially Met; NA – Not Applicable

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

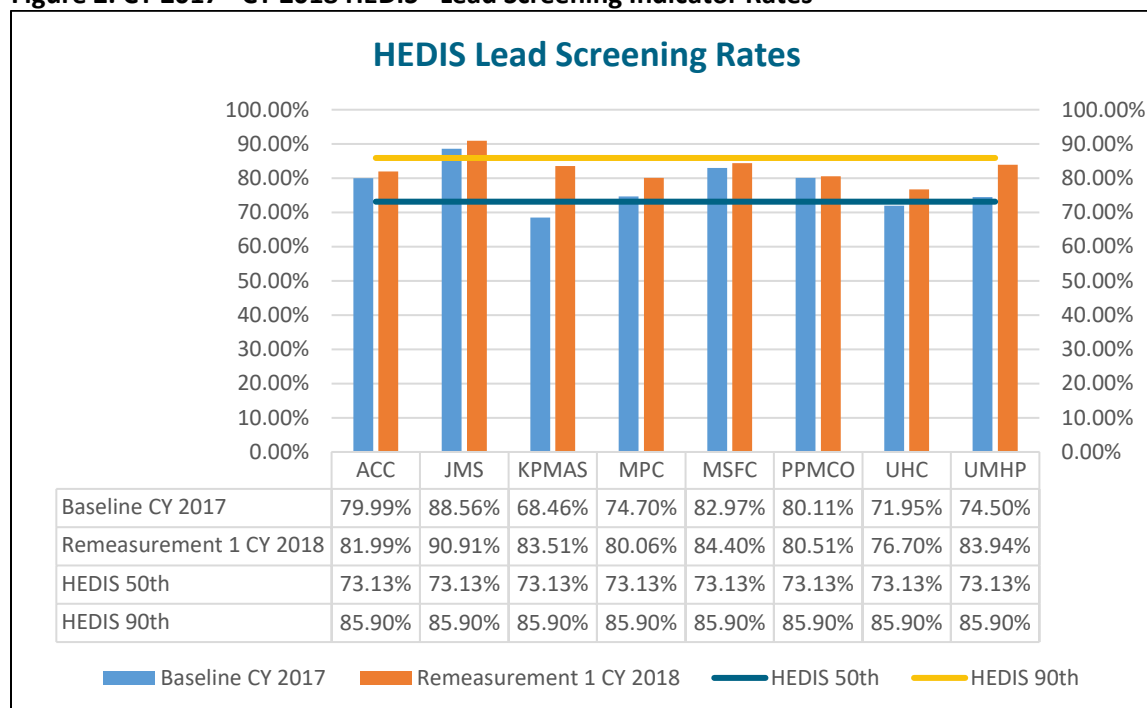
Below are examples of interventions implemented by the HealthChoice MCOs for Lead Screening PIPs:

- 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 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.
- 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**



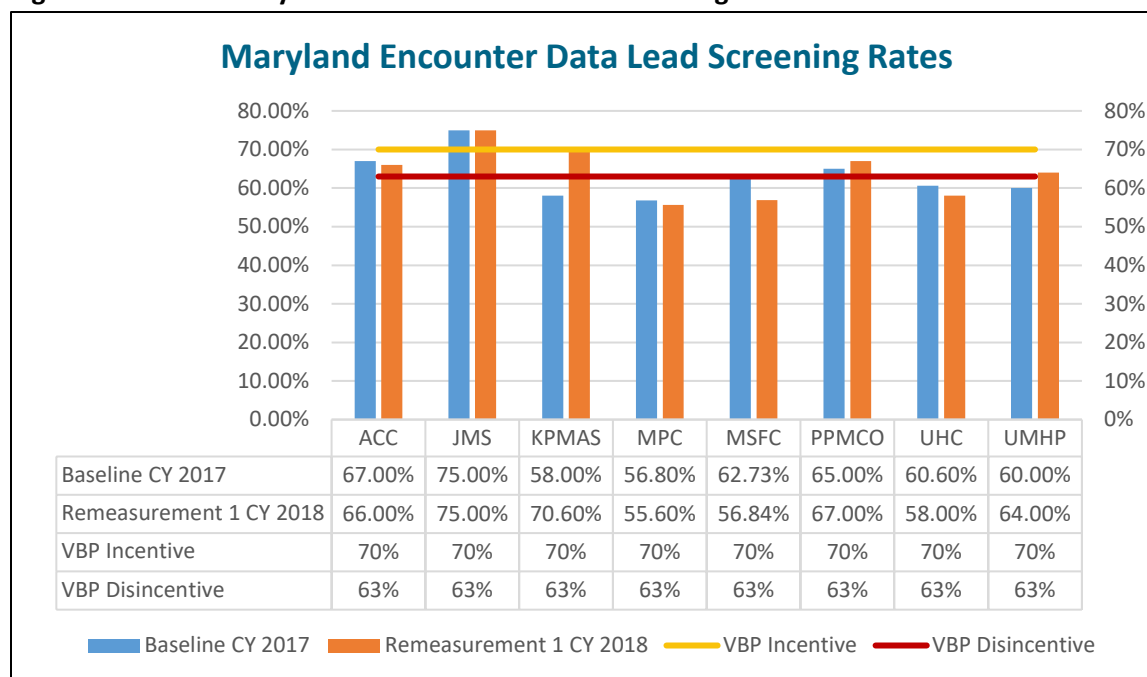
Among the majority of MCOs there is fairly narrow variation in the remeasurement 1 rates relative to the 2019 HEDIS® Medicaid 90<sup>th</sup> Percentile benchmark. JMS exceeds the 90<sup>th</sup> percentile benchmark for the Lead Screening rate. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) are performing close to or above the 75<sup>th</sup> percentile for this measure. UHC is performing mid-range between the 50<sup>th</sup> and 75<sup>th</sup> 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**



JMS and KPMAS are the only MCOs with Maryland encounter data rates for lead screening that are in the incentive benchmark range of  $\geq 70\%$  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 ( $\leq 63\%$ ).

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.

## PIP 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 where all plans demonstrated improvement. 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.

## Conclusions

All MCOs are required to participate in two PIPs, Asthma Medication Ratio and Lead Screening. CY 2018 results were submitted in September 2019, representing the second remeasurement year for the Asthma Medication Ratio PIP and the first remeasurement 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 MDH’s subcontractor.

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 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
Reported PIP 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. Additionally, 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.

**Table 6. 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	

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