Qlarant

Maryland
DEPARTMENT OF HEALTH

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

Annual Technical Report

Calendar Year 2020

Submitted April 2021

Table of Contents

List of Figures and Tables

Figures

Tables

Maryland HealthChoice Medicaid Program

2020 Annual Technical Report

Measurement Year 2019

Executive Summary

Background

As of December 31, 2019, the HealthChoice program enrolled 1,331,791 participants. The Department contracted with nine Managed Care Organizations (MCOs) during this evaluation period. Those MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid–Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)[1]

Table 1 highlights MCO profiles and quality characteristics.

Table 1. CY 2019 MCO Profiles

MCO	Contracted Since	CY 2019 Enrollment*	NCQA Accreditation Status**
ABH	2019	44,308	Accredited
ACC	1999	301,382	Commendable
JMS	1997	28,908	Excellent
KPMAS	2014	93,753	Excellent
MPC	1997	228,201	Accredited
MSFC	1997	99,773	Commendable
PPMCO	1995	324,638	Commendable
UHC	1997	157,930	Accredited
UMHP	2013	52,898	Accredited

*Source: Maryland Department of Health, MCO enrollment as of January 1, 2020.
**Source: Metastar (2020, September). Statewide Executive Summary Report HealthChoice Participating Organization HEDIS®[2] 2020 Results. Madison, WI.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires states contracting with MCOs to conduct annual, independent reviews of the managed care program. To meet these requirements, MDH

[1] Entity acquired in October 2020 and renamed CareFirst Blue Cross Blue Shield Community Health Plan of Maryland (CFCHP) as of February 2021.
[2] The MD MCO accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

contracts with Qlarant, an independent external quality review organization (EQRO). Qlarant evaluates the quality, accessibility, and timeliness of health care services furnished by the MCOs through various mandatory activities following Centers for Medicare and Medicaid Services (CMS)-developed EQRO protocols.[3] Qlarant completed the following external quality review (EQR) activities in 2019-2020 to evaluate MCO performance for measurement year (MY) 2019:

- Systems Performance Review (SPR)
- Performance Measure Validation (PMV)
- Performance Improvement Project Validations (PIPs)
- MCO Network Adequacy Validation (NAV)

In addition to completing the mandatory activities, Qlarant conducted optional activities that include:

- Encounter Data Validation (EDV)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews
- Development and production of an annual Consumer Report Card (CRC)
- Quarterly focused reviews of MCO grievances, appeals, and denials (GAD)

In addition to these EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing how data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCOs. This document serves as Qlarant's report to MDH on the assessment of MY 2019 MCO performance.

[3] The EQRO Protocols are available for download at: www.cms.gov

Qlarant's Annual Technical Report (ATR) describes EQR methodologies for completing activities, results for compliance, and performance. It includes an overview of the quality, access, and timeliness of health care services provided to Maryland's Medicaid managed care enrollees. Recommendations for improvement are made, and if acted upon, may positively impact enrollee outcomes.

Key Findings

Systems Performance Review

MCOs are expected to be fully compliant with federal and contract requirements. SPRs evaluate MCO compliance with structural and operational standards. For the MY 2019 review, Qlarant reviewed standards requiring a corrective action plan (CAP) or scored as baseline in the CY 2018 review.

CAPS were required to address areas of continued non-compliance for all but one MCO (JMS), which should increase compliance rates if successfully implemented. Table 2 displays the number of CAPs required by each MCO.

Table 2. Total Corrective Action Plans per MCO

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

Performance Improvement Projects

Eight MCOs (excluding ABH) conducted two performance improvement projects (PIPs). The Asthma Medication Ratio (AMR) PIP assessed quality of care, while the Lead Screening PIP assessed quality, timeliness, and accessibility of care. The HEDIS AMR measure was selected for the AMR PIP. Two measures were chosen for the Lead Screening PIP: HEDIS Lead Screening and Maryland Encounter Data.

Table 3 displays the percentage change in indicator results from MY 2018 to MY 2019 for each MCO.

Table 3. Percentage Change in PIP Results from MY 2018 to MY 2019

Indicator	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Asthma Medication Ratio PIP Percentage Change								
AMR	(1.9)	3.8	3.3	0.5	2.0	0.1	0.0	0.7
Lead Screening PIP Percentage Change								
HEDIS Lead	(0.6)	1.2	6.1	0*	0*	3.4	(2.3)	0*
Encounter Data	(0.5)	0.5	2.7	5.8	7.9	(2.1)	2.0	1.6

*These MCOs elected to report HEDIS 2019 audited rates for HEDIS 2020 hybrid measures based upon NCQA guidance in response to the impact of COVID-19.

Encounter Data Validation

Validation of encounter data provides the State with confidence in the completeness and accuracy of encounter data submitted by the MCOs. MDH uses information from encounter data to determine the HealthChoice population's acuity, which then impacts the calculation of MCO capitation payments.

Overall validation findings indicate that the data are complete and accurate. MCOs achieved a match rate of 98%, meaning 98% of claims submitted were supported by medical record documentation. No CAPs were required as all MCOs exceeded the 90% standard.

Value-Based Purchasing

The Value-Based Purchasing (VBP) activity uses financial incentives and disincentives to promote performance improvement. Calendar year (CY) 2019 VBP rates were drawn from HEDIS and encounter data rates reported by MCOs and/or Maryland Department of the Environment. For each of the nine selected measures, MDH calculates incentive, neutral, and disincentive ranges. These ranges are then used to determine if the MCO's quality improvement efforts have successfully resulted in improved health outcomes and if incentives should be awarded or disincentives should be assessed.

Table 4 identifies whether the MCO will receive an overall incentive or will be required to pay a disincentive based upon calculated incentive/disincentive amounts for each of the nine measures.

Table 4. Overall VBP Net Incentive Outcome by MCO

MCOs	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Outcome	D	D	I	I	D	D	D	D	I

I - Incentive, D - Disincentive

EPSDT Medical Record Review

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical record review assess quality, timeliness, and accessibility of care. Over 2,600 medical records were reviewed for this activity. CY 2019 review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. Compliance thresholds for each of the five components were set at 80%. For CY 2019, the medical record review (MRR) process was changed to a full desktop review due to the COVID-19 public health emergency, which impacted all scoring areas significantly, particularly Laboratory Test/At-Risk Screenings and Immunizations. MDH waived all CAPs in these two reporting areas, and scoring was made baseline due to the MRR process change.

Table 5 displays the total score of CY 2019 EPSDT components by MCO.

Table 5. Total Score of EPSDT Components by MCO

MCOs	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Total Percentage	79	74	97	96	78	86	83	77	77

Consumer Report Card

The Consumer Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures. Table 6 displays the overall star rating changes from CY 2019 to CY 2020.

Table 6. Star Rating Changes from CY 2019 to CY 2020

MCOs	Performance Areas					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ABH	↑	↑	⊖	⊖	↑	↑
ACC	↑	⊖	⊖	↑	⊖	↓
JMS	⊖	↑	⊖	↑	⊖	⊖
KPMAS	↑	⊖	↑	⊖	⊖	⊖
MPC	↑	⊖	⊖	⊖	⊖	⊖
MSFC	↑	↑	↓	⊖	↑	⊖
PPMCO	⊖	↓	⊖	⊖	↑	⊖
UHC	⊖	⊖	⊖	⊖	⊖	↓
UMHP	↑	↓	↑	⊖	⊖	⊖

↑ Improvement from CY 2019; ↓ decline from CY 2019; ⊖ No change

Focused Review of Grievances, Appeals, and Denials

The focused review of grievances, appeals, and denials assessed MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. This activity consisted of reviewing quarterly MCO grievance, appeal, and denial reports from the final two quarters in CY 2019 and the first two quarters in CY 2020 and a CY 2019 annual record review.

Table 7 displays an overall MCO compliance score for the review period from quarterly report submissions based upon MDH established thresholds.

Table 7. MCO Overall Compliance with Regulatory Timeframes

MCOs	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Member Grievances	PM	PM	PM	PM	PM	PM	PM	M	M
Provider Grievances	PM	PM	M	NA	PM	NA	PM	PM	M
Member Appeals	PM	PM	M	PM	M	M	PM	PM	M
Denial Determinations	PM	PM	PM	M	M	PM	PM	M	M
Denial Notifications	PM	PM	M	M	M	PM	PM	M	M

M - Met, PM - Partially Met, NA - Not Applicable

The annual record review of grievances, appeals, and denials assessed MCO compliance with processing requirements, timeliness of member notifications, and required content and ease of understanding enrollee letters.

Table 8 displays MCO overall compliance with the above components based upon the annual record review.

Table 8. MCO Overall Compliance with Record Review Components

MCOs	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Member Grievances	M	PM	M	PM	M	M	PM	M	PM
Member Appeals	PM	M	M	PM	PM	M	PM	M	M
Pre-Service Denials determinations	PM	PM	PM	M	M	M	PM	M	PM

M - Met, PM - Partially Met

Network Adequacy Validation

The Network Adequacy Validation (NAV) activity assessed the network adequacy of the nine MCOs to ensure that each has the ability to provide enrollees with timely access to needed care within a reasonable timeframe. This activity focused on two components: a survey of providers to assess routine and urgent care appointment availability and validating MCO online provider directories accuracy.

Survey results of primary care provider (PCP) compliance with routine and urgent care appointment requirements are displayed in Table 9.

Table 9. Survey Results of PCP Compliance with Routine and Urgent Care Appointments

CY 2020 NAV	Routine Care Appointment Compliance	Urgent Care Appointment Compliance
Appointment availability	**94%**	**88%**
Appointment timeframes	**100%**	**88%**

The minimum compliance score for the validation of online directories is 80%. Based on CY 2020 results, three MCOs (ABH, KPMAS, and PPMCO) must submit CAPs to Qlarant to correct PCP details noted in the online provider directory.

Healthcare Effectiveness Data and Information Set

For HEDIS 2020, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2019 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to MDH's priorities and goals.

Maryland MCOs are high performing across the majority of measures and within each measure domain. There were 27 measures/measure indicators where at least eight out of the nine MCOs performed above the National HEDIS Mean. This level of performance demonstrates that superior care is delivered to HealthChoice participants. For additional findings and comprehensive details associated with the HEDIS 2020 results, see Appendix B.

Consumer Assessment of Healthcare Providers and Systems

In 2017, MDH contracted with the Center for the Study of Services (CSS), an NCQA-certified survey vendor, to administer and report the results of the CAHPS 5.0H Member Experience Survey. The overall goal of the survey is to provide performance feedback that is actionable and that will aid health plans in improving overall member experience.

CSS administered the Adult Medicaid version of the CAHPS Health Plan Survey for the Maryland Department of Health on behalf of the HealthChoice MCOs between February 15 and May 18, 2020. For additional findings and comprehensive details associated with the 2020 CAHPS results, see Appendix C.

Conclusion

The MCOs provided evidence of meeting most federal and contract requirements for compliance and quality-related reporting. Overall, the MCOs are performing well. MCOs developed CAPs for each deficiency identified.

MDH continues to encourage an environment of compliance and quality improvement and sets high standards to promote access to quality care. The MY 2019 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Maryland managed care enrollees.

Maryland HealthChoice Medicaid Program

2020 Annual Technical Report

Measurement Year 2019

Introduction

Background

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

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

The 2020 Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities rendered during measurement years 2019 and 2020. The ATR describes external quality review (EQR) methodologies for completing activities; provides MCO performance measure results; summarizes compliance results; and includes an overview of the quality, timeliness, and accessibility of health care services furnished by the contracted MCOs.

As of December 31, 2019, the HealthChoice program enrolled 1,331,791 participants. MDH contracted with nine MCOs during this evaluation period. The MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid–Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)[4]

[4] CareFirst Community Health Plan (CFCHP) as of 02/01/2021

MBMA's Quality Strategy

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

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

EQRO Program Assessment Activities

MDH is required to annually evaluate the quality of care provided by contracting MCOs in accordance with Federal law[5]. MDH contracts with Qlarant Quality Solutions, Inc., an external quality review organization (EQRO), to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program. Federal regulations require that the EQRO perform four mandatory activities using methods consistent with CMS protocols:

- Triennial review of MCOs' operations to assess compliance with State and Federal standards for quality program operations (SPR);
- Validation of State-required performance measures (PMV);
- MCO Network Adequacy Validation (NAV); and
- Validation of State-required performance improvement projects (PIPs) underway during the prior 12 months.

Federal regulations also permit MDH to contract with an EQRO to validate encounter data submitted by the MCOs. Qlarant performed this activity on behalf of MDH in collaboration with The Hilltop Institute at the University of Maryland Baltimore County (Hilltop). Qlarant conducted each of the above activities in a manner consistent with the CMS protocols during CY 2020.

Additionally, Qlarant completed the following four review activities:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews;
- Development and production of an annual Consumer Report Card (CRC) to assist participants in selecting an MCO;
- Quarterly focused reviews of MCO grievances, appeals, and denials (GAD); and
- Encounter Data Validation (EDV).

Separate report sections address each review activity and describe the methodology and data sources used to conclude the particular focus area. The final report sections summarize overall MCO strengths, opportunities, and recommendations and assess the status of previous findings and recommendations to MBMA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice participants.

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

Systems Performance Review

Objectives

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

Methodology

Qlarant conducted CY 2019's assessment as an interim desktop review in response to MDH's decision to move to triennial rather than full annual onsite reviews. Reviewers completed this assessment by applying the systems performance standards developed in accordance with the Code of Maryland Regulation (COMAR) 10.67.04.03B(1). Standards requiring a corrective action plan (CAP) or scored as baseline in the CY 2018 review were the focus of CY 2019's SPR. Additionally, for ABH only, a sample review of appeal, grievance, adverse determination, and recredentialing records was conducted to assess compliance with applicable standards.

During the desktop reviews conducted in January and February of 2020, the team reviewed all relevant documentation needed to assess the standards. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given ten business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Qlarant documented its findings for each standard by element and component. The level of compliance for each element and component was documented with a review determination of "*Met*," "*Partially Met*," or "*Unmet*." A CAP was required for each performance standard that received a finding of "*Partially Met*" or "*Unmet*." Elements/components scored as "*Met with Opportunity*" (MwO) have been found compliant with the requirement(s) but with an opportunity to improve.

Results

Overall MCO results and findings for the six standards assessed for CY 2019 with remaining opportunities for improvement are provided below. These standards address Oversight of Delegated Entities, Enrollee Rights, Availability and Accessibility, Utilization Review, Health Education, and Fraud and Abuse.

Standard 3: Oversight of Delegated Entities

Results and Findings: Three MCOs (ABH, ACC, and KPMAS) have improvement opportunities in the area of oversight of delegated entities and require CAPs to become compliant for the CY 2020 SPR. One MCO requires quarterly updates on a CAP as a continued opportunity from CY 2018. Results are displayed in Table 10.

Table 10. Standard 3 Oversight of Delegated Entities Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS
3.1b	The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	-	PM	-
3.2	Written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.	-	-	PM
3.3a	Oversight of delegated entities' performance to ensure quality of the care and/or service provided, through review of regular reports, annual reviews, site visits, etc.	-	-	UM
3.3c	Review and approval of claims payment activities at least semi-annually, where applicable.	PM	-	UM
3.3e	Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.	UM	-	-

PM- Partially Met, UM- Unmet, - Not Applicable
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies

Standard 5: Enrollee Rights

Results and Findings: Five MCOs (ABH, ACC, KPMAS, PPMCO, and UMHP) have improvement opportunities in the area of enrollee rights and require CAPs to become compliant for the CY 2020 SPR. Two MCOs (KPMAS and PPMCO) required quarterly updates on the CAPs as a continued opportunity from CY 2018. Additionally, four MCOs (ACC, KPMAS, MPC, and PPMCO) received a finding of Met with Opportunities for improvement in the following elements/components to address for the CY 2020 SPR. Results are displayed in Table 11.

Table 11. Standard 5 Enrollee Rights Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS	MPC	PPMCO	UMHP
5.1c	The system ensures the resolution of a grievance is documented according to policy and procedure.	-	-	-	-	MwO	-
5.1g	The MCO adheres to regulatory timeframes for written acknowledgment and written resolution of all grievances, even if the resolution was previously provided verbally.	-	-	UM	-	UM	-

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS	MPC	PPMCO	UMHP
5.1h	The MCO ensures written resolution letters describe the grievance and the resolution in easy to understand language.	-	MwO	UM	-	-	-
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.	-	-	PM	-	-	-
5.3d	Must ensure the release of any information in response to a court order is reported to the patient in a timely manner.	-	-	PM	MwO		-
5.5b	As a result of the enrollee satisfaction surveys, the MCO: Implements steps to follow up on the findings.	-	-	MwO	-	-	-
5.6a	Policies and procedures are in place that address the content of new enrollee packets of information and specify the timeframes for sending such information to the enrollee.	-	UM	-	-	PM	-
5.6c	The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.	PM	-	-	-	-	-
5.6e	The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	PM	-	-	-	-	-
5.8e	MCO's electronic information provided to members must meet requirements set forth in COMAR.	-	-	-	-	-	PM

MwO- Met with Opportunity, PM- Partially Met, UM- Unmet, - Not Applicable
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies

Standard 6: Availability and Accessibility

Results and Findings: Four MCOs (ABH, MPC, PPMCO, and UMHP) have improvement opportunities in the area of availability and accessibility and require CAPs to become compliant for the CY 2020 SPR. Two MCOs (MPC and UMHP) require quarterly updates on the CAPs as these are continued opportunities from CY 2018. Results are displayed in Table 12.

Table 12. Standard 6 Availability and Accessibility Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/ Component Description	ABH	MPC	PPMCO	UMHP
6.1b	The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.	PM	UM	-	-
6.1c	The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.	-	-	-	UM
6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population as specified in COMAR.	PM	PM	PM	PM
6.3c	Trending and analysis of data are included in the Quality Assurance Plan (QAP) and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	-	-	UM	UM

PM- Partially Met, UM- Unmet, - Not Applicable
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies

Standard 7: Utilization Review

Results and Findings: Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) have improvement opportunities in the area of Utilization Review and require CAPs to become compliant for the CY 2020 SPR. One MCO (KPMAS) requires quarterly updates on the CAP as a continued opportunity from CY 2018. Six MCOs (ACC, JMS, KPMAS, MPC, MSFC, and PPMCO) received a finding of Met with Opportunities for improvement in the following elements/components to address for the CY 2020 SPR. Results are displayed in Table 13.

Table 13. Standard 7 Utilization Review Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/Component Description	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7.2f	There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/utilization management (UM) criteria on at least an annual basis.	-	-	-	-	-	-	-	-	PM
7.3c	Corrective measures implemented must be monitored.	-	-	-	-	-	-	MwO	-	-

Element/ Component Reviewed	Element/Component Description	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7.4c	Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	UM	PM	-	PM	PM	-	UM	PM	UM
7.5b	Adverse determination letters include all required components.	PM	PM	MwO	MwO	-	-	-	-	UM
7.6a	The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.	UM	MwO	-	UM	PM	-	-	-	-
7.6b	The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	UM	UM	-	MwO	MwO	-	-	PM	-
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and 10.67.09.05.	-	PM	MwO	UM	UM	MwO	PM	-	UM
7.7c	The MCO must adhere to appeal timeframes.	PM	PM	MwO	PM	MwO	PM	PM	PM	UM
7.7e	Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.	UM	-	-	-	-	-	-	-	-
7.8a	The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.	-	PM	-	-	-	MwO	MwO	-	UM
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	UM	UM	-	UM	-	-	UM	PM	UM

Element/ Component Reviewed	Element/Component Description	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7.9a	The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.	-	-	-	-	-	-	-	**PM**	-
7.9c	The MCO acts upon identified issues as a result of the review of the data.	-	-	-	**UM**	-	-	**MwO**	-	-
7.11a	The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.	**UM**	-	-	-	-	-	-	-	-

MwO- Met with Opportunity, PM- Partially Met, UM- Unmet, - Not Applicable
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies

Standard 9: Health Education

Results and Findings. All MCOs were exempt from review of the Health Education standard except for one (ABH). Results are displayed in Table 14.

Table 14. Standard 9 Health Education Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/Component Description	ABH
9.3a	Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.	**MwO**

MwO- Met with Opportunity

Standard 11: Fraud and Abuse

Results and Findings. Three MCOs (ABH, KPMAS, and UMHP) have opportunities for improvement in the area of Fraud and Abuse and require CAPs in the following components to become compliant for the CY 2020 SPR. Results are displayed in Table 15.

Table 15. Standard 11 Fraud and Abuse Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/ Component Description	ABH	KPMAS	UMHP
11.1f	A documented process to ensure services billed to the MCO were actually received by the enrollee.	**PM**	-	-
11.4c	Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate the MCO contracts with.	**PM**	**UM**	**PM**
11.4d	Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	-	**UM**	-

PM- Partially Met, UM- Unmet, - Not Applicable
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies

Conclusions

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2019, an improvement was seen for four MCOs (ACC, KPMAS, MPC, and MSFC) and a slight decrease in performance was seen for one MCO (ABH). Three MCOs (PPMCO, UHC, and UMHP) had findings that resulted in the same number of CAPs from the previous reporting year. JMS continued to receive a perfect score in the CY 2019 SPR and demonstrated the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of JMS's continuing progression to ensure quality health care delivery for their enrollees.

For additional findings, comprehensive details associated with the CY 2019 SPR Report see Appendix E.

Performance Improvement Projects

Objectives

Performance improvement projects (PIPs) are designed to achieve significant improvement sustained over time in clinical and non-clinical care areas. Projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIPs must be designed, conducted, and reported in a methodologically sound manner. Qlarant uses the *Centers for Medicare & Medicaid Services (CMS) Protocol 1, Validation of Performance Improvement Projects,* as a PIP review activity guideline[6].

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio (AMR) PIP. The Lead Screening PIP replaced the Controlling High Blood Pressure PIP in 2018. Eight of the nine MCOs conducted PIPs in 2020. Aetna Better Health (ABH) did not conduct any PIPs for the CY 2019 measurement period since they joined the HealthChoice program in October 2017. This report summarizes findings from the validation of both PIPs.

Methodology

Qlarant evaluates PIPs to determine if they were conducted in a methodical and sound manner. A successful PIP evaluation, one in which the PIP meets all or the majority of the 10-steps required, can provide MDH with confidence in the validity of project indicator rates, sampling and data collection methodologies, robust interventions, and overall study findings. Using the CMS protocol as a guide, Qlarant assesses each PIP across a 10-step process.

Qlarant rates each component within a step as *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, or *Not Applicable (NA),* which results in an assigned score as defined in Table 16 below. A final assessment is made for each of the ten steps with numeric scores provided for each component and step of the validation process. A description of the rating and the associated score follows:

Table 16. Rating Scale for PIP Validation

Rating	Criteria	Score
Met (M)	All required components are present	100%
Partially Met (PM)	At least one but not all components are present	50%
Unmet (UM)	None of the required components are present	0%
Not Applicable	None of the components are applicable	NA

Each component assessed within each step is of equal value. The total of all steps provide the PIP validation score used to evaluate whether the PIP is designed, conducted, and reported in a sound manner and determine the degree of confidence a state agency can have in reported results. Qlarant evaluates confidence levels based on the PIP validation scores as follows in Table 17.

[6] CMS EQRO Protocols

Table 17. Confidence Levels

MCO Reported Results	PIP Validation Score
High Confidence	90%-100%
Confidence	75%-89%
Low Confidence	60%-74%

Results

All AMR PIPs focused on increasing the percentage of enrollees 5 to 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 18 represents the 2020 Validation Results for all AMR PIPs.

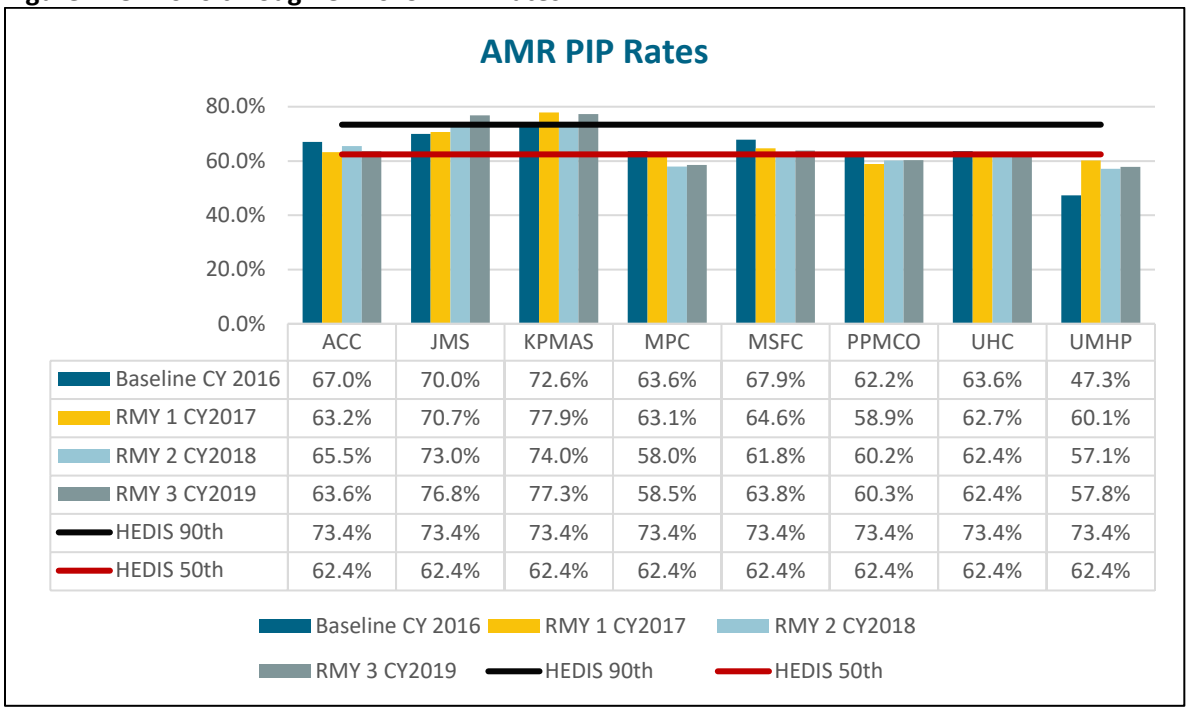
Table 18. AMR PIP Validation Results for 2020

Step/Description	2020 AMR PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Step 1. Assess the Study Methodology	NA	NA	NA	NA	NA	NA	NA	NA
Step 2. Review the Study Question(s)	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M	M
Step 4. Review the Identified Study Population	M	M	M	M	M	M	M	M
Step 5. Review Sampling Methods	NA	NA	NA	NA	NA	NA	NA	NA
Step 6. Review Data Collection Procedures	M	M	M	M	M	M	M	M
Step 7. Assess Improvement Strategies	PM	PM	M	PM	PM	PM	PM	PM
Step 8. Review Data Analysis & Interpretation of Study Results	PM	M	M	PM	M	PM	PM	PM
Step 9. Assess Whether Improvement is Real Improvement	PM	M	PM	PM	PM	PM	PM	PM
tep 10. Assess Sustained Improvement	UM	M	UM	UM	UM	UM	UM	PM

Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); White – NA (Not Applicable)

CY 2019 is the third remeasurement year of data collection for the AMR PIP. Figure 1 represents the AMR PIP indicator rates for all MCOs.

Figure 1. CY 2016 through CY 2019 AMR Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY 2016	67.0%	70.0%	72.6%	63.6%	67.9%	62.2%	63.6%	47.3%
RMY 1 CY2017	63.2%	70.7%	77.9%	63.1%	64.6%	58.9%	62.7%	60.1%
RMY 2 CY2018	65.5%	73.0%	74.0%	58.0%	61.8%	60.2%	62.4%	57.1%
RMY 3 CY2019	63.6%	76.8%	77.3%	58.5%	63.8%	60.3%	62.4%	57.8%
HEDIS 90th	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%
HEDIS 50th	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%

Note: Remeasurement Year (RMY)

All Lead Screening PIPs focused on increasing both 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 (HEDIS indicator) 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 (value-based purchasing [VBP] indicator).

Table 19 represents the 2020 Validation Results for all Lead Screening PIPs.

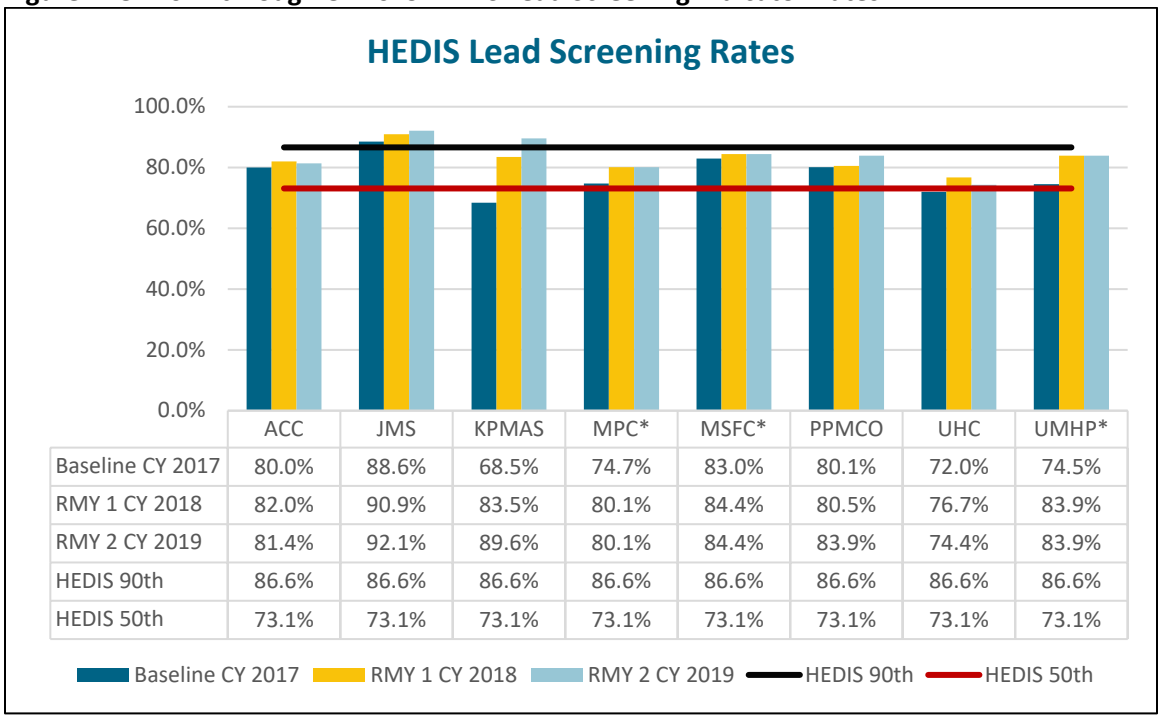
Table 19. Lead Screening PIP Validation Results for 2020

Step/Description	2020 Lead PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Step 1. Assess the Study Methodology	NA	NA	NA	NA	NA	NA	NA	NA
Step 2. Review the Study Question(s)	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M	M
Step 4. Review the Identified Study Population	M	M	M	M	M	M	M	M
Step 5. Review Sampling Methods	NA	NA	M	M	M	NA	NA	M
Step 6. Review Data Collection Procedures	M	M	M	M	M	M	M	M
Step 7. Assess Improvement Strategies	PM	PM	M	PM	PM	PM	PM	PM
Step 8. Review Data Analysis & Interpretation of Study Results	PM	M	PM	PM	M	PM	PM	PM
Step 9. Assess Whether Improvement is Real Improvement	PM	PM	M	M	M	PM	PM	PM
tep 10. Assess Sustained Improvement	PM	PM	M	UM	UM	PM	PM	PM

Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); White – NA (**N**ot Applicable)

CY 2019 is the second 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 through CY 2019 HEDIS Lead Screening Indicator Rates

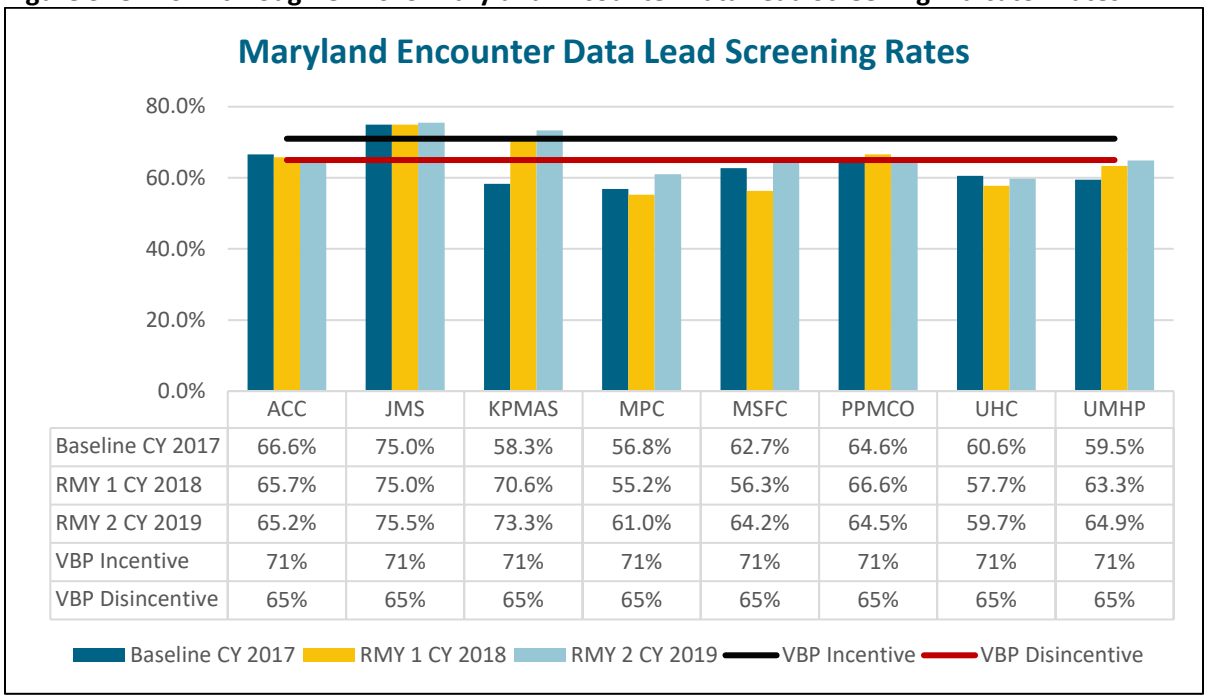


	ACC	JMS	KPMAS	MPC*	MSFC*	PPMCO	UHC	UMHP*
Baseline CY 2017	80.0%	88.6%	68.5%	74.7%	83.0%	80.1%	72.0%	74.5%
RMY 1 CY 2018	82.0%	90.9%	83.5%	80.1%	84.4%	80.5%	76.7%	83.9%
RMY 2 CY 2019	81.4%	92.1%	89.6%	80.1%	84.4%	83.9%	74.4%	83.9%
HEDIS 90th	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%
HEDIS 50th	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%

Note: Remeasurement Year (RMY)
*These MCOs elected to report HEDIS 2019 audited rates for HEDIS 2020 hybrid measures based upon NCQA guidance in response to the impact of COVID-19.

Figure 3 represents the Maryland encounter data indicator rates.

Figure 3. CY 2017 through CY 2019 Maryland Encounter Data Lead Screening Indicator Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY 2017	66.6%	75.0%	58.3%	56.8%	62.7%	64.6%	60.6%	59.5%
RMY 1 CY 2018	65.7%	75.0%	70.6%	55.2%	56.3%	66.6%	57.7%	63.3%
RMY 2 CY 2019	65.2%	75.5%	73.3%	61.0%	64.2%	64.5%	59.7%	64.9%
VBP Incentive	71%	71%	71%	71%	71%	71%	71%	71%
VBP Disincentive	65%	65%	65%	65%	65%	65%	65%	65%

Note: Remeasurement Year (RMY)

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 for the selected indicators. Tables 20 and 21 identify the level of confidence Qlarant has assigned to each MCO's AMR and Lead Screening PIPs for CY 2019 PIP performance.

Table 20. 2020 AMR PIP Validation Results - Levels of Confidence

Level of Confidence in Reported Results	Asthma Medication Ratio PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence		X	X					
Confidence					X			
Low Confidence	X			X		X	X	X

Table 21. 2020 Lead Screening PIP Validation Results - Level of Confidence

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

Conclusions

Overall, PIP performance indicator results were mixed, and opportunities for improvement remain. Confidence levels assigned to the AMR PIPs were lower than those assigned to the Lead Screening PIPs.

Over half of the MCO AMR PIPs were assigned a low confidence level while all Lead Screening PIPs were assigned a level of confidence or high confidence except one MCO's PIP that was assigned a low confidence level. This difference suggests that the implementation of a Rapid Cycle PIP methodology for Lead Screening has helped to facilitate more frequent assessments that lead to adjustments in interventions.

For additional findings and comprehensive details associated with the 2020 Annual PIP Report, please access the link in Appendix E.

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims[7] data submitted by MCOs to make key decisions. States use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. Valid and reliable encounter data is critical to states with Medicaid managed care programs as states aim to reach goals of transparency and payment reform to support efforts in quality measurement and improvement. Various provisions of the Affordable Care Act demonstrate transparency of payment and delivery of care as an important part of health reform.

CMS defines encounter data as the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid). Similar data is captured on standard claim forms like UB04 or CMS1500.
CMS requires states to conduct validation studies to assess the completeness and accuracy of encounter data submitted by MCOs. States may contract with an external quality review organization (EQRO) to conduct this activity. MDH contracted with Qlarant to conduct an encounter data validation (EDV) study of the Maryland HealthChoice Medicaid Program.

[7] Encounter data consists of claims; therefore, these two terms, encounter and claims, are used interchangeably in this report.

Validation of encounter data provides MDH a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs.

Methodology

Qlarant conducted EDV in accordance with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*. To assess the completeness and accuracy of encounter data, Qlarant completed Activities 1, 2, 4, and 5, and The Hilltop Institute, University of Maryland Baltimore County (Hilltop) completed Activity 3 of the five sequential EDV activities shown in Table 22.

Table 22. EDV Activities

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

*Completed by Hilltop

Results

State requirements for collecting and submitting encounter data. MDH sets forth the requirements for the collection and submission of encounter data by MCOs in Appendix H of the MCO's contract. It includes all Code of Maryland Regulations (COMAR) provisions applicable to MCOs, including regulations concerning encounter data.

MCO's capability to produce accurate and complete data. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Prior to examining the quality of data produced by the MCO's information system, each MCO's information system process and capabilities in capturing complete and accurate encounter data were assessed through review of the MCO's Information Systems Capabilities Assessment (ISCA) and interviews of MCO personnel, as needed. No issues were identified. Results of the document review and interview process reveal:

- All MCOs appear to have well-managed systems and processes.
- All MCOs use only standard forms and coding schemes.
- All MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service.
- All MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.
- The HealthChoice MCO average rate for processing clean claims in 30 days was 97%, with MCO-specific rates ranging from 79% to 100%.

Analysis of MCO's electronic encounter data for accuracy and completeness. Hilltop analyzed encounters failing initial EDI edits

(rejected encounters). Overall, the number of rejected encounters increased by 2.7 % during the evaluation period. This increase may be attributed to the inclusion of ABH starting in the CY 2018 analysis. The two primary reasons encounters were rejected during the evaluation period were missing data and participants not eligible for MCO services. The percentage of encounters rejected due to participants not eligible for MCO services increased from 30.3% in CY 2017 to 43.0 % in CY 2019, while the percentage rejected due to missing data decreased from 36.8% in CY 2017 to 31.5% in CY 2019. While invalid encounters increased slightly during the evaluation period, there was a notable decrease (10.8 percentage points) of encounters rejected for inconsistency.

Table 23 displays the monthly processing time for submitted encounters in CY 2017 through CY 2019.

Table 23. Distribution of Encounter Submissions Rejected by EDI Rejection Category, CY 2017 through CY 2019

New	CY 2017		CY 2018		CY 2019	
	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total
Missing	677,840	36.8%	725,751	38.4%	595,697	31.5%
Not Eligible	558,483	30.3%	638,633	33.8%	814,451	43.0%
Not Valid	276,763	15.0%	317,356	16.8%	334,314	17.7%
Inconsistent	244,463	13.3%	113,383	6.0%	46,438	2.5%
Duplicate	86,127	4.7%	96,115	5.1%	103,108	5.4%
Total	**1,843,676**	**100.0%**	**1,891,238**	**100.0%**	**1,894,008**	**100.0%**

Source: The Hilltop Institute. (2020, December). *EQR protocol 5, activity 3: Validation of encounter data, CY 2017 to CY 2019.* Baltimore, MD: UMBC.

Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data. The majority of MCOs submitted encounters to MDH within 1 to 2 days of the end date of service, followed by 8 to 31 days and 3 to 7 days. Very few encounters were submitted more than six months past the end date of service.

Nearly all claim types in CY 2019 had a higher percentage of encounters submitted within 1 to 2 days and 3 to 7 days than in CY 2017. For all encounters submitted in CY 2019, an average of 46.1% were processed by MDH within 1 to 2 days of the end date of service' an increase from 43.5% in CY 2018 and 41.3% in CY 2017.

Table 24 displays the monthly processing time for submitted encounters in CY 2017 through CY 2019.

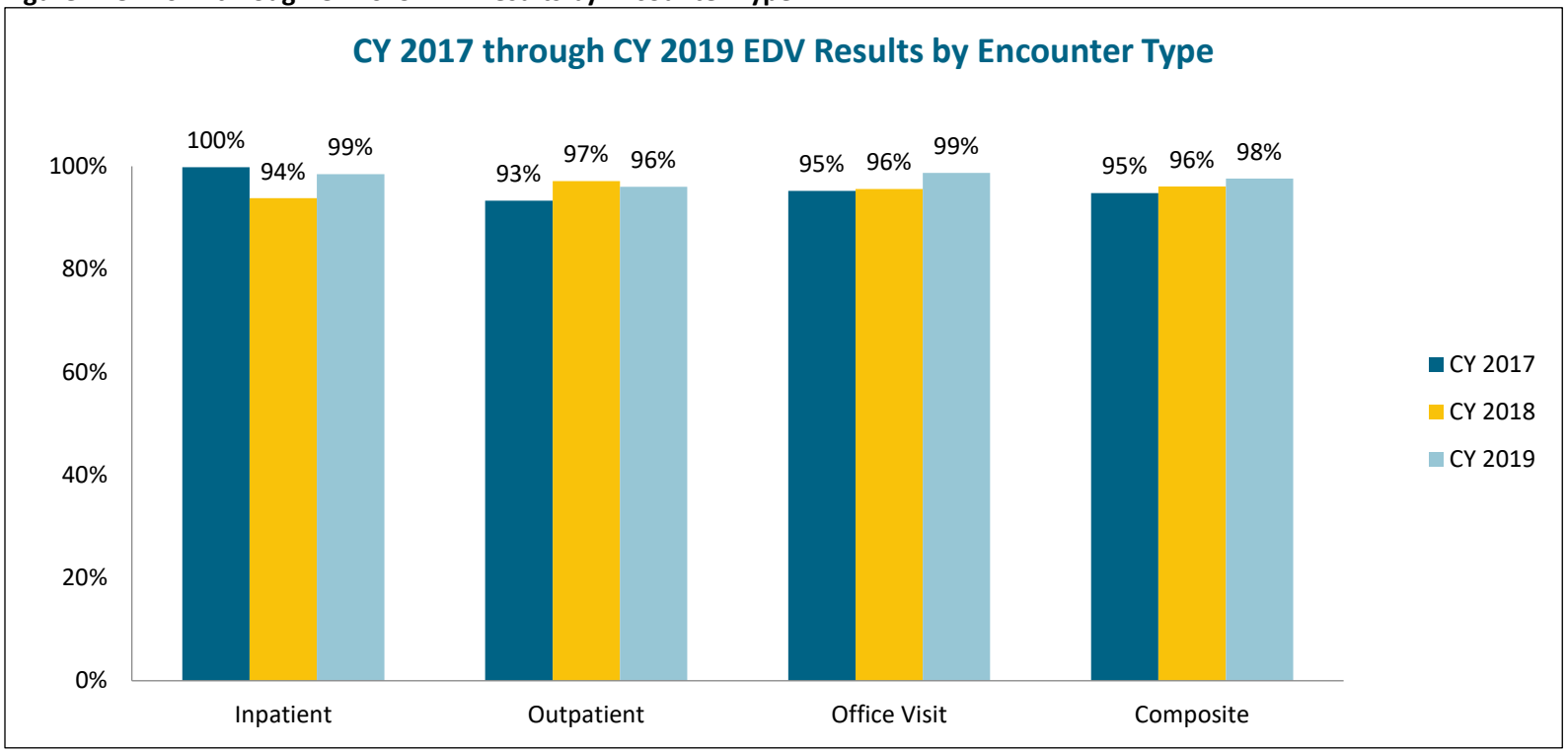
Table 24. Percentage of Accepted Encounters Submitted by Month and Processing Time, CY 2017 through CY 2019

Processing Time Range	Year	January	February	March	April	May	June	July	August	September	October	November	December	Total
1-2 days	CY 2017	40.4%	41.0%	41.5%	17.5%	46.4%	45.2%	42.7%	48.0%	41.9%	43.9%	43.2%	42.9%	**41.3%**
	CY 2018	43.8%	39.3%	38.9%	46.6%	44.9%	44.2%	40.6%	42.9%	45.1%	48.4%	43.8%	42.5%	**43.5%**
	CY 2019	42.7%	44.8%	46.9%	48.7%	44.2%	45.5%	45.0%	47.7%	41.8%	48.6%	45.9%	51.7%	**46.1%**
3-7 days	CY 2017	9.5%	10.6%	11.4%	17.3%	8.2%	12.2%	12.7%	11.0%	11.3%	9.8%	11.2%	10.7%	**11.3%**
	CY 2018	11.2%	11.7%	11.1%	11.9%	8.8%	10.8%	10.2%	12.2%	15.3%	10.9%	13.1%	9.9%	**11.4%**
	CY 2019	11.4%	13.6%	13.6%	10.3%	9.7%	14.3%	11.4%	10.5%	13.6%	11.4%	8.7%	8.4%	**11.4%**
8-31 days	CY 2017	29.4%	28.7%	26.7%	45.2%	28.6%	25.9%	26.9%	22.8%	28.5%	28.0%	28.5%	31.1%	**29.1%**
	CY 2018	25.0%	27.0%	27.2%	24.1%	29.8%	25.2%	31.2%	28.1%	22.5%	24.3%	26.0%	30.7%	**26.7%**
	CY 2019	28.6%	24.2%	21.1%	25.1%	31.0%	24.9%	27.4%	24.8%	30.1%	26.1%	30.5%	25.7%	**26.6%**
1-2 months	CY 2017	8.2%	7.3%	7.4%	9.6%	5.8%	4.9%	4.6%	6.1%	5.4%	6.7%	6.3%	5.1%	**6.5%**
	CY 2018	5.0%	8.3%	5.4%	6.8%	4.2%	6.8%	5.7%	4.7%	4.8%	5.5%	5.9%	5.8%	**5.7%**
	CY 2019	4.5%	4.5%	6.2%	5.2%	5.3%	5.2%	5.9%	6.7%	5.8%	5.0%	5.3%	4.3%	**5.3%**
2-6 months	CY 2017	7.1%	7.7%	8.2%	5.7%	6.1%	7.5%	9.1%	8.4%	9.4%	8.9%	9.6%	9.2%	**8.1%**
	CY 2018	8.1%	7.0%	11.7%	4.9%	6.5%	8.7%	7.6%	7.5%	9.0%	7.4%	9.7%	9.8%	**8.1%**
	CY 2019	8.6%	8.7%	7.8%	6.7%	6.0%	6.3%	6.3%	6.0%	5.1%	6.4%	8.6%	9.0%	**7.1%**
6-7 months	CY 2017	0.4%	0.4%	0.5%	0.7%	1.2%	1.4%	0.8%	0.8%	0.9%	1.6%	0.3%	0.4%	**0.8%**
	CY 2018	0.8%	0.4%	0.5%	0.7%	1.9%	0.7%	0.6%	2.0%	0.4%	2.2%	0.4%	0.6%	**1.0%**
	CY 2019	0.7%	0.6%	1.3%	0.5%	0.4%	0.4%	0.4%	0.4%	1.5%	1.7%	0.2%	0.4%	**0.7%**
7-12 months	CY 2017	2.7%	2.7%	2.6%	2.5%	3.3%	2.5%	2.9%	2.7%	2.6%	1.0%	0.9%	0.7%	**2.3%**
	CY 2018	2.6%	2.6%	3.5%	3.4%	3.2%	3.0%	3.6%	2.4%	2.9%	1.2%	1.1%	0.8%	**2.5%**
	CY 2019	1.9%	1.7%	1.4%	2.0%	3.0%	3.1%	3.3%	3.8%	2.1%	0.9%	0.7%	0.5%	**2.0%**
More than 1 Year	CY 2017	2.3%	1.6%	1.6%	1.4%	0.4%	0.3%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	**0.7%**
	CY 2018	3.4%	3.6%	1.8%	1.5%	0.7%	0.6%	0.5%	0.1%	0.0%	0.0%	0.0%	0.0%	**1.1%**
	CY 2019	1.8%	1.9%	1.7%	1.4%	0.4%	0.3%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	**0.7%**
Total		**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: The Hilltop Institute. (2020, December). *EQR protocol 5, activity 3: Validation of encounter data, CY 2017 to CY 2019.* Baltimore, MD: UMBC.

Analysis of medical records to confirm encounter data accuracy. Review of enrollees' medical records offers another method to examine the completeness and accuracy of encounter data. Analysis of sample data was organized by review elements including diagnosis, procedure, and revenue codes (applicable only for inpatient and outpatient). Overall EDV results for CY 2017 through CY 2019 by encounter type are displayed in Figure 4.

Figure 4. CY 2017 through CY 2019 EDV Results by Encounter Type



The composite match rate across all encounter types showed continuous improvement over the three-year period ranging from 95% to 98%.

Table 25 provides trending of the EDV records for CY 2017 through CY 2019 by encounter type.

Table 25. CY 2017 through CY 2019 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements*			Total Matched Elements			Matched Elements (%)		
	CY 2017	CY 2018	CY 2019	CY 2017	CY 2018	CY 2019	CY 2017	CY 2018	CY 2019	CY 2017	CY 2018	CY 2019
Inpatient	48	60	63	1,005	1,289	1,434	1,003	1,209	1,413	100%	94%	99%
Outpatient	474	575	538	5,479	7,386	7,288	5,113	7,170	7,000	93%	97%	96%
Office Visit	1,695	1,871	1,877	7,269	8,597	8,833	6,921	8,220	8,718	95%	96%	99%
Total	**2,217**	**2,506**	**2,478**	**13,753**	**17,272**	**17,555**	**13,037**	**16,599**	**17,131**	**95%**	**96%**	**98%**

*Possible elements include diagnosis, procedure, and revenue codes.
Note: Values reported are rounded to the nearest percentage for reporting only.

Compared to CY 2018, CY 2019 match rates for the inpatient setting increased five percentage points and the office visit setting increased by three percentage points, while outpatient match rates declined one percentage point.

MCO encounter data validation results by encounter type. For CY 2019, all HealthChoice MCOs successfully achieved match rates that equal or score above the standard of 90% in all areas of review.

Table 26 illustrates MCO and HealthChoice Aggregate (HealthChoice) match rates from CY 2017 through CY 2019 for inpatient, outpatient, and office visit encounters.

Table 26. CY 2017 through CY 2019 MCO and HealthChoice Results by Encounter Type

MCO	Inpatient			Outpatient			Office Visits		
	CY 2017	CY 2018	CY 2019	CY 2017	CY 2018	CY 2019	CY 2017	CY 2018	CY 2019
ABH	N/A	99%*	99%	N/A	98%*	96%	N/A	96%*	99%
ACC	99%	95%	95%	91%	98%	98%	93%	95%	97%
JMS	99%	95%	100%	95%	99%	97%	95%	92%	100%
KPMAS	100%	98%	100%	93%	100%	99%	95%	99%	99%
MPC	100%	98%	100%	93%	99%	97%	94%	96%	100%
MSFC	100%	98%	99%	93%	93%	90%	93%	95%	99%
PPMCO	100%	99%	99%	94%	98%	96%	97%	96%	98%
UHC	100%	95%	100%	93%	94%	95%	97%	96%	98%
UMHP	100%	54%	95%	94%	97%	99%	97%	96%	99%
HealthChoice	100%	94%	99%	93%	97%	96%	95%	96%	99%

*ABH received Not Applicable (N/A) for CY 2017 as CY 2018 was their first encounter data review.
Note: Values reported are rounded to the nearest percentage for reporting only.

Conclusions

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

Qlarant completed an EDV study for MDH based on an assessment of encounters paid during CY 2019. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters (2,478) to confirm the accuracy of codes. Overall, MCOs achieved a match rate of 98%, meaning 98% of claims submitted were supported by medical record documentation. MCOs achieved a high match rate for each encounter setting: 99% for inpatient, 96% for outpatient, and 99% for office visit.

For additional findings and comprehensive details associated with the CY 2019 EDV Report, please access the link in Appendix E.

Value-Based Purchasing

Objectives

In 1999, MDH and the Center for Health Care Strategies began to develop a value-based purchasing (VBP) initiative, with the goal of improving the health of core populations served by HealthChoice. Eventually, MDH and the Center for Health Care Strategies adopted the model of improving quality by awarding financial incentives to MCOs based on their performance.

As the EQRO, Qlarant conducts annual value-based purchasing (VBP) activities of each HealthChoice MCO by collaborating with MetaStar, Inc. (MetaStar), a NCQA-Licensed Organization, and the Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Methodology

MDH selects HEDIS and state-specific performance measures for the value-based purchasing program. Selected measures are calculated and validated per *HEDIS volume 2: Technical Specifications for Health Plans* or MDH specifications before being calibrated into incentive, neutral, and disincentive ranges. These ranges are then used to determine if the MCO's quality improvement efforts have successfully resulted in improved health outcomes and if incentives should be awarded.

For any measure that the MCO does not meet the minimum target, a disincentive of 1/9 of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of 1/9 of 1 percent of the total capitation amount paid to the MCO during the measurement year. Amounts are calculated for each measure and total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year plus any additional funds allocated by MDH for a quality initiative.

Results

According to MetaStar's annual report, *Statewide Executive Summary Report HealthChoice Participating Organization HEDIS 2020*, all VBP HEDIS measures achieved "Reportable" (R) designations for all MCOs; however, two measures for ABH, Asthma Medication Ratio and Breast Cancer Screening were "Not Applicable" (NA) due to an insufficient eligible population (denominator<30). Qlarant determined all VBP encounter data measure rates calculated by Hilltop were "Reportable" (R).

Table 27 illustrates HealthChoice MCOs' VBP performance summary for CY 2019.

Table 27. MCO CY 2019 VBP Performance Summary

Performance Measure	CY 2019 Target	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adolescent Well-Care Visits	Incentive: ≥ 73% Neutral: 68% - 72% Disincentive: ≤ 67%	42%	74%	76%	72%	59%	58%	62%	65%	73%
Ambulatory Care Visits for SSI Adults	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	58%	82%	91%	76%	85%	84%	86%	79%	88%
Ambulatory Care Visits for SSI Children	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	41%	84%	91%	80%	84%	79%	86%	80%	89%
Asthma Medication Ratio	Incentive: ≥ 72% Neutral: 66% - 71% Disincentive: ≤ 65%	NA	64%	77%	77%	59%	64%	60%	62%	58%
Breast Cancer Screening	Incentive: ≥ 75% Neutral: 70% - 74% Disincentive: ≤ 69%	NA	69%	76%	79%	63%	75%	68%	58%	77%
Comprehensive Diabetes Care - HbA1c control (<8.0%)	Incentive: ≥ 64% Neutral: 57% - 63% Disincentive: ≤ 56%	50%	52%	65%	64%	54%	58%	48%	53%	58%
Controlling High Blood Pressure	Incentive: ≥ 69% Neutral: 63% - 68% Disincentive: ≤ 62%	59%	59%	70%	82%	48%	62%	50%	62%	69%
Lead Screenings for Children - Ages 12 to 23 Months	Incentive: ≥ 71% Neutral: 66% - 70% Disincentive: ≤ 65%	56%	65%	76%	73%	61%	64%	65%	60%	65%
Well-Child Visits for Children - Ages 0 to 15 Months	Incentive: ≥ 76% Neutral: 71% - 75% Disincentive: ≤ 70%	41%	70%	74%	84%	71%	70%	73%	73%	85%

NA – not reportable due to an insufficient eligible population (<30).

Table 28 displays HealthChoice MCOs' VBP incentive or disincentive amounts for CY 2019.

Table 28. MCO CY 2019 VBP Incentive/Disincentive Amounts

Performance Measure*	MCO								
	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Valuation for Each Measure	122,698.58	1,266,581.16	222,918.99	333,920.20	1,258,011.17	518,167.47	1,652,942.72	753,038.78	280,869.98

Performance Measure*	MCO								
	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Gross Incentives for All Measures	0	1,266,581.16	1,783,351.92	2,003,521.20	0	518,167.47	0	0	1,685,219.88
Gross Disincentives for All Measures	858,890.06	8,866,068.12	0	667,840.40	7,548,067.02	3,109,004.82	9,917,656.32	6,024,310.24	561,739.96
Net Payout for All Measures	858,890.06	4,603,437.39	6,566,496.50	10,638,603.98	7,548,067.02	2,590,837.35	9,917,656.32	6,024,310.24	5,131,223.12

*Additional performance measure results are included in the complete CY 2019 Annual VBP Report in Appendix E.

For additional findings and comprehensive details associated with the CY 2019 Annual VBP Report, please access the link in Appendix E.

EPSDT Medical Record Review

Objectives

Maryland's EPSDT Program mission is to promote access to and ensure 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:

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

Methodology

Sampling methodology. MDH has an interagency governmental agreement with The Hilltop Institute of University of Maryland Baltimore County (Hilltop) to serve as the data warehouse for its encounters. Upon receiving from Hilltop the full preventive care encounters for Medical Assistance children and adolescents through 20 years of age occurring during CY 2019 from Hilltop Medical Assistance children and adolescents through 20 years of age, Qlarant selected a random sample of medical records from a pool of EPSDT-certified and non-certified PCPs. Sample size per MCO provided a 90% confidence level and 5% margin of error.

Medical record review and scoring. All Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Abstracted data from the medical record reviews was organized and analyzed within five age groups. Within each age group, specific elements were scored based on medical record documentation as follows in Table 29.

Table 29. CY 2019 Scores and Finding Equivalents

Score	Finding
Completed	2
Incomplete	1
Missing	0
Not Applicable*	N/A

***Exception** – For 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 within a component are weighted equally, scored, and added together to derive the final component score. Similarly, the composite (overall) score of all elements follows the same methodology. 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. If new elements or elements with revised criteria are introduced, the elements will be scored as baseline for that calendar year.

Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into the five component areas. Table 30 displays MCO results for CY 2019.

Table 30. CY 2019 EPSDT Component Results by MCO

Component	CY 2019 MCO Results									HealthChoice Aggregate
	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2019*
Health & Developmental History	83%	80%	99%	95%	85%	90%	87%	85%	85%	**88%**
Comprehensive Physical Examination	91%	90%	99%	99%	89%	95%	91%	91%	91%	**93%**
Laboratory Tests/At-Risk Screenings*	55%	55%	91%	89%	56%	59%	60%	57%	58%	**66%**
Immunizations*	62%	51%	94%	95%	62%	80%	74%	58%	57%	**71%**
Health Education/ Anticipatory Guidance	90%	86%	99%	100%	89%	93%	92%	89%	90%	**92%**
Total Score	**79%**	**74%**	**97%**	**96%**	**78%**	**86%**	**83%**	**77%**	**77%**	**83%**

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

*CY 2019 results for Laboratory Tests/At-Risk Screenings and Immunizations are baseline as a result of the change in MRR process due to the COVID-19 public health emergency.

Table 31 displays Health and Developmental History element results for each MCO.

Table 31. CY 2019 Health and Developmental History Element Results

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Recorded Medical History	93%	89%	100%	100%	94%	97%	94%	92%	94%	**95%**
Recorded Family History	80%	72%	98%	98%	78%	87%	81%	78%	80%	**84%**
Recorded Perinatal History	39%	34%	94%	99%	58%	64%	56%	55%	45%	**58%**
**Recorded Maternal Depression Screening	44%	83%	75%	77%	70%	50%	50%	60%	44%	**58%**
Recorded Psychosocial History	88%	84%	100%	98%	88%	95%	90%	89%	90%	**91%**
*Recorded Developmental Surveillance/ History (0-20 Years of Age)	92%	90%	97%	98%	91%	97%	94%	92%	96%	**94%**
Recorded Developmental Screening Tool	73%	64%	98%	76%	87%	70%	57%	54%	60%	**70%**
Recorded Autism Screening Tool	68%	59%	97%	60%	85%	72%	73%	55%	63%	**69%**
Recorded Mental/ Behavioral Health Assessment	96%	90%	100%	99%	92%	95%	94%	94%	94%	**95%**
Recorded Substance Use Assessment	81%	70%	99%	99%	75%	80%	87%	80%	76%	**83%**
Depression Screening	57%	54%	98%	51%	56%	71%	63%	61%	63%	**65%**
Component Score	**83%**	**80%**	**99%**	**95%**	**85%**	**90%**	**87%**	**85%**	**85%**	**88%**

Underlined element scores denote scores below the 80% minimum compliance requirement
*denotes element scored as a baseline in CY 2019
**Element scored atypically as a baseline in both CY 2018 and CY 2019

Table 32 displays Comprehensive Physical Examination element results for each MCO.

Table 32. CY 2019 Comprehensive Physical Examination Element Results

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Documentation of Minimum 5 Systems Examined	98%	98%	100%	100%	96%	99%	98%	100%	99%	**99%**
Vision Assessment	93%	91%	100%	98%	90%	93%	93%	91%	95%	**94%**
Hearing Assessment	92%	88%	100%	98%	89%	93%	92%	89%	94%	**93%**
Nutritional Assessment	91%	90%	100%	99%	90%	97%	96%	94%	94%	**95%**
Conducted Oral Assessment	91%	94%	100%	100%	91%	95%	95%	92%	96%	**95%**
Measured Height	99%	98%	100%	99%	97%	98%	96%	98%	97%	**98%**
Graphed Height	86%	84%	98%	99%	84%	95%	86%	84%	85%	**89%**
Measured Weight	99%	98%	100%	100%	97%	98%	96%	99%	98%	**98%**
Graphed Weight	86%	84%	98%	100%	83%	95%	86%	84%	85%	**89%**
BMI Percentile	86%	82%	100%	99%	85%	95%	84%	86%	82%	**89%**
BMI Graphing	85%	81%	100%	99%	81%	95%	84%	80%	80%	**87%**
Measured Head Circumference	90%	83%	90%	96%	86%	90%	91%	84%	86%	**89%**
Graphed Head Circumference	72%	60%	73%	96%	67%	75%	57%	54%	60%	**70%**
Measured Blood Pressure	97%	95%	100%	99%	93%	97%	93%	95%	94%	**96%**
Component Score	**91%**	**90%**	**99%**	**99%**	**89%**	**95%**	**91%**	**91%**	**91%**	**93%**

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

Table 33 displays Laboratory Test/At-Risk Screenings element results for each MCO.

Table 33. CY 2019 Laboratory Test/At-Risk Screenings Element Results*

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Newborn Metabolic Screen	29%	20%	67%	68%	53%	45%	42%	33%	52%	**47%**
Recorded TB Risk Assessment[1]	69%	77%	99%	98%	74%	79%	79%	75%	72%	**81%**

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Recorded Cholesterol Risk Assessment	70%	73%	99%	92%	71%	85%	78%	80%	76%	**81%**
9-11 year Dyslipidemia Lab Test per Schedule[1]	31%	23%	71%	69%	17%	32%	22%	19%	26%	**36%**
18-21 year Dyslipidemia Lab Test per Schedule[1]	17%	56%	90%	67%	60%	50%	67%	50%	79%	**65%**
Conducted Lead Risk Assessment	79%	81%	97%	99%	83%	86%	83%	75%	82%	**85%**
12 Month Blood Lead Test	37%	30%	82%	86%	34%	35%	42%	23%	27%	**46%**
24 Month Blood Lead Test	28%	32%	83%	87%	33%	32%	45%	38%	43%	**49%**
3 – 5 Year (Baseline) Blood Lead Test	88%	86%	100%	98%	93%	85%	100%	94%	94%	**94%**
Referral to Lab for Blood Lead Test	49%	43%	90%	100%	52%	40%	57%	46%	57%	**61%**
Conducted Anemia Risk Assessment	73%	63%	99%	91%	67%	87%	65%	65%	74%	**76%**
12 Month Anemia Test per Schedule[1]	35%	28%	79%	86%	37%	29%	37%	23%	23%	**44%**
24 Month Anemia Test per Schedule	31%	34%	82%	87%	33%	26%	45%	37%	42%	**49%**
3-5 Year Anemia Test per Schedule	87%	89%	100%	98%	88%	80%	100%	94%	93%	**93%**
Recorded STI/HIV Risk Assessment	73%	76%	99%	80%	78%	72%	75%	80%	82%	**81%**
HIV Test Per Schedule[1]	25%	29%	92%	85%	24%	55%	64%	31%	33%	**61%**
Component Score	**55%**	**55%**	**91%**	**89%**	**56%**	**59%**	**60%**	**57%**	**58%**	**66%**

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

[1]Element criteria revised

*denotes CY 2019 results are baseline as a result of the change in MRR process due to the COVID-19 public health emergency and should be reviewed with caution.

Table 34 displays Immunizations element results for each MCO.

Table 34. CY 2019 Immunization Element Results*

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Hepatitis B	61%	46%	97%	95%	61%	81%	73%	54%	53%	**69%**
DTaP	73%	58%	97%	99%	76%	85%	87%	67%	66%	**79%**
HiB	67%	53%	97%	99%	71%	85%	84%	62%	62%	**76%**
PCV-7 or PCV-13	67%	53%	96%	99%	70%	84%	81%	65%	61%	**75%**
IPV	63%	47%	97%	95%	62%	82%	75%	56%	55%	**71%**
MMR	61%	47%	97%	95%	62%	82%	73%	58%	52%	**70%**
VAR	60%	47%	97%	94%	63%	81%	73%	57%	52%	**70%**
TDaP	52%	52%	99%	97%	57%	81%	72%	54%	52%	**70%**
Influenza	53%	58%	76%	96%	58%	69%	74%	61%	58%	**69%**
MCV4	54%	56%	98%	96%	60%	81%	74%	59%	59%	**72%**
Hepatitis A	56%	47%	97%	91%	54%	78%	70%	54%	50%	**67%**
Rotavirus	76%	81%	86%	100%	74%	100%	83%	100%	76%	**83%**
HPV[1]	55%	52%	99%	90%	61%	77%	75%	63%	63%	**72%**
Assessed Immunizations Up-to-Date	66%	56%	85%	94%	63%	77%	72%	61%	61%	**71%**
Component Score	**62%**	**51%**	**94%**	**95%**	**62%**	**80%**	**74%**	**58%**	**57%**	**71%**

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

[1]Data collected for informational purposes only; not used in the calculation of the overall component score

*denotes CY 2019 results are baseline as a result of the change in MRR process due to the COVID-19 public health emergency and should be reviewed with caution.

Table 35 displays Health Education/Anticipatory Guidance element results for each MCO.

Table 35. CY 2019 Health Education/Anticipatory Guidance Element Results

Element	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Documented Age Appropriate Anticipatory Guidance	92%	93%	99%	100%	92%	97%	96%	95%	94%	**95%**
Documented Health Education/Referral for Identified Problems/Tests	98%	96%	100%	100%	96%	99%	98%	99%	99%	**98%**
Documented Referral to Dentist	76%	73%	100%	99%	80%	85%	79%	74%	73%	**83%**
Specified Requirements for Return Visit	91%	81%	98%	100%	88%	91%	93%	89%	90%	**91%**
Component Score	**90%**	**86%**	**99%**	**100%**	**89%**	**93%**	**92%**	**89%**	**90%**	**92%**

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

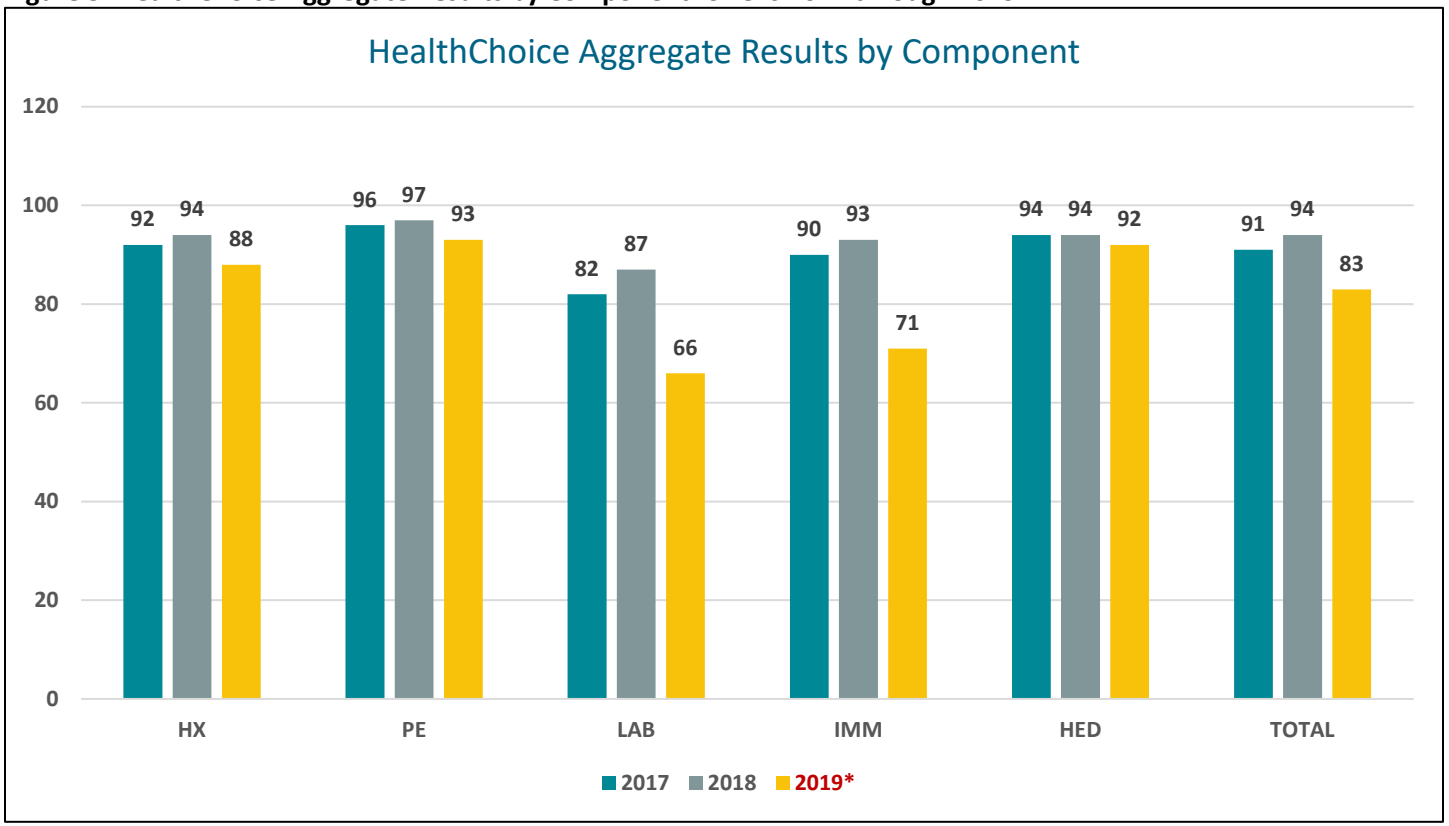
Table 36 displays the abbreviation used for each component and MCO total composite score in Figure 5.

Table 36. Component and Composite Score Abbreviations

Component/Composite Score	Abbreviation
Health and Developmental History	HX
Comprehensive Physical Exam	PE
Laboratory Tests/At-Risk Screenings	LAB
Immunizations	IMM
Health Education/Anticipatory Guidance	HED
Total Composite Score	TOTAL

Figure 5 demonstrates HealthChoice Aggregate results by component for CYs 2017 through 2019.

Figure 5. HealthChoice Aggregate Results by Component for CYs 2017 through 2019



Note: CY 2017 HealthChoice Aggregate results did not include ABH rates; ABH was not required to report for CY 2017.
*Results for Lab and IMM are baseline as a result of the change in MRR process due to the COVID-19 public health emergency.

Conclusions

The HealthChoice Aggregate met or exceeded the 80% minimum compliance threshold set by MDH for three of the five components. Additionally, all five component scores decreased when comparing the CY 2019 scores to the CY 2018 scores. Health and Development History and Comprehensive Physical Exam decreased by six and four percentage points, respectively, and Laboratory Test/At-Risk Screenings and Immunizations decreased 21 and 22 percentage points, respectively. Health Education/Anticipatory Guidance remained more consistent, having only decreased by two percentage points (92%) when compared to CY 2018 (94%). For CY 2019, the MRR process was changed to a full desktop review due to the COVID-19 public health emergency which impacted all scoring areas, particularly Laboratory Test/At-Risk Screenings and Immunizations.

For additional findings and comprehensive details associated with the CY 2019 EPSDT Report, please access the link in Appendix E.

Consumer Report Card

Objectives

The Consumer Report Card is designed to assist Medicaid participants in their selection of a HealthChoice MCO by facilitating relative comparisons of the quality of health care provided by the available health plans.

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

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

HealthChoice enrollees are directed to focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all enrollees; the remaining categories are relevant to specific enrollees (i.e., children, children with chronic illness, women, and adults with chronic illness).

Methodology

Each MCO's actual score on select performance measures is compared with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average. Performance measures are selected from HEDIS, CAHPS survey, and Maryland's encounter data measures.

Results

Table 37 provides the results of the CY 2020 Consumer Report Card.

Table 37. CY 2020 Consumer Report Card Results

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

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

Table 38 displays the overall star rating changes from CY 2019 to CY 2020.

Table 38. Star Rating Changes from CY 2019 to CY 2020

MCOs	Performance Areas					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ABH	↑	↑	~~0~~	~~0~~	↑	↑
ACC	↑	~~0~~	~~0~~	↑	~~0~~	↓
JMS	~~0~~	↑	~~0~~	↑	~~0~~	~~0~~
KPMAS	↑	~~0~~	↑	~~0~~	~~0~~	~~0~~
MPC	↑	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~
MSFC	↑	↑	↓	~~0~~	↑	~~0~~
PPMCO	~~0~~	↓	~~0~~	~~0~~	↑	~~0~~
UHC	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~	↓
UMHP	↑	↓	↑	~~0~~	~~0~~	~~0~~

↑ Improvement from CY 2019; ↓ decline from CY 2019; ~~0~~ No change

For comprehensive details on the information reporting strategy and analytic methods associated with production of the CY 2020 Consumer Report Card, please access the link to the Information Reporting Strategy and Analytic Methodology in Appendix D.

English and Spanish versions of the 2020 Maryland Report Card are available in Appendix E.

Focused Review of Grievances, Appeals, and Denials

Objectives

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

Review objectives address the following:

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

Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of each quarter to Qlarant. Qlarant validates and compares data to identify areas of non-compliance and MCO-specific or statewide specific trends. MCOs were provided quarterly reviews of their submissions which included required follow-up for data issues, ongoing non-compliance, or negative trends when identified.

In addition to quarterly reviews, Qlarant conducted an annual record review using a random sampling approach. Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each MCO's SPR report. Results of the record reviews were shared with appropriate staff of each MCO, and technical assistance provided as needed, to facilitate improved compliance.

Results

The percentage of compliance demonstrated for various components is represented by a review determination as displayed in Table 39.

Table 39. Review Determinations

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

Figure 6 displays a comparison of MCO averages of grievances, appeals, and pre-service denials per 1000 members and grievances per 1000 providers for the review period spanning from the third quarter of 2019 through the second quarter of 2020.

Figure 6. Average Grievance, Appeals, Pre-service Denials/1000 Members

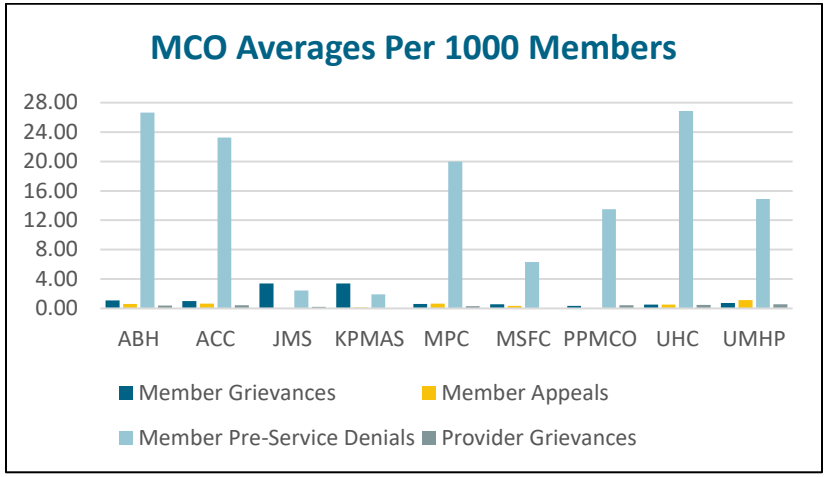


Table 40 displays MCO reported compliance with resolution timeframes for member grievances based on MCO quarterly submissions.

Table 40. MCO Reported Compliance with Member Grievance Resolution Timeframes

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	PM	M	PM	PM	PM	PM	PM	M	M
Q4 2019	PM	PM	PM	PM	M	M	PM	M	M
Q1 2020	PM*	M	M	PM*	M	M	PM*	M	M
Q2 2020	M	M	M	PM	M	M	PM	M	M

M - Met; PM - Partially Met
*Since the compliance threshold was lowered for the third month of the quarter, it is not possible to determine compliance for the entire quarter for these MCOs.

Table 41 displays MCO reported compliance with resolution timeframes for provider grievances based on MCO quarterly submissions.

Table 41. MCO Reported Compliance with Provider Grievance Resolution Timeframes

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	PM	NA	M	NA	PM	NA	PM	NA	M
Q4 2019	M	PM	M	NA	M	NA	M	NA	M
Q1 2020	M	PM	NA	NA	M	NA	M	NA	M
Q2 2020	PM	PM	M	NA	NA	NA	M	PM	M

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

Table 42 presents a comparison of the annual grievance record review results across MCOs.

Table 42. CY 2019 MCO Annual Grievance Record Review Results

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

M – Met; PM - Partially Met; UM – Unmet

Comparisons of MCO reported compliance with resolution timeframes for enrollee appeals are displayed in Table 43 based on MCO quarterly submissions.

Table 43. MCO Reported Compliance with Enrollee Appeal Resolution Timeframes

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2019	M	PM	M	M	M	M	M	PM	M
Q4 2019	M	PM	M	PM	M	M	PM	M	M
Q1 2020	PM	PM	NA	M	M	M	PM	M	M
Q2 2020	PM	PM	NA	M	M	M	PM	M	M

M - Met; PM - Partially Met; **NA** - Not Applicable/No data reported

Table 44 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2019.

Table 44. CY 2019 MCO Appeal Record Review Results

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

M – Met; PM - Partially Met; UM – Unmet; NA - Not Applicable/No data reported

Table 45 displays results of the MCOs' reported compliance with pre-service determination timeframes. As a result of the State of Emergency declared by Governor Hogan in response to the COVID-19 pandemic, MDH agreed to relax the threshold from 95% to 90% during this period. Compliance for the second quarter was determined based upon the lower threshold. Since the State of Emergency was declared on March 5, 2020, it was not possible to assess the impact of the change on the first quarter MCO reported results.

Table 45. MCO Reported Compliance with Pre-Service Determination Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q3 2019	NA	96%	100%	NA	NA	NA	33%	99%	100%
Q4 2019	100%	93%	NA	100%	NA	100%	17%	97%	100%
Q1 2020	100%	97%	NA	100%	100%	100%	25%*	96%	100%
Q2 2020	100%	88%	NA	100%	100%	0%	63%	100%	NA
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q3 2019	94%	94%	99%	97%	98%	100%	82%	98%	100%
Q4 2019	95%	72%	96%	99%	97%	100%	73%	99%	100%
Q1 2020	96%	90%*	NA	96%	100%	100%	76%*	97%	100%
Q2 2020	93%	99%	75%	98%	99%	100%	97%	99%	97%
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q3 2019	100%	100%	100%	NA	100%	100%	97%	100%	100%
Q4 2019	99%	100%	100%	NA	100%	97%	98%	100%	100%
Q1 2020	98%	100%	99%	NA	99%	93%*	98%	100%	100%
Q2 2020	97%	100%	100%	NA	99%	100%	98%	100%	100%

NA - Not Applicable/No data reported; **Green** – Met compliance threshold
***Red** - Result below the 95% compliance threshold for third, fourth, and first quarters and below the 90% threshold for the second quarter.

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are highlighted in Figure 7.

Figure 7. MCO Compliance with Pre-Service Determination Timeframes (Record Review)

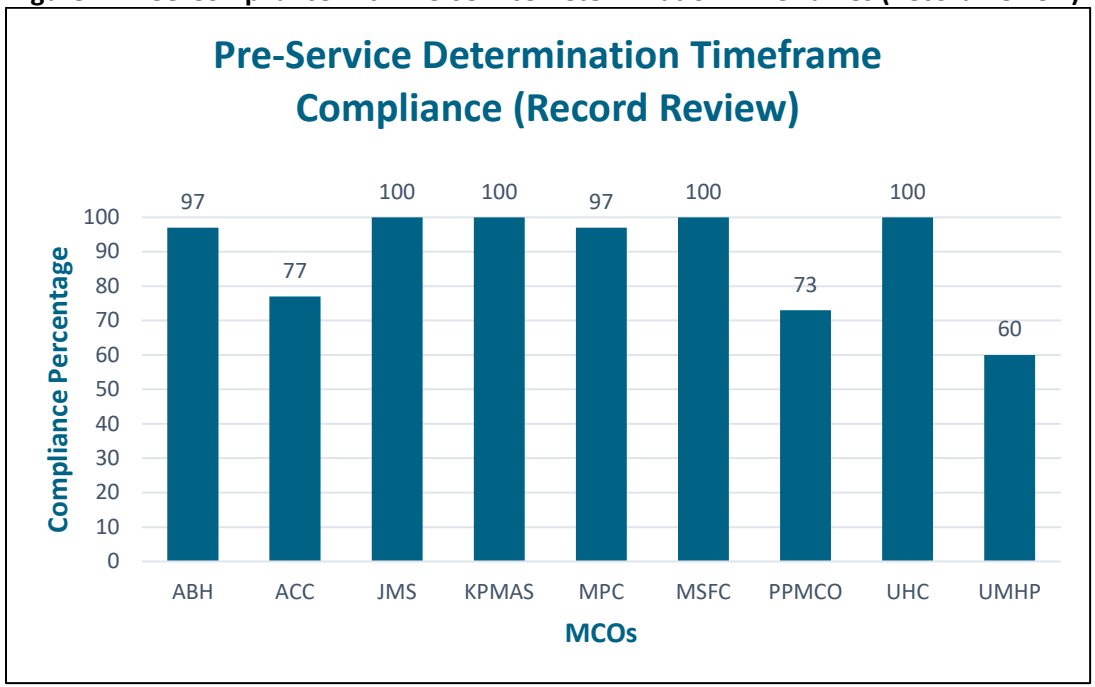


Table 46 displays the issues identified during a review of each MCO's adverse determination records.

Table 46. MCO Adverse Determination Record Review Issues

MCO	Issues Identified
ABH	Notification Turnaround Times & Letter Components
ACC	Determination Turnaround Times
JMS	Documentation of Prescriber Notification
PPMCO	Determination Turnaround Times
UMHP	Determination Turnaround Times & Letter Components

Note: No issues were identified for KPMAS, MPC, MSFC, or UHC

Results of MCO reported compliance with adverse determination notification timeframes based on the quarterly reports are highlighted in Table 45. In addition to relaxing the compliance threshold for preauthorization determination timeliness during the declared State of Emergency, MDH also relaxed the threshold for adverse determination notification timeliness from 95% to 90% as of March 5, 2020.

Table 47. MCO-Reported Compliance with Adverse Determination Notification Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q3 2019	NA	100%	100%	NA	NA	NA	67%	100%	100%
Q4 2019	100%	100%	NA	100%	NA	100%	17%	100%	100%
Q1 2020	100%	96%	NA	100%	100%	100%	25%*	100%	100%
Q2 2020	100%	100%	NA	100%	100%	0%	38%	100%	NA
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q3 2019	93%	98%	100%	100%	99%	100%	79%	100%	100%
Q4 2019	99%	98%	100%	100%	100%	100%	71%	100%	100%
Q1 2020	99%	94%*	NA	99%	99%	100%	74%*	100%	100%
Q2 2020	97%	99%	100%	100%	99%	100%	97%	100%	100%
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q3 2019	100%	100%	100%	NA	100%	100%	97%	100%	100%
Q4 2019	99%	100%	100%	NA	100%	97%	98%	100%	100%
Q1 2020	98%	100%	99%	NA	99%	91%*	98%	100%	100%
Q2 2020	97%	100%	100%	NA	99%	99%	100%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2019	NA	NA	NA	NA	NA	NA	NA	NA	NA
Q4 2019	99%	NA	NA	95%	NA	NA	98%	NA	NA
Q1 2020	99%	100%	99%	100%	100%	87%*	98%	100%	97%
Q2 2020	100%	100%	100%	98%	100%	100%	98%	100%	100%

NA - Not Applicable/No data reported; **Green** – Met compliance threshold

***Red** - Results below the 95% compliance threshold for third, fourth, and first quarters and below the 90% threshold for the second quarter.

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are highlighted in Figure 8.

Figure 8. MCO Compliance with Adverse Determination Notification Timeframes (Record Review)

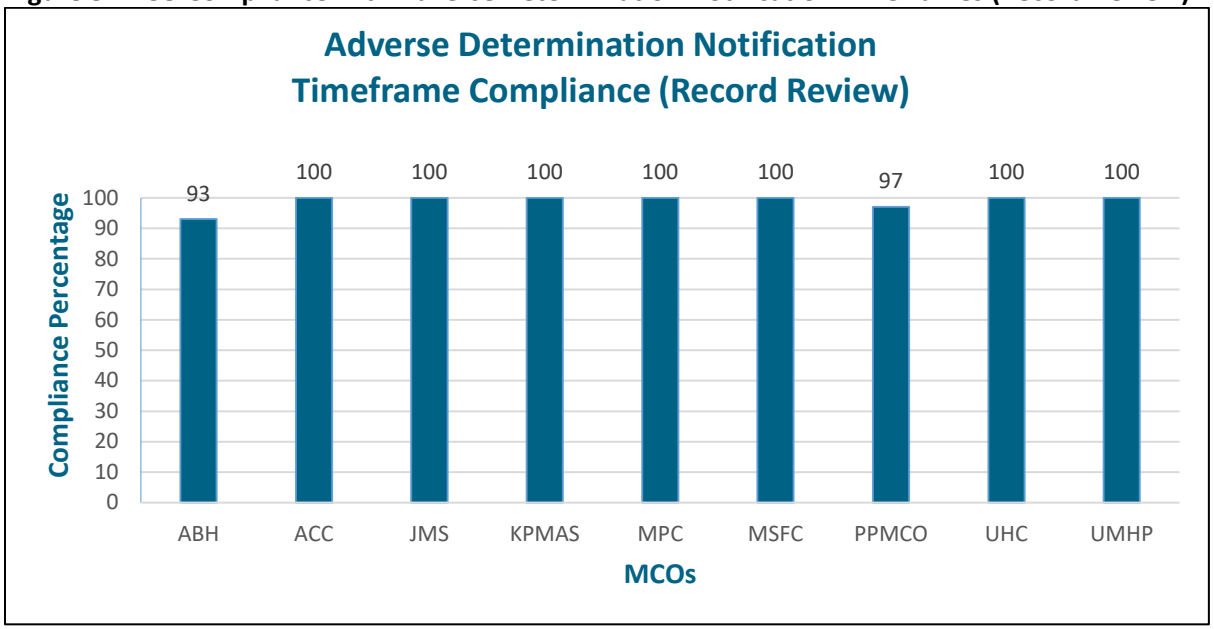


Table 48 provides adverse determination record review results across MCOs from CY 2019.

Table 48. Results of CY 2019 Adverse Determination Record Reviews

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

M – Met; PM - Partially Met; NA - Not Applicable/No data reported

Conclusions

Based upon the outcomes of quarterly and annual studies, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice enrollees is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriate classification and resolution of grievances (ABH, JMS, KPMAS, MPC, MSFC, UHC)
- Full documentation of grievance issues (All MCOs)
- Written notice of grievance resolution to the enrollee (ABH, JMS, MPC, MSFC, PPMCO, UHC, UMHP)
- Appeals processed based upon level of urgency (ABH, ACC, JMS, KPMAS, MSFC, UHC, UMHP)
- Appeal decisions made by health care professional with appropriate expertise (ABH, ACC, JMS, KPMAS, MSFC, UHC, UMHP)
- Appeal decisions documented and available to the enrollee in easy to understand language (ABH, ACC, JMS, KPMAS, MSFC, UHC, UMHP)
- Written notification timeframe for non-emergency appeal resolution and notification (ABH, ACC, JMS, KPMAS, MPC, MSFC, UHC, UMHP)
- Timely pre-service adverse determination written notifications (ACC, JMS, KPMAS, MPC, MSFC, PPMCO, UHC, UMHP)
- Required components in adverse determination letters
- Adverse determinations appropriate based upon MCO medical necessity criteria and policies

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

- Timely resolution of member grievances (7/9 MCOs)
- Timely resolution of member appeals (5/9 MCOs)
- Timely resolution of provider grievances (5/9 MCOs)
- Timely pre-service determinations (3/9 MCOs)

Validity of the data submitted by the MCOs continues to be a challenge and suggests an ongoing absence of quality oversight. Consequently, assessment results need to be considered with some caution. Recommendations have been provided to both MDH and the MCOs for increasing the validity of reports, such as routine quality oversight of report submissions, and cross training of staff to ensure continuity in the event of staff turnover or absences.

For additional findings and comprehensive details associated with the 2020 Annual Focused Study report, please access the link in Appendix E.

Network Adequacy Validation

Objectives

Availability of Services (42 CFR §438.206) requires MCOs to make services included in the contract available to enrollees 24 hours a day, 7 days a week, when medically necessary. While providers may not be accessible physically 24/7, enrollees should be able to contact their PCP offices and seek instruction on obtaining care after-hours. Many provider offices have on-call provider contact information and/or a nurse line. At the very least, an answering machine should direct the member on what to do in the event of an emergency–hang up and dial 911. The purpose of the NAV task is to:

- Validate the accuracy of MCOs' online provider directories; and
- Assess compliance with State access and availability requirements.

Methodology

CMS has not issued an EQR protocol for evaluating network adequacy. To complete the CY 2020 NAV task, Qlarant conducted two separate surveys, a telephone survey to a sample of provider offices and a validation survey to verify the accuracy of MCO online provider directories.

The sample for the telephone survey was obtained from each MCO's online provider directory. Two of the four surveyors and two of the three validators returned from CY 2019 survey activities, providing consistency in survey administration. The survey solicited responses to verify PCP information, including:

- Name and address of the PCP
- Whether the PCP accepts the listed MCO and new Medicaid enrollees
- Routine and urgent care appointment availability

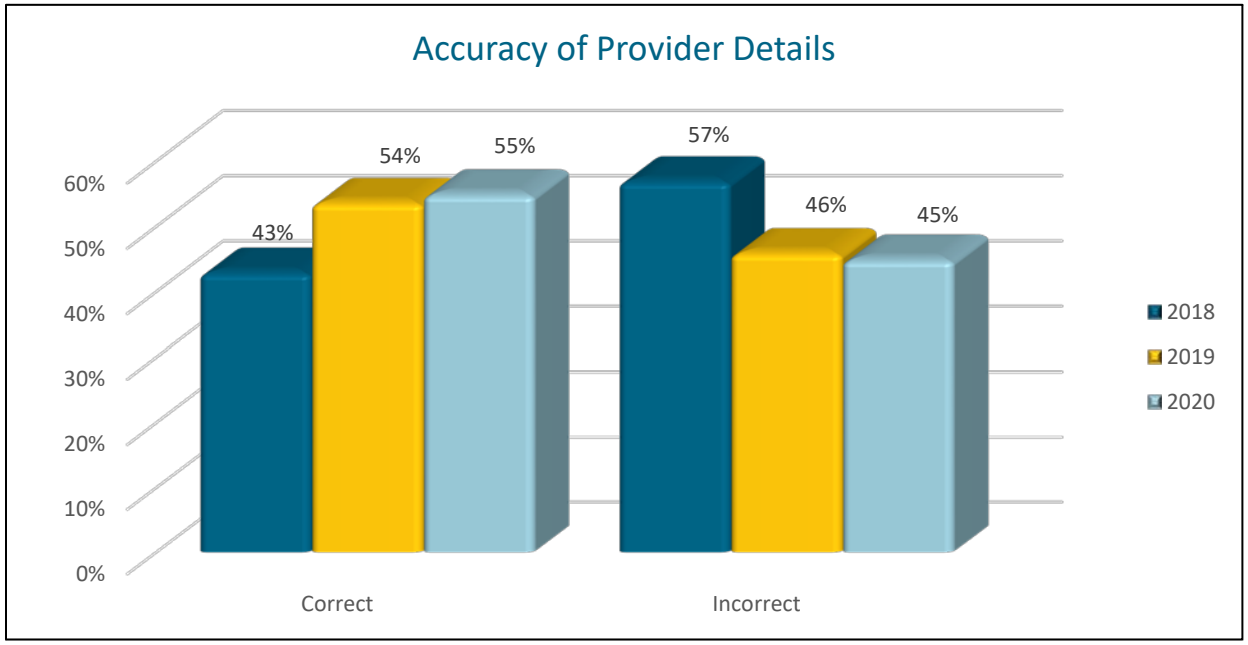
The validation survey verified the following information using the MCOs' online provider directories:

- Correct address as furnished by the MCO
- Correct phone number as furnished by the MCO
- Acceptance of new Medicaid patients
- Ages served by the PCP
- Languages spoken by the PCP
- Whether the practice had accommodations for disabled patients, and identified specific Americans with Disabilities Act (ADA) accessible equipment

Results

Accuracy of PCP information. Telephonic surveys verified the accuracy of PCP information in each MCO's online provider directory. Accuracy of PCP information results of the telephonic survey for all HealthChoice MCOs are presented in Figure 9.

Figure 9. Accuracy of Provider Details

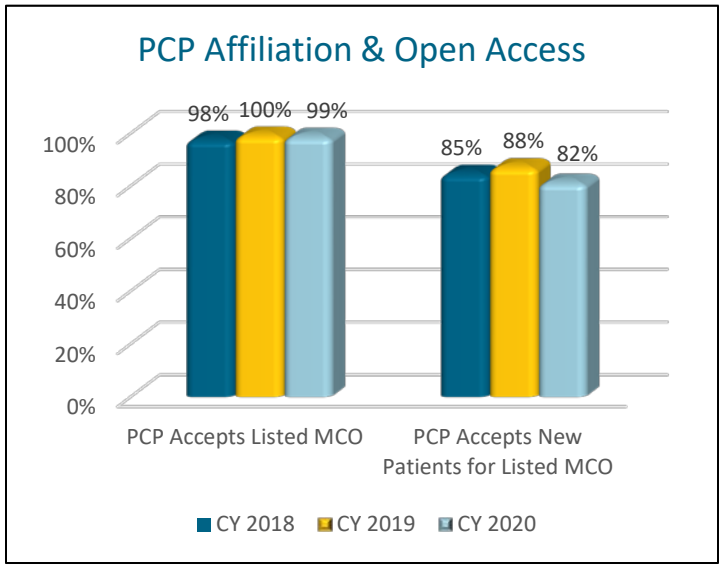


Survey results demonstrate the accuracy of PCP information provided by the MCOs has remained steady in CY 2019 and CY 2020. Overall survey results exhibited:

- A 3 percentage point decrease in CY 2020 (21 or 1%) from CY 2019 (78 or 4%) for incorrect PCP telephone numbers.
- Percentage consistency for PCPs identified as no longer with the practice in CY 2020 (261 or 13%) and in CY 2019 (259 or 13%).
- A 7 percentage point decrease for PCPs identified as not providing services at the location provided in CY 2020 (34 or 2%) from CY 2019 (183 or 9%).
- Both CY 2020 (<1% or 9) and CY 2019 (<1% or 10) saw no change in reported office closures.

The CY 2020 telephonic surveys validated whether PCPs accepted the listed MCO and new Medicaid patients, as illustrated in Figure 10.

Figure 10. PCP Affiliation & Open Access



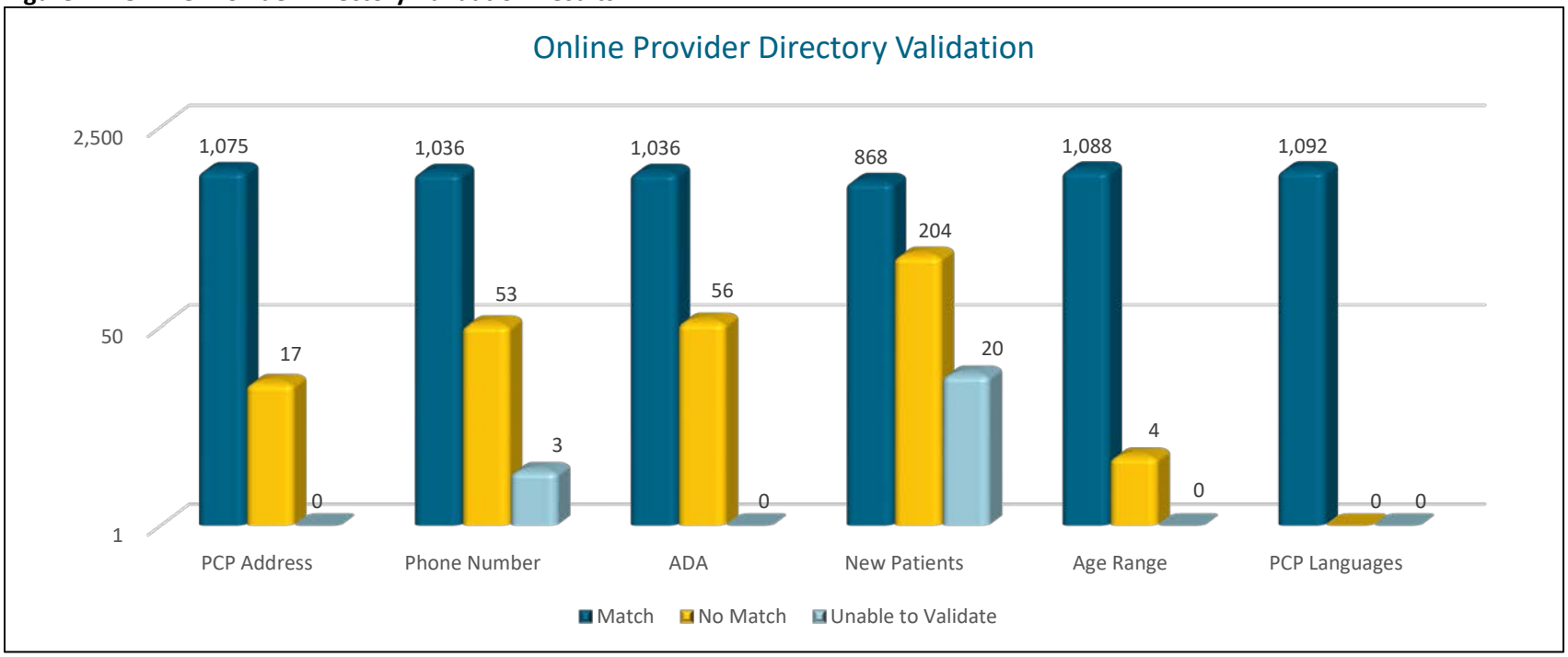
PCP Affiliation & Open Access

- In CY 2020, 99% of PCPs surveyed confirmed acceptance of the listed MCO. Only 11 PCPs surveyed were unable to confirm acceptance of the listed MCO.
- The majority of PCPs surveyed (82%) report accepting new patients in CY 2020.

In respect to the decrease in surveyed PCPs accepting new patients, it should be noted that beginning in CY 2020, the methodology changed whereby the surveyors specifically asked if the PCP accepted "new Medicaid patients for the listed MCO," whereas in past years, surveyors simply asked if the PCP accepted "new patients" or "new Medicaid patients."

Validation of MCO online provider directories. Qlarant validated the information in the MCO's online provider directory for each PCP that completed the telephone survey. Results of the online provider directory survey validation are presented in Figure 11.

Figure 11. Online Provider Directory Validation Results



In CY 2020, 1,129 PCPs reported that they were active with an MCO; however, 37 PCPs were not found in the MCO's online provider directory; therefore, 1,092 PCPs were validated against the MCO's online provider directories for compliance with the regulations. CY 2019 results were similar with 55 PCPs not found in the MCO's online provider directory from 1,139 successful survey calls.

HealthChoice aggregate results for validation of online provider directories. HealthChoice aggregate results for the validation of online provider directories are presented in Table 49.

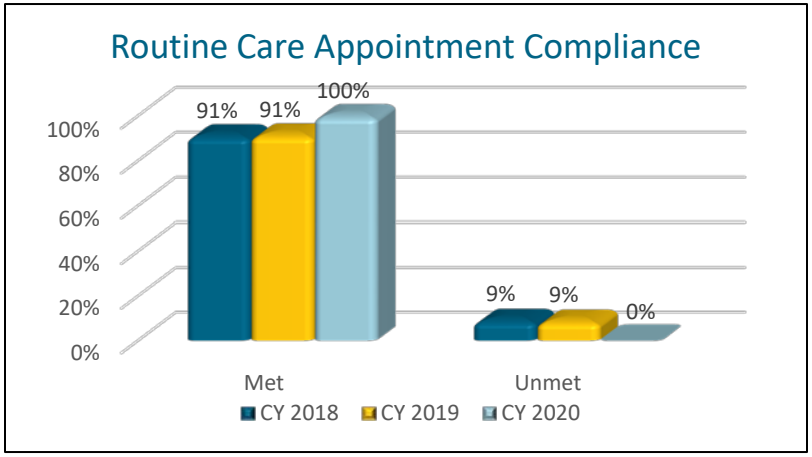
Table 49. CY 2020 HealthChoice Aggregate Results for Validation of Online Provider Directories

Requirement	HealthChoice Aggregate
PCP Listed in Online Directory	**97%** ↑
PCP's Practice Location Matched Survey Response	**98%** ↑
PCP's Practice Telephone Number Matched Survey Response	**95%** ↑
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	**79%** ↑
Specifies Age of Patients Seen	**100%** ↑
Specifies Languages Spoken by PCP	**100%** ↑
Practice has Accommodations for Patients with Disabilities (with specifics details)	**84%** ↑

Underline denotes that the 80% minimum compliance score is unmet
↑ Improvement from CY 2019; ↓ decline from CY 2019

Compliance with routine appointment requirements. Survey results of PCP compliance with routine appointment requirements are presented in Figure 12.

Figure 12. Routine Care Appointment Compliance



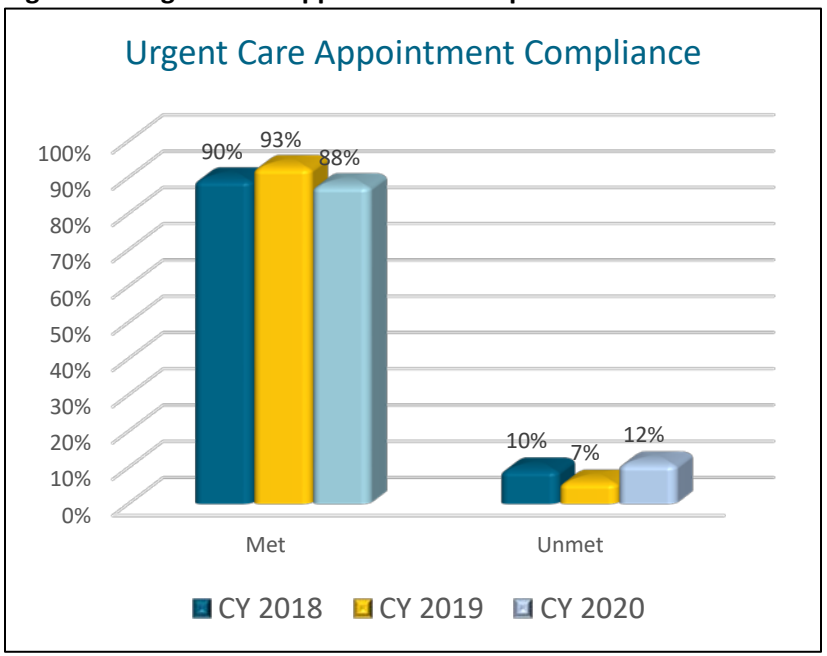
Routine Care Appointment Compliance

- Of the 1,129 PCPs successfully surveyed, 94% (1,066) provided routine care appointment availability.
- 100% of PCPs that provided routine care appointment availability (1,066) met compliance with the routine appointment timeframes.

It should be noted that even during a pandemic, HealthChoice providers were flexible in their accommodations and achieved higher routine appointment compliance rates when compared to CY 2018 and CY 2019.

Compliance with urgent care appointments. Survey results for PCP compliance with urgent care appointments are presented in Figure 13.

Figure 13. Urgent Care Appointment Compliance



Urgent Care Appointment Compliance

- Of the 1,129 PCPs surveyed, the majority of PCPs provided urgent care appointments and met the 48-hour urgent care timeframes requests (88% or 995).
- Compliance timeframes were achieved by offering appointments with another provider in the same practice (25% or 288).

Of the 12% (131) surveyed PCPs not meeting the urgent appointment compliance timeframes, 96% (126) directed enrollees to an urgent care clinic or an emergency department, and 4% (5) did not provide any guidance. The option of directing the enrollee to an urgent care clinic appears to be a standard practice among PCPs when an urgent care appointment cannot be made upon request. Investigation of member complaints or grievances may provide MDH further insight into whether enrollees are accessing urgent care services or emergency services due to PCP referrals.

MCO-specific results for compliance with appointment requirements. Aggregate results for compliance with routine and urgent care appointment timeframe requirements are presented in Table 50.

Table 50. CY 2020 HealthChoice Aggregate Results for Compliance with Appointment Requirements

Requirement	HealthChoice Aggregate
Compliance with Routine Care Appointment Timeframe (within 30 days)	
Compliant with Timeframe	100%
# of Wait Days (Average)	7
# of Wait Days (Range)	0-30
Compliance with Urgent Care Appointment Timeframe (within 48 hours)	
Appointment Available w/ Requested PCP at Same Location w/ 48 hours	63%
Compliance with Urgent Care Appointment Timeframe (within 48 hours)*	
Appointment Available w/ Another PCP at Same Location w/ 48 hours	25%
Compliance w/ Urgent Care Appointment	88%

*Due to rounding, some totals may not correspond with the sum of the separate figures.

Conclusions

The overall response rate for CY 2020 surveys was 55%, a decrease of 1 percentage point from CY 2019 (56%). Even though the provider listings are provided directly from the MCOs, a fluctuating trend of inaccurate information continues. The CY 2020 rate (55%) of accuracy with PCP addresses and phone numbers improved continuously from CY 2018 (43%) and CY 2019 (54%) and resulted in a positive trend year over year. All but 11 of 2,039 PCPs surveyed for open access in 2020 (99%) demonstrated that they accepted the listed MCO; this is a 1 percentage point decrease from CY 2019 results (100%) and a 1 percentage point increase over CY 2018 (98%) results. Additionally, the majority of PCPs in CY 2020 (82%) accepted new patients for the listed MCO, a 6 percentage point decrease over CY 2019 (88%) results, and a 3 percentage point decrease over the CY 2018 (85%) results. Of the successful calls available for online provider directory validation, acceptance of new Medicaid patients match rates increased 12 percentage points from CY 2019 at 67% to 79% in CY 2020.

Overall, routine appointment compliance rates improved from CY 2018 to CY 2020. A total increase of 9 percentage points was reflected in routine care appointment compliance, from 91% in both CY 2018 and CY 2019 to 100% in CY 2020. Improvements may be due to allowing practices to schedule an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the required care timeframe. Urgent care appointment compliance rates decreased slightly to 88% in CY 2020 from CY 2019 (93%) and CY 2018 (90%).

While improvements were demonstrated in CY 2020, staff at provider offices and online provider directories are still not accurately communicating or reflecting whether or not they are accepting new Medicaid patients, which prevents enrollees from scheduling appointments with their preferred PCP. Considering MDH relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, these barriers warrant further investigation to determine if they impact network adequacy determinations. Such barriers may cause enrollees who are unable to contact their PCP to seek care from urgent care facilities or emergency departments, hence driving up overall state health care

cost. Furthermore, enrollees may delay annual preventative care visits for themselves or their children if they are unable to contact a PCP and/or obtain an appointment.

For additional findings and comprehensive details associated with the CY 2020 NAV Report, please access the link in Appendix E.

Healthcare Effectiveness Data and Information Set

See Appendix B.

Consumer Assessment of Health Providers and Systems

See Appendix C.

MCO Quality, Access, Timeliness Assessment

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

- **Quality**, as it pertains to external quality review, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." ([CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D– Quality Assessment and Performance Improvement,* [June 2002]).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001)*.

MCO Aggregate Strengths, Opportunities, and Recommendations

Table 51. MCO Strengths, Opportunities, and Recommendations

Quality	Access	Timeliness	Strengths, Opportunities, and Recommendations
Systems Performance Review			
√	√	√	**Strength**. • MCOs demonstrate the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of their continuing progression to ensure the delivery of quality health care for their enrollees.
Performance Improvement Projects			
√	√	√	**Recommendations.** • Complete an in-depth barrier analysis at least annually to identify root causes of suboptimal performance and to effectively drive improvement. • Develop robust, system–level interventions in response to identified barriers. • 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. • Assess interventions for their effectiveness, and initiate adjustments where outcomes are unsatisfactory. • Ensure that data analysis is consistent with the defined data analysis plan, both quantitative and qualitative. • Ensure that MCO reported rates are consistent in the number of decimal places for all measurement periods and with audited rates.
Encounter Data Validation			
√			**Strengths.** • MCOs appear to have well-managed systems and processes. • MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.

Quality	Access	Timeliness	Strengths, Opportunities, and Recommendations
			• The HealthChoice MCO average rate for processing clean claims in 30 days was 97%. • The CY 2019 composite match rate of 98% is an increase of 2 percentage points from CY 2018 (96%). • All MCOs met the Qlarant recommended match rate of 90% for all encounter types reviewed. • Seven of the nine MCOs achieved a match rate of 99% or greater for inpatient encounters across all code types.
EPSDT Medical Record Review			
√	√	√	**Recommendations.** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with Maryland Healthy Kids Program standards. Collaborate with assigned State Healthy Kids/EPSDT Nurses to assist in reeducating providers and supporting staff on current standards of preventive health care. • Educate the MCO provider network regarding revisions and new standards to the Maryland Schedule of Preventive Health Care using the MCO provider newsletter and/or practice visits by MCO staff. • Encourage network providers to use the Maryland Healthy Kids Program's age-appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventive services according to the Maryland Schedule of Preventive Health Care. • Reinforce preventive care standards as they apply to adolescents and young adults assigned to family practice and internal medicine PCPs. • Assist practices as they implement electronic medical records to ensure all Maryland Healthy Kids Program requirements are incorporated into these tools and records are accessible during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date according to the Maryland Schedule of Preventive Health Care, check if children received services from a previous PCP or MCO to prevent duplication, and assist the PCP by scheduling a preventive care visit based on this information. • When other outreach efforts have been unsuccessful, refer children who fail to make health care appointments to the local health department for assistance in bringing them into care. • Remind providers they are required to enroll in the VFC program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.

Quality	Access	Timeliness	Strengths, Opportunities, and Recommendations
Focused Review of Grievances, Appeals, and Denials			
√		√	**Strengths.** • Grievances were fully documented; appropriately classified and resolved; and written resolutions were provided to enrollees by the majority of MCOs. • Appeals were processed based upon the level of urgency; decisions were made by health care professionals with appropriate expertise; and enrollees were provided written notification of appeal resolution in easy to understand language by the majority of MCOs. • Adverse determinations in response to a preauthorization request were appropriate based upon MCO medical necessity criteria and policies; enrollee notifications were timely and included all required components for the majority of MCOs.
√		√	**Opportunities.** • Timeliness of resolution of enrollee and provider grievances remains an ongoing opportunity for the majority of MCOs. • Timely resolution of enrollee appeals and verbal notification of expedited appeal decisions remain as continuing opportunities for improvement for the majority of MCOs. • Timeliness of pre-service determinations remains an opportunity for the majority of MCOs.
√		√	**Recommendations.** • Cross train at least one additional staff member on quarterly grievance, appeal, and denial reports to ensure continuity in the event of staff turnover or absence. • Educate appeal staff to process appeals based upon the initial filing date, (oral or written) rather than the date written consent is received from the enrollee authorizing the provider to file on their behalf. • Educate preauthorization staff on requirements to request additional clinical information as needed within 2 business days of receipt of the preauthorization request and make a determination within two business days of receipt of additional clinical information. (The 14 calendar day timeframe for making a determination has led to confusion relating to these requirements.) • Ensure new model notices are consistently used and that embedded calendar dates are accurately calculated. • The number of provider grievances appears to be under reported by at least some of the MCOs. It does not appear that all MCOs have an effective process in place for capturing provider grievances which may be submitted to various departments. MCOs need to establish a cross functional work group to address

Quality	Access	Timeliness	Strengths, Opportunities, and Recommendations
			the various points of entry and develop a process for aggregation of all grievances to support accurate reporting.
Network Adequacy Validation			
√	√	√	**Strength.** • All PCPs surveyed (99%) accepted the MCO listed in the provider directory. • Almost all of the PCPs surveyed (94%) provided routine appointment availability, and of those, 100% were compliant with appointment timeframe compliance.
√	√		**Opportunity.** • Accuracy of the provider telephone number and/or address remains an area of weakness across HealthChoice MCOs.
√	√		**Recommendation.** • Provide complete and accurate PCP information. • Notify PCPs of the Maryland network adequacy validation survey timeframe and promote participation one month before the surveys begin. • Refrain from completing any MCO-specific provider surveys within the same timeframe as the Maryland network adequacy validation surveys to optimize PCP participation. • Frequently inspect online provider directories to ensure the status of accepting new Medicaid patients is accurate and communicate this information with provider office staff. • Ensure that MCO's online provider directory includes ADA specific information when the provider identifies as being handicap accessible, namely that the practice location has accommodations for patients with disabilities, including offices, exam room(s), and equipment. • Clearly indicate appointment call center telephone numbers in online directory web pages so members know what number to contact to schedule appointments for those MCOs with centralized scheduling processes. • Add the customer service department's telephone number or a scheduling assistance telephone number on the bottom of each directory page for member reference. • Share how current the information is in the online directory by adding a date stamp at the bottom of each page. • Ensure the glossary is easily located.

Assessment of Previous Recommendations

The following table identified recommendations made in the previous ATR (MY 2018) and the follow-up activities completed in 2019.

Table 52. 2019 Compliance with 2018 Recommendations

2019 Compliance with 2018 Recommendations		
Task	2018 Recommendation	2019 Compliance
All	Implement the MCO Performance Monitoring Policy and Financial Sanction Policy in response to continually underperforming MCOs.	MDH implemented both policies resulting in financial sanctions imposed against one MCO for continued under performance and an MCO notification of corrective action in accordance with the Performance Monitoring Policy.
	Continue to support, provide guidance, and work collaboratively with each MCO as they work to meet all requirements.	
	Continue to review reports and provide recommendations as needed to each MCO.	
SPR	Consider reinstituting comprehensive onsite Systems Performance Reviews to ensure a consistently high level of MCO performance.	

State Recommendations

Considering the results for measures of quality, access, and timeliness of care for the contracted MCOs, Qlarant developed the following recommendations for MDH:

Performance Improvement Projects

Consider further incentivizing MCOs to fully commit to demonstrating significant and sustainable improvement through implementation of robust, timely interventions.

Encounter Data Validation

- Continue to monitor 8ER reports to identify trends and encourage encounter data quality improvement (The Hilltop Institute, 2020).
- Review MCOs that have a significantly higher percentage of rejected encounters than accepted encounters (The Hilltop Institute, 2020).
- Continue to work with the MCOs to improve the quality and integrity of encounter submissions with complete and accurate pay data (The Hilltop Institute, 2020). For CY 2020,

MDH should ensure that MMIS2 continues to store the correct sum of the total paid institutional service lines (The Hilltop Institute, 2020).

- Continue to monitor monthly submissions to ensure that the MCOs submit data in a timely manner (The Hilltop Institute, 2020). MCOs that submit encounters more than 8 months after the date of service, which is the maximum time allotted for an encounter to be submitted to MDH, should be targeted for improvement (The Hilltop Institute, 2020).
- Continue to monitor PCP visits by MCO in future encounter data validations (The Hilltop Institute, 2020).
- Continue to review these data and compare trends in future annual encounter data validations to look for consistency (The Hilltop Institute, 2020).
- Continue to review and audit the participant-level reports that Hilltop generated for delivery, dementia, and individuals over age 65, as well as missing age outlier data (The Hilltop Institute, 2020).
- Instruct MCOs to have their providers update and maintain accurate billing/claims address information to reduce returned mail and thus increase the amount of records received for review. A total of 300 provider letters were returned to Qlarant for CY 2019 which contained requests for 697 patients.
- Communicate with provider offices to reinforce the requirement to supply all supporting medical record documentation for the encounter data review so that all minimum samples can be met in a timely manner.
- Work with Hilltop to remedy encounter data issues where the MCO is identified as the provider.

Focused Review of Grievances, Appeals, and Denials

- Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions and explore options to support ongoing data quality of reports.
- Explore options to support data quality of MCO quarterly grievance, appeal, and denial reports.
- Cross check MCO reported provider grievances with grievances submitted to MDH to ensure all grievances are counted in MCO reports.
- Clarify requirements for HepC preauthorization and appeal reporting requirements to ensure a consistent understanding among MCOs.
- Consider conducting a focused record review of pharmacy related denials and appeals to determine key drivers of the consistently high volume among MCOs.
- Explore options for implementing the federal requirement for enrollee written consent for a provider or authorized representative to file an appeal on their behalf to ensure this regulation does not present an access issue.
- Consider submitting revised language for COMAR 10.67.09.02 to replace grievance “decision timeframes” with “resolution and notification timeframes” and a recommendation to include the requirement for sending written acknowledgment of grievance receipt within 5 calendar days. As currently written, there are no regulatory timeframes for sending the member a written resolution of their grievance. Similarly, this regulation does not include the requirement for sending a written acknowledgement of receipt of a member grievance.

Network Adequacy Validation

- Promote standards/best practices for MCOs' online provider directory information, including:
    - Use of consistent lexicon for provider detail information.
    - Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks.
    - Require all directories to state the date the information was last updated for easy monitoring.
- Continue to monitor MCO complaints regarding the use of urgent care and emergency department services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.

Conclusion

The MCOs provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, the MCOs are performing well. MCOs are actively working to address deficiencies identified during the course of the review. The MCOs are able to trend performance to gauge where it meets and exceeds requirements and to identify opportunity for improvement. By implementing interventions and addressing these opportunities, the MCOs will facilitate improvement in the areas of quality, access, and timeliness of care for the Maryland HealthChoice Medicaid program population.

MDH has effectively managed oversight and collaboratively worked with the MCOs and the EQRO to ensure successful program operations and monitoring of performance.

Appendices/Attachments

Introduction

MCO-Specific Summaries

MCO profiles and summary findings are based upon the quality assurance activities that took place in calendar years 2019-2020 for the Maryland HealthChoice program. Strengths, improvements, and opportunities for improvement are noted for each MCO, as applicable, within the tables that follow.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result calculation to promote a high degree of standardization of HEDIS measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit™[8]. To ensure audit consistency, only NCQA-licensed organizations using NCQA-certified Auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

Maryland Department of Health (MDH) contracted with MetaStar, Inc. (MetaStar), a NCQA-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results.

Consumer Assessment of Healthcare Providers and Systems

Introduced by the Agency for Healthcare Research and Quality (AHRQ) in the mid-1990s, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program encompasses the full range of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as accessibility of services and provider communication skills. The National Committee for Quality Assurance (NCQA) uses the Health Plan CAHPS survey in its Health Plan Accreditation Program as part of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures health plan performance on important dimensions of care and service and is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. The Health Plan CAHPS survey represents the patient (member) experience component of the HEDIS measurement set. The survey measures patient experience of care and gives a general indication of how well the health plan meets members'

[8] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

expectations. Parents or caretakers of surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months.

2020 Final IRS and Methodology

This report explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH will release in 2020, based on data reported from the MCOs in CY 2019. The information reporting strategy explains the principles used to determine the most appropriate and effective methods of reporting quality information to Medicaid participants, the intended target audience. The analytic method provides statistical basis and the analysis method used for reporting comparative MCO performance.

Full Report Resources

Identifies task-specific reports provided by Qlarant and where to access additional findings and comprehensive details associated with these reports.

Appendix A: MCO-Specific Summaries

Aetna Better Health of Maryland (ABH) External Quality Review (EQR) Findings

Table 53. ABH Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
2019	44,308	Accredited
Findings		
Systems Performance Review	**Strengths:** • ABH has implemented a robust quality oversight structure, with meaningful discussions on performance metrics by both ABH leadership and providers. Assigned action planning addresses any identified improvement areas. • ABH has communicated sanctioning incidents of fraud, waste, and abuse (FWA) to members through the member handbook and member newsletters. These member documents indicate members can report FWA without fear of reprisal. • ABH provided excellent evidence of timely and comprehensive monitoring and oversight of all delegates with active engagement of ABH staff. **Improvement:** • ABH successfully met two of the four components in the Oversight of Delegation Entities standard identified as opportunities in the CY 2018 review. **Opportunities:** • ABH has five CAPs in the following standards: Oversight of Delegated Entities, Enrollee Rights, Availability and Accessibility, Utilization Review, and Fraud and Abuse. • ABH has one met with an opportunity finding in the Health Education standard.	

Encounter Data Validation	**Strengths:** • ABH appears to have an information system and processes capable of capturing complete and accurate encounter data. • ABH is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • ABH achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • ABH achieved a match rate of 99% for all office visit codes reviewed; a 3 percentage point increase from 96% in CY 2018.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • Three of the four elements in Health Education/Anticipatory Guidance met the 80% minimum compliance rate in the range of 91% to 98%. **Improvements:** • Documented Referral to Dentist improved two percentage points from CY 2018 and registered at 76% for CY 2019. **Opportunities:** • ABH's Comprehensive Physical Exam component score of 91% is slightly below the HealthChoice Aggregate score of 93%.
Consumer Report Card	**Opportunities:** ★ In three of the six performance areas (Access to Care, Doctor Communication and Service, and Taking Care of Women). Note: Two of the six performance areas were N/A and does not describe the performance or quality of care provided by the health plan.

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • ABH's grievance records were well organized with excellent layout and included a full description of the grievance and appropriate resolution. • Enrollee grievance, appeal, and adverse determination letters were all written in plain language and provided detailed explanations of the resolution or determination, as applicable. **Opportunities:** • ABH did not demonstrate consistent compliance with regulatory timeframes for enrollee and provider notification of grievance resolutions, enrollee appeal resolution notifications, pre-service determinations, and enrollee adverse determination notifications. • ABH did not demonstrate consistent compliance in documenting reasonable attempts to provide the enrollee prompt verbal notice of denial of expedited appeal resolution and resolution of an expedited appeal. • ABH did not demonstrate consistent compliance in utilizing the MDH approved template for member appeal resolution letters was not consistently utilized. • Adverse determination letters did not consistently include all required components.
Network Adequacy Validation	**Strengths:** • ABH's online provider directory is easy to review and includes designated placeholders for each component required by regulation. • ABH scored above the 80% compliance threshold established by MDH in five of the seven categories and achieved 100% in two online directory categories in the CY 2020 validation. **Opportunities:** • ABH demonstrated continued opportunities for improvement identified in the CY 2019 validation to: o Include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment in its online provider directories. o Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.

Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

AMERIGROUP Community Care (ACC) External Quality Review (EQR) Findings

Table 54. ACC Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1999	301,382	Commendable
Findings		
Systems Performance Review	**Strength:** • ACC demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of ACC's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • ACC successfully resolved CAPs in the Availability and Accessibility and Fraud and Abuse standards required in response to identified opportunities in the CY 2018 review. **Opportunities:** • ACC has three CAPs in the following standards: Oversight of Delegated Entities, Enrollee Rights, and Utilization Review. • ACC has two met with an opportunity findings in the Enrollee Rights and Utilization Review standards.	
Performance Improvement Projects	**Opportunities:** • For both PIPS, ACC did not demonstrate that its interventions are robust, timely, designed to increase engagement, and assessed for effectiveness throughout the measurement year and revised as needed. • For both PIPs, ACC did not demonstrate that it uses its data to identify opportunities to address cultural and linguistic barriers and implement targeted interventions in response to identified opportunities.	

	• For both PIPs, ACC did not provide quantitative and qualitative analyses consistent with its data analysis plan, including an assessment of the effectiveness of interventions implemented to increase the selected indicator rates. • For the AMR PIP, ACC did not accurately and clearly present all numerical results and findings.
Encounter Data Validation	**Strengths:** • ACC appears to have an information system and processes capable of capturing complete and accurate encounter data. • ACC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • ACC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • ACC has demonstrated a continued improvement in matched office visit encounters from 93% in CY 2017 to 97% in CY 2019.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • Three of the four elements of the Health Education/Anticipatory Guidance component exceeded the MDH's 80% minimum compliance rate requirement. **Opportunities**: • Negative trends were identified in these elements: o Documented Health Education/Referral for Identified Problems/Tests o Documented Referral to Dentist o Specified Requirements for Return Visit
Consumer Report Card	**Strengths:** ★★★In two of the six performance areas (Access to Care and Keeping Kids Healthy). **Improvements:** ★★★In one of the six performance areas (Access to Care). ★★In one of the six performance areas (Care for Kids with Chronic Illness).

	Opportunities: ★ In one of the six performance areas (Care for Adults with Chronic Illness)
Focused Review of Grievances, Appeals, and Denials	**Strengths:** • ACC's enrollee grievance, appeal, and adverse determination letters were all written in plain language and provided detailed explanations of the resolution or determination, as applicable. • Enrollee appeal resolution letters clearly and fully described the reasons for both upheld and overturned decisions of an adverse determination and are considered a best practice. **Opportunities:** • ACC did not demonstrate consistent compliance with regulatory timeframes for enrollee written acknowledgment of a grievance, enrollee and provider notification of grievance resolution, enrollee notification of appeal resolution, pre-service determinations, and enrollee adverse determination notifications. • ACC did not consistently demonstrate correct categorization of enrollee grievances and resolution date or documentation of steps to resolve enrollee grievances in case records. Additionally, not all enrollee grievance letters included an appropriate resolution.
Network Adequacy Validation	**Strengths:** • ACC's online provider directory is easy to read, available on one page, and includes placeholders for each component required by regulation. • ACC scored above the 80% compliance threshold established by MDH in all areas and achieved 100% in two online directory categories. **Improvements:** • ACC effectively implemented its CAP from the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients align with responses provided in the online directory; and o Include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment in their online provider directories.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.

Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

Jai Medical Systems, Inc. (JMS) External Quality Review (EQR) Findings

Table 55. JMS Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1997	28,908	Excellent
Findings		
Systems Performance Review	**Strengths:** • JMS demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of JMS' continuing progression to ensure the delivery of quality health care for their enrollees. • JMS has had no CAPs required in response to review findings in the last 10 years. **Opportunity:** • JMS has three met with an opportunity findings in the Utilization Review standard.	
Performance Improvement Projects	**Strengths:** • JMS is performing above the HEDIS 2020 Medicaid 90th percentile for both the AMR and Lead Screening rates. **Improvements:** • JMS has demonstrated sustained improvement in the AMR rate over baseline. • Both the HEDIS and the Value-based Performance Lead Screening rates demonstrated improvement over the prior remeasurement. **Opportunities:** • For both PIPs, JMS did not demonstrate that its interventions addressed varied groups specific to their cultural and linguistic needs.	

Encounter Data Validation	**Strengths:** • JMS appears to have an information system and processes capable of capturing complete and accurate encounter data. • JMS is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • JMS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • JMS achieved match rates of 100% for all inpatient and office visit codes reviewed, a 5 and an 8 percentage point increase respectively over CY 2018 rates.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • JMS' Health and Developmental History component score of 99% is 11 percentage points above the HealthChoice Aggregate score of 88%. • JMS scored above the HealthChoice Aggregate in all 14 elements that comprise the Comprehensive Physical Exam component. • JMS sustained a 99% rate over the three-year period for both Health and Development History and Health Education/Anticipatory Guidance components. • JMS's performance surpassed the HealthChoice Aggregate in all components and achieved well above the 80% minimum compliance threshold resulting in a 97% total composite score.
Consumer Report Card	**Strengths:** ★★★ in all six performance areas (Access to Care, Doctor Communication and Service, Keeping Kids Healthy, Care for Kids with Chronic Illness, Taking Care of Women, and Care for Adults with Chronic Illness). **Improvements:** ★★★ In two of the six performance areas (Doctor Communication and Service and Care for Kids with Chronic Illness).

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • All enrollee grievances were appropriately classified and fully described in case notes. • All enrollee grievance letters were written in plain language with a full description of the grievance and an appropriate resolution. • JMS demonstrated consistent compliance with appeal resolution and adverse determination notification timeframes. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • All appeal resolution letters not only provided the credentials of the physician reviewer but also any specialized training relevant to the appeal request which is considered a best practice. **Opportunities:** • Billing/financial related enrollee grievances consistently represent the top service category. • JMS did not consistently demonstrate compliance with enrollee grievance resolution and pre-service determination timeframes. • Case records did not consistently document prescriber notification of review outcome within 24 hours of receipt of a preauthorization request.
Network Adequacy Validation	**Strengths:** • JMS's online provider directory is easy to read, and includes placeholders and responses for each component required by regulation. • JMS scored above the 80% compliance threshold established by MDH in all areas and achieved 100% in five online directory categories with the most significant improvement in ADA specific accommodations. **Improvements:** • JMS effectively implemented its CAP from the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients align with responses provided in the online directory. o Indicate that the practice has accommodations for physical disabilities in its online provider directories. o Include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment disabilities in its online provider directories.

Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS) External Quality Review (EQR) Findings

Table 56. KPMAS Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
2014	93,753	Excellent
Findings		
Systems Performance Review	**Strength:** • KPMAS demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of KPMAS' continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • KPMAS successfully resolved the CAP in the Availability and Accessibility standard required in response to identified opportunities in the CY 2018 review. **Opportunities:** • KPMAS has four CAPs in the following standards: Oversight of Delegated Entities, Enrollee Rights, Utilization Review, and Fraud and Abuse. • KPMAS has three met with an opportunity findings, one in the Enrollee Rights standard and two in the Utilization Review standard.	

Performance Improvement Projects	**Strengths:** • KPMAS is performing above the HEDIS 2020 Medicaid 90th percentile for both the AMR and Lead Screening rates. **Improvements:** • Improvement in both the HEDIS and VBP Lead Screening rates from remeasurement 1 to remeasurement 2 and from baseline to remeasurement 2 was determined to be statistically significant. **Opportunity:** • For the Lead Screening PIP, KPMAS did not present its numerical PIP results and findings accurately and clearly.
Encounter Data Validation	**Strengths:** • KPMAS appears to have an information system and processes capable of capturing complete and accurate encounter data. • KPMAS is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • KPMAS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • KPMAS achieved a match rate of 100% for all inpatient codes reviewed, a 2 percentage point increase from the CY 2018 rate of 98%.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • All components achieved well above the 80% minimum compliance threshold range from 89% to 100%, resulting in a 96% total composite score. **Improvement:** • KPMAS's Comprehensive Physical Exam and Health Education/Anticipatory Guidance components each demonstrated continuous improvement over the three-year period.

Consumer Report Card	**Strengths:** ★★★In three of the six performance areas (Keeping Kids Healthy, Taking Care of Women, and Care for Adults with Chronic Illness). **Improvements:** ★★In two of the six performance areas (Access to Care and Keeping Kids Healthy).
Focused Review of Grievances, Appeals, and Denials	**Strengths:** • KPMAS case records reflected thorough documentation of the grievance and steps to resolve. • All grievances were appropriately categorized and resolved. • Appeal resolution letters were written in plain language. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • KPMAS demonstrated consistent compliance with pre-service determination and adverse determination notification timeframes. • Appeal case records were very detailed and are considered a best practice. **Opportunities:** • KPMAS did not demonstrate consistent compliance with regulatory timeframes for grievance acknowledgment letters and grievance and appeal resolution letters. • Grievance resolution letters did not consistently include a description of the grievance and its resolution. • Named fields in letter templates were not consistently replaced with required information such as member name or description of the grievance. • MDH-approved grievance letter templates were not consistently utilized. • Attitude/service related service categories represent the majority of enrollee grievances. • KPMAS did not consistently demonstrate documentation of a reasonable attempt to provide oral notification of an expedited appeal resolution. • Adverse determination letters did not consistently reflect accurate calculation of the appeal filing deadline.

Network Adequacy Validation	**Strengths:** • KPMAS's online provider directory is easy to read, includes placeholders and responses, and includes all components required by regulation. • KPMAS scored above the 80% threshold in six of the seven categories and achieved 100% in five of the categories. **Opportunity:** • KPMAS demonstrated a continued opportunity for improvement identified in the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients align with responses provided in the online directory.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

Maryland Physicians Care (MPC) External Quality Review (EQR) Findings

Table 57. MPC Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1997	228,201	Accredited
Findings		

Systems Performance Review	**Strength:** • MPC demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of MPC's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • MPC successfully resolved CAPs in the Availability and Accessibility and Fraud and Abuse standards required in response to identified opportunities in the CY 2018 review. **Opportunities:** • MPC has two CAPs in the following standards: Availability and Accessibility and Utilization Review. • MPC has three met with an opportunity findings, one in the Enrollee Rights standard and two in the Utilization Review standard.
Performance Improvement Projects	**Improvement:** • MPC demonstrated a statistically significant improvement in the VBP Lead Screening rate from the prior measurement year and from baseline. **Opportunities:** • For the AMR PIP, MPC did not implement robust interventions early in the measurement year and ensure that it is able to measure each intervention's impact on the AMR rate. • For both PIPs, MPC did not develop any targeted interventions based upon a root cause analysis of identified linguistic and cultural disparities. • For both PIPs, MPC did not demonstrate that its quantitative analysis was consistent with its data analysis plan.

Encounter Data Validation	**Strength:** • MPC appears to have an information system and processes capable of capturing complete and accurate encounter data. • MPC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MPC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • MPC achieved a match rate of 100% for all inpatient codes reviewed, a 2 percentage point increase from the CY 2018 rate of 98%. • MPC has demonstrated a continued improvement in matched office visit encounters from 94% in CY 2017 to 100% in CY 2019.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • Thirteen of the 14 elements of the Comprehensive Physical Exam component exceeded MDH's 80% minimum compliance requirement. • All four elements of the Health Education/Anticipatory Guidance component met or exceeded MDH's minimum 80% compliance threshold. **Improvements:** • MPC's Recorded Autism Screening Tool element within the Health and Developmental History component demonstrated an upward trend over a three year-period. • MPC made a noticeable improvement in Recorded Developmental Screening Tool from CY 2018 (72%) to CY 2019 (87%). • MPC showed improvement in the Documented Referral to Dentist, increasing two percentage points to 80% in CY 2019 when compared to CY 2018 (78%).

Consumer Report Card	**Strengths:** ★★★In one of the six performance areas (Access to Care). **Improvement:** ★★★In one of the six performance areas (Access to Care). **Opportunities:** ★ In three of the six performance areas (Keeping Kids Healthy, Taking Care of Women, and Care for Adults with Chronic Illness).
Focused Review of Grievances, Appeals, and Denials	**Strengths:** • All MPC grievances were appropriately categorized and resolved. • Case notes were very detailed in describing the grievance and steps to resolve. • All grievance letters were written in plain language and describe the grievance and its resolution. • All appeal resolution letters were written in plain language. • Consistent compliance with appeal resolution and pre-service determination and adverse determination notification timeframes was reported for all four quarters. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. **Opportunities:** • MPC did not consistently demonstrate compliance with enrollee and provider grievance resolution timeframes. • Access related enrollee grievances consistently appear in the list of top service categories. • Appeals were not consistently processed based upon the level of urgency. • The receipt date of the appeal was often revised to reflect the date of written consent. • Appeal case notes did not consistently document denials of requests for an expedited resolution and a reasonable attempt to provide the enrollee with oral notice of the denial of a request for an expedited appeal resolution. • Appeal decisions were not consistently made by health care professionals with appropriate clinical expertise as required by the MCO's policies. • MPC did not consistently demonstrate a reasonable attempt to provide the enrollee prompt verbal notice of an expedited appeal resolution. • Appeal resolution letters were not consistently written in plain language.

Network Adequacy Validation	**Strength:** • MPC's online provider directory is easy to read, available on one page, and includes placeholders for all components required by regulation. • MPC scored above the 80% compliance threshold established by MDH and achieved 100% for four of the seven online directory categories. **Improvements:** • MPC effectively implemented its CAP from the CY 2019 validation to: o Consistently reflect in its online provider directories accurate providers, phone numbers, and address information so enrollees can identify and contact new PCPs in their area. o Ensure staff responses regarding accepting new Medicaid patients align with the responses provided in the online directory. o Indicate what ages the provider serves in its online provider directories. o Consistently include responses for languages spoken by the PCP in its online provider directories. o Include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment in its online provider directories. .
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

MedStar Family Choice, Inc. (MSFC) External Quality Review (EQR) Findings

Table 58. MSFC Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1997	99,773	Commendable
Findings		
Systems Performance Review	**Strength:** • MSFC demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of MSFC's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • MSFC successfully resolved CAPs in the Enrollee Rights and Availability and Accessibility standards required in response to identified opportunities in the CY 2018 review. **Opportunities:** • MSFC has one CAP in the Utilization Review standard. • MSFC has two met with an opportunity findings in the Utilization Review standard.	
Performance Improvement Projects	**Improvement:** • MSFC demonstrated statistically significant improvement in the VBP Lead Screening rate from the prior year. **Opportunities:** • For both PIPs, MSFC did not demonstrate effective use of its data on cultural and linguistic disparities and social determinants of health to develop targeted interventions that address the root causes of non-compliance.	

Encounter Data Validation	**Strengths:** • MSFC appears to have an information system and processes capable of capturing complete and accurate encounter data. • MSFC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MSFC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvements:** • MSFC achieved a match rate of 99% for all inpatient codes reviewed, a 1 percentage point increase from the CY 2018 rate of 98%. • MSFC has demonstrated a continued improvement in matched office visit encounters from 93% in CY 2017 to 99% in CY 2019.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • MSFC surpassed the HealthChoice Aggregate and met the minimum compliance threshold for four components (Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/ Anticipatory Guidance) which resulted in a total composite score of 86%. • Thirteen of the 14 elements in the Comprehensive Physical Exam component scored above the MDH's 80% minimum compliance requirement. **Opportunities:** • Measured Blood Pressure demonstrated a negative trend year over year. • Documented Referral to Dentist showed a negative trend year over year.
Consumer Report Card	**Strengths:** ★★★In two of the six performance areas (Access to Care and Doctor Communication and Service). **Improvements:** ★★★In two of the six performance areas (Access to Care and Doctor Communication and Service). ★★In one of the six performance areas (Taking Care of Women). **Opportunities:** ★ In one of the six performance areas (Keeping Kids Healthy).

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • MSFC case notes and resolution letters provide a detailed description of the grievance and resolution. • All grievances were appropriately categorized and resolved and enrollee letters were written in plain language. • MSFC consistently met regulatory timeframes for appeal resolution. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • All appeal resolution letters are in plain language and provide detailed explanation of the reason for the uphold decision and is considered a best practice. **Opportunities:** • MSFC did not consistently demonstrate compliance with regulatory timeframes for enrollee grievance resolutions and pre-service determinations and adverse determination notifications. • Access related enrollee grievances consistently appear in the list of top service categories. • The receipt date of the appeal was often revised to reflect the date of written consent. • Appeal resolution letters provide limited explanation of the reason for the overturn decision.
Network Adequacy Validation	**Strengths:** • MSFC's online provider directory is easy to read, available on one page, and includes placeholders and responses for all components required by regulation. • MSFC scored above the 80% compliance threshold established by MDH in six of the seven categories and achieved 100% in two online directory categories. **Opportunity:** • Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

Priority Partners (PPMCO) External Quality Review (EQR) Findings

Table 59. PPMCO Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1995	324,638	Commendable
Findings		
Systems Performance Review	**Strength:** • PPMCO demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of PPMCO's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • PPMCO successfully met four elements/components in Enrollee Rights, three in Availability and Accessibility, and two in Utilization Review identified as opportunities in the CY 2018 review. **Opportunities:** • PPMCO has three CAPs in the Enrollee Rights, Availability and Accessibility, and Utilization Review standards. • PPMCO has four met with an opportunity findings, one in the Enrollee Rights standard and three in Utilization Review standard.	
Performance Improvement Projects	**Opportunities:** • For both PIPs, PPMCO did not demonstrate implementation of timely, direct, enrollee focused interventions that are measurable to determine their impact on the selected rates. • For both PIPs, PPMCO did not develop interventions that are culturally and linguistically appropriate based upon an in-depth barrier analysis. • For the AMR PIP, PPMCO did not assess the impact of individual interventions on the rate consistent with its data analysis plan. • For both PIPs, PPMCO did not present all numerical PIP results and findings accurately and clearly.	

Encounter Data Validation	**Strengths:** • PPMCO appears to have an information system and processes capable of capturing complete and accurate encounter data. • PPMCO is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • PPMCO achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • PPMCO achieved a match rate of 98% for all office visit codes reviewed, a 2 percentage point increase from the CY 2018 rate of 96%.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • PPMCO scored above the HealthChoice Aggregate in two elements and equal to the aggregate in one element comprising the Health Education/Anticipatory Guidance component. • PPMCO scored above the HealthChoice Aggregate in two elements and equal to the HealthChoice Aggregate in one element comprising the Comprehensive Physical Exam component. **Opportunities:** • PPMCO's Health and Developmental History component score of 87% is one percentage point below the HealthChoice Aggregate score of 88%. • Depression Screening identified a negative trend over a three year period.
Consumer Report Card	**Strengths:** ★★★In one of the six performance areas (Access to Care) **Improvement:** ★★In one of the six performance areas (Taking Care of Women). **Opportunities:** ★ In one of the six performance areas (Care for Adults with Chronic Illness).

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • Grievances and their resolution were well documented in case notes and resolutions were appropriate. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • Grievance resolution letters were written in plain language and provided in both English and Spanish which is considered a best practice. **Opportunities:** • PPMCO did not consistently demonstrate appropriate categorization of grievances. • PPMCO did not consistently demonstrate compliance with timeframes for grievance and appeal resolutions and pre-service determination and adverse determination notifications. • Attitude and billing/financial related enrollee grievances consistently represent the top service categories. • Appeals were not consistently processed based upon level of urgency and, if an expedited resolution request was denied, the decision was not consistently documented in case notes and communicated orally and in writing to the enrollee. • PPMCO did not consistently demonstrate reasonable attempts to provide the enrollee prompt verbal notice of expedited appeal resolution. • Appeal case notes did not consistently document physician review of appeals. • PPMCO did not consistently send enrollees an appeal resolution letter. • Adverse determination letters did not consistently identify the correct deadline for requesting continuation of benefits.

Network Adequacy Validation	**Strengths:** • PPMCO's online provider directory is easy to read and includes placeholders and responses for all components required by regulation. • PPMCO scored above the 80% compliance threshold established by MDH in six of the seven categories and achieved 100% in one online directory category. **Improvement:** • PPMCO effectively implemented its CAP from the CY 2019 validation to: o Specify ADA accessibility responses for the provider regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment. **Opportunity:** • PPMCO demonstrated a continued opportunity for improvement identified in the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

UnitedHealthcare Community Plan (UHC) External Quality Review (EQR) Findings

Table 60. UHC Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
1997	157,930	Accredited
Findings		
Systems Performance Review	**Strength:** • UHC demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of UHC's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • UHC successfully met one component in Utilization Review identified as an opportunity in the CY 2018 review. **Opportunity:** • UHC has one CAP in the Utilization Review standard.	
Performance Improvement Projects	**Opportunities:** • For the AMR PIP, UHC has not implemented any new interventions since January 2017 despite a declining rate. • For the AMR PIP, UHC did not demonstrate that it assesses the impact of its interventions on the AMR rate and that assessments of effectiveness are consistent with the measurement year under review. • For the Lead Screening PIP, UHC did not demonstrate robust, timely interventions with a particular focus on early interventions for the VBP measure population.	

Encounter Data Validation	**Strength:** • UHC appears to have an information system and processes capable of capturing complete and accurate encounter data. • UHC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • UHC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvement:** • UHC has shown an upward trend in matched outpatient encounters for three successive years.
Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • UHC scored above the HealthChoice Aggregate in two elements and equal to the HealthChoice Aggregate in one element that comprise the Comprehensive Physical Exam component. • Documentation of Minimum 5 Systems Examined performed well and scored 100%. **Opportunities:** • UHC's Health Education/Anticipatory Guidance component score of 89% is three percentage points below the HealthChoice Aggregate score of 92%. • Documented Referral to Dentist demonstrated a negative trend year over year.
Consumer Report Card	**Strengths:** ★★★In one of the six performance areas (Access to Care) **Opportunities:** ★ In two of the six performance areas (Taking Care of Women and Care for Adults with Chronic Illness)

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • UHC's grievances and their resolution are well documented in case notes and in resolution letters. • Grievances are appropriately categorized and resolved. • Compliance with regulatory timeframes was consistently demonstrated for enrollee grievances and pre-service determination and adverse determination notifications. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • Grievance case records provide comprehensive documentation of peer review in response to quality of care complaints and include all correspondence between providers and vendors which is considered a best practice. • Grievance resolution letters are in plain language and provide a full description of the grievance and the steps to resolve including feedback from service providers in response to any quality of care/quality of service issues. This is considered a best practice. • All member adverse determination and appeal letters were written in plain language and include the Non-Discrimination Statement in both English and Spanish which is considered a best practice. **Opportunities:** • UHC did not consistently demonstrate consistent compliance with resolution timeframes for provider grievances and enrollee appeals. • Billing/financial related enrollee grievances have consistently represented the top service category. • Adverse determination letters did not consistently identify the correct deadlines for requesting an appeal and continuation of benefits.
Network Adequacy Validation	**Strengths:** • UHC's online provider directory is easy to read and includes placeholders and responses for all components required by regulation. • UHC scored above the 80% compliance threshold established by MDH and achieved 100% in two online validation categories. **Improvement:** • UHC effectively implemented its CAP from the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients align with responses provided in the online directory.

Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

University of Maryland Health Partners (UMHP) External Quality Review (EQR) Findings

Table 61. UMHP Profile and Findings

Contracted Since	CY 2019 Enrollment	NCQA Accreditation Status
2013	52,898	Accredited
Findings		
Systems Performance Review	**Strength:** • UMHP demonstrates the ability to design and implement effective quality assurance systems. The CY 2019 interim desktop review provided evidence of UMHP's continuing progression to ensure the delivery of quality health care for their enrollees. **Improvement:** • UMHP successfully met five components in Enrollee Rights, three in Availability and Accessibility, two in Utilization Review, and three in Fraud and Abuse identified as opportunities in the CY 2018 review. **Opportunity:** • UMHP has four CAPs in Enrollee Rights, Availability and Accessibility, Utilization Review, and Fraud and Abuse standards.	

Performance Improvement Projects	**Improvement:** • UMHP has demonstrated sustained improvement in the AMR and VBP Lead Screening rates from baseline over repeat measurement years. **Opportunities:** • For the AMR PIP, UMHP did not describe the barrier(s) the intervention is addressing in the Interventions Table. • For both PIPs, UMHP did not demonstrate development and implementation of robust, timely, and comprehensive interventions early in the measurement year to have a more meaningful impact on the selected rates. • For both PIPs, completion of a more in-depth barrier analysis of population subgroups is required to identify opportunities for improvement based upon cultural attitudes, beliefs, and behaviors. • For both PIPs, UMHP did not demonstrate that its analysis was consistent with data analysis plan, including assessing the impact/effectiveness of each intervention on the selected rate. • For the Lead Screening PIP, UMHP did not demonstrate that it developed interventions that address all components of the system, member, provider, and MCO, and are based upon a comprehensive root cause barrier analysis. • For the Lead Screening PIP, UMHP did not present its PIP results and findings accurately and clearly. • For the Lead Screening PIP, UMHP established long term goals for both indicators that are below the required 10 percentage point increase over baseline.
Encounter Data Validation	**Strengths:** • UMHP appears to have an information system and processes capable of capturing complete and accurate encounter data. • UMHP is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • UMHP achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. **Improvements:** • UMHP displayed significant improvement for the CY 2019 inpatient codes reviewed. This improvement illustrates the enhanced partnership between the MCO and the providers, as during CY 2018, it was noted that UMHP providers did not submit enough records to meet the minimum sample requested. • UMHP has shown an upward trend in matched outpatient encounters for three successive years.

Early and Periodic Screening, Diagnosis, and Treatment	**Strengths:** • UMHP scored above the HealthChoice Aggregate in three elements and equal to the HealthChoice Aggregate in two elements that comprise the Comprehensive Physical Exam component. **Improvements:** • Documented Health Education/Referral for Identified Problems/Tests demonstrated a positive trend year over year. **Opportunities:** • UMHP's Health Education/Anticipatory Guidance component score of 90% is two percentage points below the HealthChoice Aggregate score of 92%.
Consumer Report Card	**Improvements:** ★★In two of the six performance areas (Access to Care and Keeping Kids Healthy). **Opportunities:** ★In two of the six performance areas (Doctor Communication and Service, Care for Adults with Chronic Illness).

Focused Review of Grievances, Appeals, and Denials	**Strengths:** • All grievance resolutions were appropriate. • UMHP demonstrated consistent compliance with all timeframes for grievance and appeal resolution and pre-service determination and adverse determination notifications. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • Case records provided comprehensive documentation of the grievance and the steps to resolve including responses from providers and vendors as appropriate. This detailed feedback also was included in resolution letters and is considered a best practice. • All appeal resolution letters provided extremely detailed information in plain language as to the reason for the uphold or overturn of the initial denial and is considered a best practice. **Opportunities:** • UMHP did not consistently demonstrate appropriate categorization of grievances. • Billing/financial related enrollee grievances have consistently represented the top service category. • UMHP did not consistently demonstrate compliance with sending written acknowledgment of enrollee grievances within 5 calendar days. • UMHP did not consistently demonstrate timely mailing of grievance resolution letters. • UMHP did not consistently utilize the adverse determination model notice template which includes language regarding continuation of benefits rights, process, and timeframe for requesting.

Network Adequacy Validation	**Strengths:** • UMHP's online provider directory includes placeholders and responses for all components required by regulation. • UMHP scored above the 80% compliance threshold established by MDH and achieved 100% in four online validation categories. **Improvements:** • UMHP effectively implemented its CAP from the CY 2019 validation to: o Ensure staff responses regarding accepting new Medicaid patients align with responses provided in the online directory. Members use the online directory to search for new PCPs and should receive the same information when calling the provider directly. o Specify ages served by the provider in its online provider directories. o Specify ADA accessibility responses for the provider in its online provider directories. o Include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment in its online provider directories.
Healthcare Effectiveness Data and Information Set (HEDIS)	See Appendix B.
Consumer Assessment of Health Providers and Systems (CAHPS)	See Appendix C.

Appendix B: Healthcare Effectiveness Data and Information Set

Statewide Executive Summary Report HealthChoice Participating Organizations HEDIS 2020

Appendix C: Consumer Assessment of Healthcare Providers and Systems

State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations Adult and Child Populations 2020 CAHPS 5.0H Member Experience Survey

Appendix D: 2020 Final IRS and Methodology

Information Reporting Strategy & Analytic Methodology for the 2020 Maryland HealthChoice Consumer Report Card

FINAL

December 2019

Introduction

As a part of its External Quality Review contract with the Maryland Department of Health (MDH), Qlarant is responsible for developing a Medicaid Consumer Report Card.

The Report Card is meant to help Medicaid participants select a HealthChoice managed care organization (MCO). Information in the Report Card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use in developing the Report Card that the MDH will release in 2020, based on data reported from the MCOs in CY 2019. This report is organized as follows:

Section II: Information Reporting Strategy explains the principles used to determine the most appropriate and effective methods of reporting quality information to Medicaid participants, the intended target audience.

Section III: Analytic Method provides statistical basis and the analysis method to be used for reporting comparative MCO performance.

Appendices:

A. Reporting Categories and Measures
B. Questions Comprising CAHPS Measures for the Medicaid Product Line
C. Statistical Methodology to Compare MCO Performance

Information Reporting Strategy

The most formidable challenge facing all consumer information projects is how to communicate a large amount of complex information in an understandable and meaningful manner, while fairly and accurately representing the data. In determining the appropriate content for Maryland's HealthChoice Report Card, principles were identified that addressed these fundamental questions:

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

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

ORGANIZING INFORMATION

Group relevant information in a minimal number of reporting categories and in single-level summary scores.

Recommendation—To enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience, the Qlarant team will design the Report Card to include six categories, with one level of summary scores (measure roll-ups) per MCO, for each reporting category.

Rationale—Research has shown that people have difficulty comparing MCO performance when information is presented in too many topic areas. To include a comprehensive set of performance measures in an effective consumer-information product (one that does not present more information than is appropriate for an audience of Medicaid participants), measures must be combined into a limited number of reporting categories that are meaningful to the target audience.

Group measures into reporting categories that are meaningful to consumers.

Recommendation—Based on a review of the potential measures available for the Report Card (HEDIS, CAHPS, and Maryland's encounter data measures), the team recommends the following reporting categories:

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

Rationale—The recommended categories are based on measures reported by HealthChoice MCOs in 2018 and designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in the areas most important to them and their families.

The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness.

Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

MEASURE SELECTION

Select measures that apply to project goals.

The measures that the project team considered for inclusion in the Report Card are derived from those that MDH requires MCOs to report, which include HEDIS measures; the CAHPS results from both the Adult Questionnaire and the Child Questionnaire; and MDH's encounter data measures.

Each year, the team has created measure selection criteria that has a consistent and logical framework for determining which quality of care measures are to be included in each composite.

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

Appendix A includes the complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

HEDIS Measures

Summary of HEDIS 2019 Measure Changes

The following Measure Specification and HEDIS General Updates do not affect the Report Card methodology. For detailed changes, refer to *HEDIS 2019, Volume 2: Technical Specifications for Health Plans.*

Measure Specific Updates

- *Breast Cancer Screening*:
  - No changes.

- *Appropriate Testing for Children With Pharyngitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Immunizations for Adolescents*:
  - Added optional exclusions for Tdap.

- *Appropriate Treatment for Children With Upper Respiratory Infection*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Controlling High Blood Pressure*:
  - Revised the definition of representative Blood Pressure (BP) to indicate the BP reading must occur on or after the second diagnosis of hypertension.
  - Removed the diabetes flag identification form the event/diagnosis criteria.
  - Added administrative method for reporting.
  - Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
  - Updated the Hybrid specification to indicate that sample size reduction is not allowed.
  - Removed the requirement to confirm the hypertension diagnosis.
  - Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

- *Comprehensive Diabetes Care*
  - Added telehealth into the measure specifications.
  - Added methods to identify bilatrerial eye enucleation.
  - Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
  - Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

HEDIS 2019 General Updates

- Telehealth is incorporated into several measures.
- Certified Federally Qualified Health Centers (FQHC) are considered PCPs. Certification must be reviewed and approved by an auditor.

CAHPS Patient Experience Survey Measures

Consistent with the 2019 Consumer Report Card, it is recommend that results of both the CAHPS Health Plan Survey 5.0H, Adult Version and the CAHPS Health Plan Survey 5.0H, Child Version with the Children With Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.0H Child Questionnaire allows reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic illness. For each population, results include the same ratings, composites, and individual question summary rates. In addition, five CCC measures are reported for the population of children with chronic illness.

Appendix B shows the questions comprising the CAHPS 5.0H measures recommended for the Report Card and their score values.

Summary of CAHPS Measure Changes for 2019

- No modifications were made to the CAHPS Survey for CY 2019

Overall Reporting Category Changes for 2020 Report Card

- Access to Care
  - No changes
- Doctor Communication and Service
  - No changes
- Keeping Kids Healthy
  - No changes
- Care for Kids with Chronic Illness
  - No changes
- Taking Care of Women
  - No changes
- Care for Adults With Chronic Illness
  - No changes

FORMAT

Display information in a format that is easy to read and understand.

The following principles are important when designing Report Cards:

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

Recommendation—An 11 x 18-inch, one page document, with English on one side and Spanish on the opposite side. This one-page document allows presentation of all information. Measure explanations can be integrated on the same page as performance results, helping readers match the explanation to the data.

Draft document contents at a sixth-grade reading level, with short, direct sentences intended to relate to the audience's particular concerns. Avoid terms and concepts unfamiliar to the general public. Explanations of performance ratings, measure descriptions, and instructions for using the Report Card will be straightforward and action-oriented. Translate contents into Spanish using an experienced translation vendor.

Rationale—Cognitive testing conducted for similar projects showed that Medicaid participants had difficulty associating data in charts with explanations if they were presented elsewhere in the Report Card. Consumers prefer a format that groups related data on a single page. Given the number of MCOs whose information is being presented in Maryland's HealthChoice Report Card, a one-page document format will allow easy access to information.

RATING SCALE

Rate MCOs on a tri-level rating scale.

Recommendation—Compare each MCO's performance with the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice MCOs ("the Maryland HealthChoice MCO average"). Use stars or circles to represent performance that is "above," "the same as" or "below" the Maryland HealthChoice MCO average.

Rationale—A tri-level rating scale in a matrix that displays performance across selected performance categories provides participants with an easy-to-read "picture" of quality performance across plans and presents data in a manner that emphasizes meaningful differences between MCOs that are available to them. (Refer to *Section III: Analytic Method*.) This methodology differs from similar methodologies that compare MCO performance with ideal targets or national percentiles. This approach is more useful in an environment where consumers must choose from a group of MCOs.

At this time, developing an overall rating for each MCO is not recommended. The current reporting strategy allows Report Card users to decide which performance areas are most important to them when selecting an MCO.

Analytic Method

The Report Card compare each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average.[9]

The goal of analysis is to generate reliable and useful information that can be used by Medicaid participants to make relative comparisons of the quality of health care provided by Maryland's HealthChoice MCOs. Information should allow consumers to easily detect differences in MCO performance. The index of differences should compare MCO-to-MCO quality performance directly, and the differences between MCOs should be statistically reliable.

[9]For state performance reports directed at participants, NCQA believes it is most appropriate to compare an MCO's performance with the average of all MCOs serving the state. NCQA does not recommend comparing MCOs with a statewide average that has been weighted proportionally to the enrollment size of each MCO. A weighted average emphasizes MCOs with higher enrollments and is used to measure the overall statewide average. Report cards compare a MCO's performance relative to other MCOs, rather than presenting how well the state's Medicaid MCOs serve participants *overall*. In a Report Card, each MCO represents an equally valid option to the reader, regardless of enrollment size.

Handling Missing Values

Replacing missing values can create three issues. Analysts need to first decide which pool of observed (nonmissing) MCOs should be used to derive replacement values for missing data and thendecide how imputed values will be chosen. Alternatives are fixed values (such as "zero" or "the 25th percentile for all MCOs in the nation"), calculated values (such as means or regression estimates), or probable selected values (such as multiplying imputed values). Finally, analysts determine the method used to replace missing values; one that should not provide an incentive for poorly performing plans to intentionally fail to report data. For example, if missing values are replaced with the mean of nonmissing cases, scores for MCOs that perform below the mean would be higher if they fail to report.

Replacing missing Medicaid MCO data with commercial plan data is inappropriate because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual *State of Health Care Quality Report* have consistently shown substantial regional differences in performance of commercial managed care plans. Assuming that regional differences generalize to Medicaid MCOs, it would be inappropriate to use the entire group of national Medicaid MCOs to replace missing values for Maryland HealthChoice MCOs.

Using a regional group of MCOs to derive missing values was determined to be inappropriate also because of substantial differences in Medicaid program administration across states. In other words, reporting of Medicaid data is skewed to a few large states with large Medicaid managed care enrollment.

For these reasons, Maryland HealthChoice MCOs should serve as the pool from which replacement values for missing data are generated. A disadvantage to using only Maryland HealthChoice MCOs for missing data replacement is that there are fewer than 20 MCOs available to derive replacement values. Data-intensive imputation procedures, such as regression or multiple imputations, are unlikely to be employed.

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

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

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

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

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

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

Handling New MCOs

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

Members Who Switch Products/Product Lines

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

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

Case-Mix Adjustment of CAHPS Data

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

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

Statistical Methodology

The statistical methodology includes the following steps:

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

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

Quality Control

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

Appendix A: Reporting Categories and Measures

CATEGORY: ACCESS TO CARE	DATA SOURCE	WEIGHT
Getting Needed Care (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Getting Care Quickly (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Customer Service (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Children and Adolescents' Access to Primary Care Practitioners (12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12-19 years)	HEDIS	1/7
Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years)	HEDIS	1/7
Access to Care - SSI Adult (21 years or older)*	MDH Encounter Data	1/7
Access to Care – SSI Children (ages 0-20)*	MDH Encounter Data	1/7
CATEGORY: DOCTOR COMMUNICATION AND SERVICE	**DATA SOURCE**	**WEIGHT**
Rating of All Health Care (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Personal Doctor (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Specialist Seen Most Often (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
How Well Doctors Communicate (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Shared Decision Making ("Yes" composite global proportion^)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Health Promotion and Education ("Yes" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Coordination of Care ("Usually" and "Always" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
CATEGORY: KEEPING KIDS HEALTHY	**DATA SOURCE**	**WEIGHT**
Childhood Immunization Status (Combo 3)*	HEDIS	1/8
Appropriate Treatment for Children With Upper Respiratory Infections (3 months-18 years)	HEDIS	1/8
Appropriate Testing for Children With Pharyngitis (2-18 years)	HEDIS	1/8
Well-Child Visits in the First 15 Months of Life (6+ visit rate)	HEDIS	1/8

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*	HEDIS	1/8
Adolescent Well-Care Visits (12-21 years)*	HEDIS	1/8
Lead Screening (12 through 23 months)*	MDH Encounter Data, MDE Lead Registry, FFS Data	1/8
Immunization for Adolescents (Combo 1)*	HEDIS	1/8
CATEGORY: CARE FOR KIDS WITH CHRONIC ILLNESS	**DATA SOURCE**	**WEIGHT**
Access to Prescription Medicines (question mean)	CAHPS 5.0H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (composite mean)	CAHPS 5.0H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Family Centered Care: Getting Needed Information (question mean)	CAHPS 5.0H MC	1/6
Coordination of Care for Children With Chronic Conditions ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Asthma Medication Ratio [5-18 years (combine 5-11 years and 12-18 years)]*	HEDIS	1/6
CATEGORY: TAKING CARE OF WOMEN	**DATA SOURCE**	**WEIGHT**
Breast Cancer Screening*	HEDIS	1/5
Cervical Cancer Screening	HEDIS	1/5
Chlamydia Screening (Total Rate: 16-24 years)	HEDIS	1/5
Timeliness of Prenatal Care	HEDIS	1/5
Postpartum Care*	HEDIS	1/5
CATEGORY: CARE FOR ADULTS WITH CHRONIC ILLNESS	**DATA SOURCE**	**WEIGHT**
CDC: Hemoglobin A1c (HbA1c) Testing*	HEDIS	1/8
CDC: HbA1c Poor Control (>9.0%) Note: MCO rate used in the analysis is the inverse score, in order to provide consistency with other measures (i.e. higher % is better)	HEDIS	1/8
CDC: Eye Exam (Retinal) Performed	HEDIS	1/8
CDC: Medical Attention for Nephropathy	HEDIS	1/8
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	HEDIS	1/8
Use of Imaging Studies for Low Back Pain	HEDIS	1/8
Asthma Medication Ratio [19-64 years (combine 19-50 years and 51-64 years)]*	HEDIS	1/8
Controlling High Blood Pressure*	HEDIS	1/8

*Maryland Value-Based Purchasing measure

^Note this composite should be calculated using Composite Global Proportion instead of the Composite Mean

Appendix B: CAHPS 5.0H Measures for the Medicaid Product Line

The table below displays the questions, response choices and corresponding score values used to calculate results for the CAHPS 5.0H Adult Questionnaire and Child Questionnaire [With Children with Chronic Conditions measure (CCC)]. The sampling protocol for the Child Questionnaire allows for the reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic conditions.

Question	Getting Needed Care	Response Choices	Score Values
Q25=MA **Q46=MC**	In the last 6 months, how often was it easy to get appointments with specialists?	Never Sometimes Usually Always	1 1 2 3
Q14=MA **Q15=MC**	In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	Never Sometimes Usually Always	1 1 2 3
Question	**Getting Care Quickly**	**Response Choices**	**Score Values**
Q4=MA **Q4=MC**	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never Sometimes Usually Always	1 1 2 3
Q6=MA **Q6=MC**	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never Sometimes Usually Always	1 1 2 3
Question	**How Well Doctors Communicate**	**Response Choices**	**Score Values**
Q17=MA **Q32=MC**	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	Never Sometimes Usually Always	1 1 2 3
Q18=MA **Q33=MC**	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always	1 1 2 3

Q19=MA **Q34=MC**	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always	1 1 2 3
Q20=MA **Q37=MC**	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always	1 1 2 3
Question	**Customer Service**	**Response Choices**	**Score Values**
Q31=MA **Q50=MC**	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never Sometimes Usually Always	1 1 2 3
Q32=MA **Q51=MC**	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never Sometimes Usually Always	1 1 2 3
Question	**Shared Decision Making**	**Response Choices**	**Score Values**
Q10=MA **Q11=MC**	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Yes No	1 0
Q11=MA **Q12=MC**	Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Yes No	1 0
Q12=MA **Q13=MC**	When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Yes No	1 0
Question	**Health Promotion and Education**	**Response Choices**	**Score Values**
Q8=MA **Q8=MC**	In the last 6 months, did you and a doctor or other health provider talk specific things you could do to prevent illness?	Yes No	1 0
Question	**Coordination of Care**	**Response Choices**	**Score Values**
Q22=MA **Q40=MC**	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	Never Sometimes Usually Always	0 0 1 1

Question	Rating of Health Care	Response Choices	Score Values
Q13	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	0>=Q13<=6 Q13>=7<=8 Q13>=9<=10	1 2 3
Q14	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?	0>=Q14<=6 Q14>=7<=8 Q14>=9<=10	1 2 3
Question	**Rating of Personal Doctor**	**Response Choices**	**Score Values**
Q23	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	0>=Q23<=6 Q23>=7<=8 Q23>=9<=10	1 2 3
Q41	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?	0>=Q41<=6 Q41>=7<=8 Q41>=9<=10	1 2 3
Question	**Rating of Specialist**	**Response Choices**	**Score Values**
Q27	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q27<=6 Q27>=7<=8 Q27>=9<=10	1 2 3
Q48	We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q48<=6 Q48>=7<=8 Q48>=9<=10	1 2 3

Key: MA = CAHPS 5.0H Medicaid Adult Questionnaire MC = CAHPS 5.0H Medicaid Child Questionnaire (With CCC measure)

CAHPS 5.0H Child Questionnaire Measures

The following questions from the CAHPS 5.0H Child Questionnaire provide information on parents' experience with their child's health plan for the population of children with chronic conditions. The five CCC measures summarize satisfaction with basic components of care essential for

successful treatment, management and support of children with chronic conditions. The child is included in the CCC population calculations if one or more of the following survey-based screening criteria are true:

- Child currently needs/uses **medicine prescribed by a doctor** for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs/uses more **medical, mental health or educational services** than is usual for most children the same age due to a medical, behavioral or other health condition lasting/ expected to last 12 months or more.
- Child is **limited or prevented** in any way in his or her ability to do the things most children of the same age can do because of a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs to get **special therapy**, such as physical, occupational or speech therapy for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child has any kind of emotional, developmental or behavioral problem lasting/expected to last 12 months or more for which he or she needs or gets **treatment or counseling**.

Question	Access to Prescription Medicines	Response Choices	Score Values
Q56	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never Sometimes Usually Always	1 1 2 3
Question	**Access to Specialized Services**	**Response Choices**	**Score Values**
Q20	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always	1 1 2 3
Q23	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always	1 1 2 3
Q26	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always	1 1 2 3
Question	**Family-Centered Care: Personal Doctor Who Knows Child**	**Response Choices**	**Score Values**
Q38	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes No	1 0

Q43	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes No	1 0
Q44	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes No	1 0
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**	**Score Values**
Q9	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never Sometimes Usually Always	1 1 2 3
Question	**Coordination of Care for Children With Chronic Conditions**	**Response Choices**	**Score Values**
Q18	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes No	1 0
Q29	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes No	1 0

Appendix E: Full Report Reference Page

Access all reports identified below on MDH's Quality Assurance website.

Systems Performance Review

CY 2019 Statewide Executive Summary Report

Performance Improvement Projects

2020 Annual PIP Report

Encounter Data Validation

CY 2019 EDV Report

Value-Based Purchasing

CY 2019 VBP Report

Early and Periodic Screening, Diagnosis, and Treatment

CY 2019 EPSDT Statewide Executive Summary Report

Consumer Report Card

2020 Maryland Consumer Report Card English and Spanish

Focused Review of Grievances, Appeals, & Denials

2020 Annual Grievances, Appeals, & Denials Report

Network Adequacy Validation

CY 2020 Network Adequacy Report