



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

Annual Technical Report (ATR) Notice to Public July 30, 2026

THE EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) MEDICAL RECORD REVIEW REPORT IS UNDERGOING ADDITIONAL REVIEW.

Effective June 22, 2026, the Maryland Department of Health (MDH) is reviewing an issue that impacts the EPSDT Medical Record Review activity scores for both the individual managed care organizations (MCOs) and the HealthChoice Aggregate. This issue specifically impacts the Laboratory Tests/At-Risk Screenings component data detailed in the sections below:

- Executive Summary: page 20
- EPSDT Reporting: pages 133-148
- MCO Specific Summaries: pages 169-244

Please interpret these findings with caution until the review concludes. MDH will provide notice if the report requires additional revisions.

If you have any questions, email mdh.hcqa@maryland.gov.



**Maryland HealthChoice Program
Medicaid Annual Technical Report
Calendar Year 2025**

Submitted April 2026

Table of Contents

Maryland HealthChoice Medicaid Program 2025 Annual Technical Report

2025 Executive Summary	12
Introduction	12
Key Findings	13
Healthcare Effectiveness Data and Information Set	21
Consumer Assessment of Healthcare Providers and Systems	22
Conclusion	22
2025 Annual Technical Report	23
Introduction	23
Background	23
Purpose	25
Performance Improvement Project Validation	26
Objective	26
Methodology	27
Results	31
Conclusion	41
Additional Information	46
Performance Measure Validation	46
Objective	46
Methodology	46
Results	69
Conclusion	72
Additional Information	75

Systems Performance Review	75
Objective	75
Methodology	75
Results	78
Conclusion	81
Additional Information	83
Network Adequacy Validation	83
Objective	83
Methodology	84
Results	90
Conclusion	108
Additional Information	114
Encounter Data Validation	114
Objective	114
Methodology	115
Results	116
Conclusion	131
Additional Information	133
Early and Periodic Screening, Diagnosis, and Treatment	133
Objective	133
Methodology	133
Results	137
Conclusion	145
Additional Information	148
Consumer Report Card	148

Objective	148
Methodology	149
Results	149
Conclusion	150
Additional Information	151
Grievances, Appeals, and Denials Focused Study.....	151
Objective	151
Methodology	151
Results	154
Conclusion	159
Additional Information	163
State Recommendations	163
Recommendations on How the State Can Target Quality Strategy Goals and Objectives	164
Appendices Introduction	167
Section Summaries	167
MCO-Specific Summaries	167
SPR Standards and Guidelines	167
Hilltop's MY 2024 Encounter Data Validation Report.....	167
2025 Final IRS and Methodology.....	167
Report Reference Page	167
Report Requirements	168
Appendix A: MCO-Specific Summaries	169
ABH	169
Quality, Access, and Timeliness	169
Assessment of Previous Recommendations.....	176

CFCHP	177
Quality, Access, and Timeliness	177
Assessment of Previous Recommendations	184
JMS	186
Quality, Access, and Timeliness	186
Assessment of Previous Recommendations	192
KPMAS	192
Quality, Access, and Timeliness	192
Assessment of Previous Recommendations	199
MPC	201
Quality, Access, and Timeliness	201
Assessment of Previous Recommendations	207
MSFC	208
Quality, Access, and Timeliness	208
Assessment of Previous Recommendations	215
PPMCO	216
Quality, Access, and Timeliness	216
Assessment of Previous Recommendations	223
UHC	224
Quality, Access, and Timeliness	224
Assessment of Previous Recommendations	232
WPM	233
Quality, Access, and Timeliness	233
Assessment of Previous Recommendations	241
Appendix B: MY 2024 Maryland Standards Crosswalks and Guidelines	245

Guidelines.....	245
SPR Standards and Guidelines	245
Crosswalks	323
Deeming Eligibility	323
SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk	324
Appendix C: Hilltop’s MY 2024 Encounter Data Validation Report.....	325
Appendix D: 2024 Maryland HealthChoice Consumer Report Card Information Reporting Strategy and Analytic Methodology	326
Appendix E: Report Reference Page	342
Appendix F: Report Requirements.....	343

List of Figures and Tables

Figures

Figure 1. MY 2024 Indicator Rates (Prenatal Care PIP)	32
Figure 2. MY 2024 PPC-AD Indicator Rates (Postpartum Care-Related PIP)	36
Figure 3. MY 2024 W30: 0-15 Months Indicator Rates (Postpartum Care-Related PIP)	37
Figure 4. MY 2024 W30: 15-30 Months Indicator Rates (Postpartum Care-Related PIP)	38
Figure 5. MY 2024 CIS-3 Indicator Rates (Postpartum Care-Related PIP)	39
Figure 6. Three-Year Comprehensive Trending of CAPs and MwOs.....	79
Figure 7. MYs 2023 to 2025 Accuracy of Online Directory Contact Information (Phone Number and Address) (NAV)	97
Figure 8. MY 2025 Responses by Call Attempt for Successful Contacts (NAV)	98
Figure 9. MYs 2023 to 2025 PCP Affiliation and Open Access (NAV)	99
Figure 10. MYs 2023 to 2025 Unsuccessful Surveys due to "No Contact" (NAV).....	101
Figure 11. MYs 2023 to 2025 Unsuccessful Surveys due to "PCP Response" (NAV)	102
Figure 12. MYs 2023 to 2025 Percent of PCPs in Compliance with Routine Care Appointment Standards (NAV)	104
Figure 13. MYs 2023 to 2025 Percent of PCPs in Compliance with Urgent Care Appointment Standards (NAV).....	105
Figure 14. MYs 2023 to 2025 Provider Directory Validation Results (NAV)	107
Figure 15. MYs 2022 to 2024 HealthChoice Aggregate Results by Component (EPSDT)	139

Tables

Table 1. EQR Activities Conducted During 2025.....	13
Table 2. MY 2024 Remeasurement Indicator Rate Percentages (PIP).....	14
Table 3. Total Available Funds (PHIP)	15
Table 4. MY 2024 Total CAP Summary per MCO (SPR).....	15
Table 5. MY 2024 Validation Results for Provider-to-Enrollee Ratios (NAV)	17
Table 6. MY 2024 Validation Results for Time and Distance Standards (NAV).....	18
Table 7. MY 2025 Total CAP Summary per MCO (NAV).....	18
Table 8. MY 2024 MCO and HealthChoice Results by Encounter Type (EDV)	19

Table 9. MY 2024 Total CAPs per MCO (EPSDT)	20
Table 10. 2025 Results (CRC)	20
Table 11. Star Rating Changes from 2024 to 2025 (CRC)	20
Table 12. Comparison of GAD Opportunities for Improvement from MY 2022 to MY 2024 (GAD)	21
Table 13. MY 2024 MCO Profiles	24
Table 14. HealthChoice Program Goals and Objectives	25
Table 15. MY 2024 MDH-Selected Topics (PIP)	27
Table 16. MY 2024 Remeasurement Validation Rating and Confidence Levels (Prenatal Care PIP)	33
Table 17. MY 2024 Remeasurement Performance Comparison to NCQA's Quality Compass (Prenatal Care PIP)	34
Table 18. MY 2024 MCO-Selected Strategies and Correlating HEDIS Measures (Postpartum Care-Related PIP)	34
Table 19. MY 2024 Validation Rating and Confidence Levels (Postpartum Care-Related PIP)	35
Table 20. MY 2024 Remeasurement Performance Comparison to NCQA's Quality Compass (Postpartum Care-Related PIP)	40
Table 21. MY 2024 Remeasurement Overall Performance (Prenatal Care PIP)	42
Table 22. MY 2024 Remeasurement Overall Performance (Postpartum Care-Related PIP)	43
Table 23. MY 2024 HealthChoice Performance Against Quality Strategy Targets (PIP)	43
Table 24. MY 2024 Strengths, Improvements, and Recommendations (PIP)	45
Table 25. MY 2024 Summary of MetaStar's HEDIS Measure Results (HEDIS)	49
Table 26. MY 2024 Strengths, Improvements, and Recommendations (HEDIS)	59
Table 27. Summary of Trends in Performance on Key HealthChoice Adult Medicaid Survey Measures (CAHPS)	60
Table 28. Summary of Trends in Performance on Key HealthChoice Adult Medicaid Survey Measures (Continued) (CAHPS)	61
Table 29. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC Survey Measures (CAHPS)	62
Table 30. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC Survey Measures (Continued) (CAHPS)	63
Table 31. Summary of Trends in Performance on CCC Survey Measures (CAHPS)	64
Table 32. MY 2024 Strengths, Improvements, and Recommendations (CAHPS)	65
Table 33. MY 2024 Measures (PHIP)	66
Table 34. Qlarant's MY 2024 Encounter Data Measure Validation Results (PHIP)	67
Table 35. MetaStar's MY 2024 HEDIS Measure Validation Results (PHIP)	67
Table 36. Total Available Funds (PHIP)	70
Table 37. Tier 1 Performance Incentives: MY 2024 Benchmark Percentiles (PHIP)	70
Table 38. Improvement Incentives (PHIP Tier 2)	71

Table 39. MY 2024 Performance Incentive Dollars Awarded (PHIP Tier 1)	71
Table 40. MY 2024 Improvement Incentive Dollars Awarded (PHIP Tier 2).....	72
Table 41. MY 2024 Round 1 Incentive Award Summary (PHIP Tier 1 & Tier 2)	73
Table 42. MY 2024 Round 1 and Round 2 Incentives Awarded (PHIP Summary)	73
Table 43. MY 2024 Maryland Reportable Rate Against Quality Strategy Targets	74
Table 44. MY 2024 Validation Review Determinations (SPR).....	77
Table 45. HealthChoice Aggregate Scores At-A-Glance (SPR)	78
Table 46. MY 2024 MCO Opportunity Findings (SPR)	80
Table 47. MY 2024 MCO and HealthChoice Aggregate Results (SPR)	81
Table 48. MY 2024 Recommended CAP Closures (SPR)	82
Table 49. MY 2024 Strengths, Improvements, and Recommendations (SPR)	83
Table 50. Data and Documentation Obtained (NAV)	84
Table 51. MY 2025 Contracted PCPs and Sample Size by MCO (NAV)	86
Table 52. MY 2024 Validation Review Determinations (NAV)	87
Table 53. MY 2025 Validation Review Determinations (NAV).....	88
Table 54. MY 2025 Summary of Activities (NAV)	88
Table 55. MY 2024 Provider-to-Enrollee Standards (NAV).....	91
Table 56. Number of Indicators Included for MY 2024 MCO Provider-to-Enrollee Ratios (NAV)	93
Table 57. MY 2024 Time and Distance Standards (NAV).....	94
Table 58. Number of Indicators Included for MY 2024 Time and Distance Standards (NAV)	96
Table 59. MYs 2023 to 2025 Number of Surveys Conducted and Successful PCP Contacts (NAV)	98
Table 60. MY 2025 MCO Results from Successful Contacts for Accuracy of PCP Information (NAV)	100
Table 61. MY 2025 "No Contact" Categories by MCO (NAV)	101
Table 62. MY 2025 "PCP Response" by MCO (NAV)	103
Table 63. MY 2025 Network Adequacy Appointment Requirements (NAV).....	103
Table 64. MY 2025 MCO and HealthChoice Results for Compliance with Routine Care Appointment Standards (within 30 days) (NAV)	104
Table 65. MY 2025 MCO and HealthChoice Results for Compliance with Urgent Care Appointment Standards (within 48 hours) (NAV).....	105
Table 66. MY 2025 Network Adequacy Requirements for Provider Directories (NAV).....	106
Table 67. MY 2025 MCO and HealthChoice Results for Provider Directory Validations (NAV)	108
Table 68. MY 2025 HealthChoice Performance Against Quality Strategy Targets (NAV)	112

Table 69. MYs 2024 and 2025 Strengths, Improvements, and Recommendations (NAV)	113
Table 70. MY 2024 Encounter Data Requirements (EDV)	117
Table 71. MY 2024 ISCA Summary (EDV)	119
Table 72. MYs 2022 to 2024 Minimum Sample Required for Review by Encounter Type (EDV)	121
Table 73. MY 2024 MCO EDV Medical Record Review Response Rates by Encounter Type (EDV)	121
Table 74. MY 2024 Review Determinations (EDV)	122
Table 75. MYs 2022 through 2024 Results by Encounter Type (EDV).....	123
Table 76. MYs 2022 through 2024 Inpatient Encounter Type Results by Code (EDV)	124
Table 77. MY 2024 MCO Inpatient Results by Code Type (EDV).....	124
Table 78. MYs 2022 through 2024 Outpatient Encounter Type Results by Code (EDV).....	125
Table 79. MY 2024 MCO Outpatient Results by Code Type (EDV).....	126
Table 80. MYs 2022 through 2024 Office Visit Results by Code (EDV)	127
Table 81. MY 2024 MCO Office Visit Results by Code Type (EDV)	128
Table 82. MYs 2022 through 2024 MCO and HealthChoice Results by Encounter Type (EDV)	128
Table 83. MYs 2022 through 2024 Coding Error Reasons for <i>No Match</i> Findings by Encounter Type (EDV).....	129
Table 84. MYs 2022 through 2024 Lack of Documentation Reasons for <i>No Match</i> Findings by Encounter Type (EDV).....	130
Table 85. MYs 2022 through 2024 Upcoding Reasons for <i>No Match</i> Findings by Encounter Type (EDV).....	130
Table 86. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets (EDV)	131
Table 87. MY 2024 Strengths, Improvements, and Recommendations (EDV).....	132
Table 88. MY 2024 MCO and HealthChoice Sample Size Summary (EPSDT)	136
Table 89. MY 2024 Validation Review Determinations and Scoring (EPSDT).....	136
Table 90. MY 2024 Component Results by MCO and Measurement Year Aggregates (EPSDT).....	138
Table 91. MY 2024 Health and Developmental History Element Results and Measurement Year Aggregates (EPSDT).....	140
Table 92. MY 2024 Comprehensive Physical Examination Element Results and Measurement Year Aggregates (EPSDT)	141
Table 93. MY 2024 Laboratory Tests/At-Risk Screenings Element Results and Measurement Year Aggregates (EPSDT)	142
Table 94. MY 2024 Immunizations Element Results and Measurement Year Aggregates (EPSDT)	144
Table 95. MY 2024 Health Education/Anticipatory Guidance Element Results and Measurement Year Aggregates (EPSDT)	145
Table 96. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets (EPSDT).....	146
Table 97. MY 2024 Strengths, Improvements, and Recommendations (EPSDT)	147
Table 98. 2025 Results (CRC).....	149

Table 99. Star Rating Changes from 2024 to 2025 (CRC)	149
Table 100. 2025 Strengths, Improvements, and Recommendations (CRC)	151
Table 101. MY 2024 Validation Review Determinations (GAD).....	152
Table 102. Annual Trending of Compliance with Enrollee Grievance Resolution Timeframes (GAD MCO-Reported Results).....	154
Table 103. Annual Trending of Compliance with Provider Grievance Resolution Timeframes (GAD MCO-Reported Results)	155
Table 104. Annual Trending of Compliance with Enrollee Appeal Resolution Timeframes (GAD MCO-Reported Results).....	155
Table 105. Annual Trending of Compliance with Pre-Service Determination Timeframes (GAD MCO-Reported Results)	156
Table 106. Annual Trending of Compliance with Adverse Determination Notification Timeframes (GAD MCO-Reported Results).....	156
Table 107. MY 2024 MCO Annual Grievance Results (GAD Record Review).....	157
Table 108. MY 2024 MCO Annual Appeal Results (GAD Record Review)	157
Table 109. MY 2024 MCO Annual Adverse Determination Results (GAD Record Review)	158
Table 110. MY 2024 MCO Adverse Determination Issues (GAD Record Review)	159
Table 111. MY 2024 MCO Overall Compliance with Regulatory Timeframes (GAD)	159
Table 112. MY 2024 MCO Overall Compliance with Record Review Components (GAD).....	160
Table 113. MY 2024 Strengths, Improvements, and Recommendations (GAD)	161
Table 114. MY 2024 Summary of Opportunities for Improvement (GAD).....	162
Table 115. HealthChoice Program Goals and Objectives	163
Table 116. ABH Strengths, Improvements, and Recommendations	169
Table 117. ABH Assessment of Previous Annual Recommendations.....	176
Table 118. CFCHP Strengths, Improvements, and Recommendations.....	177
Table 119. CFCHP Assessment of Previous Annual Recommendations	185
Table 120. JMS Strengths, Improvements, and Recommendations.....	186
Table 121. KPMAS Strengths, Improvements, and Recommendations.....	192
Table 122. KPMAS Assessment of Previous Annual Recommendations	199
Table 123. MPC Strengths, Improvements, and Recommendations.....	201
Table 124. MPC Assessment of Previous Annual Recommendations	207
Table 125. MSFC Strengths, Improvements, and Recommendations	209
Table 126. MSFC Assessment of Previous Annual Recommendations	215
Table 127. PPMCO Strengths, Improvements, and Recommendations	216
Table 128. PPMCO Assessment of Previous Annual Recommendations	223

Table 129. UHC Strengths, Improvements, and Recommendations	225
Table 130. UHC Assessment of Previous Annual Recommendations.....	232
Table 131. WPM Strengths, Improvements, and Recommendations	233
Table 132. WPM Assessment of Previous Annual Recommendations.....	242
Table 133. Measure Specific Updates	328
Table 134. Formatting Elements	331
Table 135. Access to Care Measures.....	336
Table 136. Doctor Communication & Service Measures.....	336
Table 137. Keeping Kids Healthy Measures	337
Table 138. Care for Kids with Chronic Illness Measures.....	337
Table 139. Pregnancy and Infant Care Measures.....	337
Table 140. Keeping Adults Healthy Measures	338
Table 141. Adult Questionnaire with Never, Sometimes, Usually, or Always Responses	338
Table 142. Adult Questionnaire with Worst Through Best Responses.....	339
Table 143. Adult Questionnaire with Yes or No Responses	340
Table 144. Child Questionnaire with Never, Sometimes, Usually, or Always Responses	341
Table 145. Child Questionnaire with Yes or No Responses	341

Maryland HealthChoice Program

Annual Technical Report

2025 Executive Summary

Introduction

The Maryland Department of Health (MDH) contracts with Qlarant, an external quality review organization (EQRO), to evaluate Maryland's managed care program, known as HealthChoice. HealthChoice has served Marylanders on Medicaid since June 1997 under the authority of a Section 1115 waiver of the Social Security Act. Providing quality healthcare that is equitable, patient-focused, prevention-oriented, coordinated, accessible, and cost-effective is a guiding principle for HealthChoice for the following nine managed care organizations (MCOs) contracted to provide services:

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield Community Health Plan (CFCHP)
- 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)
- Wellpoint Maryland (WPM)

As the Maryland EQRO, Qlarant evaluates MCO compliance with federal and contractual requirements by conducting multiple external quality review (EQR) activities, including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review, also referenced as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- 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)
- Grievances, Appeals, and Denials (GAD) Focused Study

Qlarant conducted EQR activities throughout 2025 and evaluated MCO compliance and performance for measurement years (MYs) 2023, 2024, and 2025, as applicable. MDH is working towards minimizing disparities amongst the HealthChoice population by integrating health equity and a disparity lens into the HealthChoice framework. Comparisons between the Code of Maryland Regulations (COMAR) and the Code of Federal Regulations (42 CFR) §438.350 standards are provided, as applicable, to establish set standards for compliance and performance guiding MCO and program evaluations. Qlarant followed Centers for Medicare & Medicaid Services (CMS) EQR Protocols to conduct activities. This report summarizes results from all EQR activities and includes conclusions drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. No MCOs were exempt from the EQR conducted for MYs 2023, 2024, and 2025. During 2025, Qlarant evaluated the following performance periods (MYs) for each EQR activity identified below.

Table 1. EQR Activities Conducted During 2025

EQR Activity During 2025	MCO Performance Period [^]
PIP Validation	2024: January 1 – December 31
PMV	2024: January 1 – December 31
SPR	2024: January 1 – December 31
NAV	2024: January 1 – December 31
NAV Focused Study	2025: June 30 – August 29
EDV	2024: January 1 – December 31
EPSDT Medical Record Reviews	2024: January 1 – December 31
CRC	2023: January 1 – December 31
GAD Focused Study	2024: January 1 – December 31

[^] MCO performance period is the timeframe that was evaluated during the EQR activity. Qlarant evaluates the most current MCO information, data, or results available for each EQR activity.

Key Findings

Performance Improvement Project Validation. PIPs are designed to achieve and sustain improvement in clinical outcomes, administrative processes, or enrollee satisfaction. PIPs use a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying root causes, barriers, and implementing targeted interventions. MDH incorporates PIPs to align with statewide public health and the specific Medicaid Innovation initiatives in [Maryland's Statewide Integrated Health Improvement Strategy](#). MCOs completed perinatal PIPs related to the Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP) topics to reduce severe morbidity and address preventive care services in early childhood.

MCOs utilized Healthcare Effectiveness Data and Information Set (HEDIS)[®] performance measures following the [MY 2024 HEDIS measure descriptions](#) to evaluate the following:

- **Timeliness of Prenatal and Postpartum Care (PPC):** The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these enrollees, the measure assesses the following facets of prenatal and postpartum care.
 - Timeliness of Prenatal Care (PPC-CH): The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
 - Postpartum Care (PPC-AD): The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.
- **Well-Child Visits in the First 30 Months of Life (W30):** The percentage of enrollees who had the following number of well-child visits with a primary care provider (PCP) during the last 15 months. The following rates are reported:
 - W30 (0-15 Months): Children who turned 15 months old during the measurement year: Six or more well-child visits.
 - W30 (15-30 Months): Children who turned 30 months old during the measurement year: Two or more well-child visits.
- **Childhood Immunization Status (CIS-3):** The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HEPB) and one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Table 2. MY 2024 Remeasurement Indicator Rate Percentages (PIP)

Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Prenatal Care PIP: PPC-CH	87.9%	95.1%	88.3%	94.6%	92.7%	83.8%	89.8%	85.4%	87.8%
Postpartum Care-Related PIP: PPC-AD	83.3%	89.1%	87.8%	95.2%	81.8%	85.0%	84.2%	79.6%	84.4%
Postpartum Care-Related PIP: W30 (0-15 Months)	53.3%	68.1%	54.6%	79.1%	60.9%	58.1%	62.6%	64.0%	61.0%
Postpartum Care-Related PIP: W30 (15-30 Months)	71.4%	70.9%	74.7%	79.6%	72.2%	76.8%	75.7%	76.3%	80.1%
Postpartum Care-Related PIP: CIS-3	68.6%	71.5%	67.5%	77.9%	72.8%	68.4%	76.2%	70.1%	75.9%

Performance Measure Validation. MDH utilizes the Population Health Incentive Program (PHIP) activities as part of an incentive program designed to provide financial incentives to MCOs, based on their performance in standardized measures that demonstrate high-quality care. MY 2024 is the third implementation year of the two-round design for selected HEDIS and MDH-developed encounter measures. Qlarant completed PHIP activities in collaboration with MetaStar, Inc. (MetaStar) and The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop). MDH contracts with MetaStar to conduct HEDIS audits and Hilltop to calculate PHIP encounter data measures. Qlarant validates the encounter

data measures calculated by Hilltop and reports financial incentives, as provided by MDH. Performance incentives rewarded MCO scores against benchmarks at or above the fiftieth percentile during the MY. Improvement incentives rewarded year-over-year improvement. Round 2 incentives rewarded MCOs earning above 80% of possible Round 1 incentives, and performing significantly well on the HEDIS Performance Monitoring Policy requirements for MY 2024.

All nine MCOs received a Round 1, Tier 1 performance incentive and a Round 1, Tier 2 improvement incentive. No MCOs received Round 2 incentives.

Table 3. Total Available Funds (PHIP)

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Available for Incentives (based on % cap approved by DBM [*])	\$797,688	\$1,392,778	\$495,590	\$1,348,572	\$3,329,417	\$1,376,461	\$4,502,823	\$2,080,461	\$3,577,976
Max Payout for Each of the Measures (1/8th of available cap)	\$99,711	\$174,097	\$61,949	\$168,572	\$416,177	\$172,058	\$562,853	\$260,058	\$447,247

^{*}Department of Budget and Management

Systems Performance Review. SPRs evaluate MCO compliance with structural and operational standards. Qlarant evaluated MY 2024 MCO compliance with federal and contractual requirements as a comprehensive review. Comprehensive reviews included a pre-audit overview and survey, onsite or virtual reviews, exit letters, reporting, and corrective action plans (CAPs). The next comprehensive review will occur in MY 2027, reflecting MDH's decision for triennial, rather than annual, onsite reviews. MDH established the minimum compliance score for each federal and contractual standard at 100%. Qlarant evaluates CAPs for MCOs not meeting minimum compliance by standard, instead of by individual components or elements.

JMS continues to maintain full compliance at 100%, without required CAPs, for multiple years. CAPs were required to address areas of noncompliance for the remaining eight MCOs, which should improve compliance rates if successfully implemented. The following tables identify the number of quarterly and annual CAPs required by each MCO, contrast the number of CAPs reviewed with those successfully closed, and identify any remaining CAP opportunities.

Table 4. MY 2024 Total CAP Summary per MCO (SPR)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Annual CAPs Required	3	1	0	4	1	4	2	4	3
Total Annual CAPs Closed	0	0	0	0	0	0	0	0	0
MY 2023 CAP Comparison	↑	↑	∅	↑	↑	↑	↑	↑	↑

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Quarterly CAPs Required	0	1	0	0	0	0	0	0	1
Total Quarterly CAPs Closed	0	1	0	1	1	0	0	0	1
Remaining Quarterly CAP Opportunities	∅	∅	∅	↓	↓	∅	∅	∅	∅

Green and ↓ = positive improvement (decrease in CAPs); Pink and ↑ = negative increase in CAPs; White and ∅ = no change in required CAPs.

Note: Comprehensive review years (i.e., MY 2024) typically yield more CAPs than in interim review years (i.e., MY 2023).

Network Adequacy Validation. MY 2024 is the first remeasurement period after MY 2023's baseline study for assessing provider-to-enrollee ratios and time and distance standards. A validation rating for each MCO was assigned to individual indicators, ranging from *No Confidence* to *High Confidence*.

Provider-to-Enrollee Ratios. MY 2024's activities observed the following MCO's indicator performance for provider-to-enrollee ratios:

- **ABH:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **CFCHP:** One of the two required indicators, PCP, achieved a validation rating of *High Confidence* with a validation score of 100%. The second required indicator, Pediatric PCP, achieved a validation rating of *Low Confidence* with a validation score of 50%. CFCHP submitted Pediatric PCP ratios of zero despite the enrollment file and provider file containing eligible counts. Three of the additional indicators (PCP subspecialties) achieved a validation rating of *High Confidence* with a validation score of 100%. The remaining seventeen additional indicators (Obstetrics (OB)/Gynecology (GYN), Core Specialists, Major Specialists, Other Specialists) achieved a validation rating of *Moderate Confidence* with a validation score of 53.3%. The total enrollee counts CFCHP used to calculate the ratios for these specific specialties were less than the total enrollee counts that should have been used.
- **JMS:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **KPMAS:** All required indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **MPC:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **MSFC:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **PPMCO:** One of the two required indicators, PCP, achieved a validation rating of *High Confidence* with a validation score of 100%. The second required indicator, Pediatric PCP, achieved a validation rating of *Moderate Confidence* with a validation score of 62.5%. After reviewing PPMCO's submitted documentation, analysts determined that the total enrollee count remained the same for every provider type (i.e., adults were included in the counts focusing on the pediatric PCPs and specialties and all males were included in specialties focused on women's health).
- **UHC:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **WPM:** One of the two required indicators, Pediatric PCP, achieved a validation rating of *High Confidence* with a validation score of 100%. The second required indicator, PCP, was not reported and could not be validated for all other PCPs not exclusively identified as Pediatric PCPs. One PCP subspecialty, Family/General Practitioners, was identified and achieved a validation rating of *High Confidence* with a validation score of 100%. All other additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.

Table 5. MY 2024 Validation Results for Provider-to-Enrollee Ratios (NAV)

Validation Results	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Indicators Identified	28	22	33	2	26	28	26	22	26
High Confidence (90.0% to 100%)	28	4	33	2	26	28	21	22	25
Moderate Confidence (51.0% to 89.9%)	0	17	0	0	0	0	5	0	0
Low Confidence (10.0% to 50.9%)	0	1	0	0	0	0	0	0	0
No Confidence (0.0% to 9.9%)	0	0	0	0	0	0	0	0	0
Could Not Be Validated	0	0	0	0	0	0	0	0	1

Time and Distance Standards. MY 2024's activities observed the following MCO's indicator performance for time and distance standards:

- **ABH:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **CFCHP:** Fifty-four of the 75 required indicators achieved a validation rating of *High Confidence* with a validation score of 100%. The remaining 21 required indicators (Pediatric PCP, Prenatal Providers, OB/GYN, Pediatric Specialties) achieved a validation rating of *Moderate Confidence* with a validation score of 64.7%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population and women's population, respectively. Further follow-up determined this methodology was intentional by the MCO to ensure adequate coverage.
- **JMS:** All required indicators achieved a validation rating of *High Confidence* with a validation score of 100%. The additional indicators (Hematology/Oncology/Radiation Oncology, Podiatry) could not be validated. JMS monitored these provider types and reported a percentage for compliance, but did not provide the time or distance metrics, such as average or maximum time and distance.
- **KPMAS:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **MPC:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **MSFC:** All required and additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **PPMCO:** Sixty of the 75 required indicators achieved a validation rating of *High Confidence* with a validation score of 100%. The remaining 15 required indicators (Pediatric PCP, Pediatric Specialties) achieved a validation rating of *Moderate Confidence* with a validation score of 62.5%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population. All additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **UHC:** All required indicators achieved a validation rating of *High Confidence* with a validation score of 100%.
- **WPM:** Seventy-two of the 75 required indicators achieved a validation rating of *High Confidence* with a validation score of 100%. The other three required indicators, PCP, were not reported as a consolidated group and could not be validated. Two PCP subspecialties (Family/General Practitioners and Internal Medicine) were identified, and their six indicators achieved a validation rating of *High Confidence* with a validation score of 100%. All other additional indicators achieved a validation rating of *High Confidence* with a validation score of 100%.

Table 6. MY 2024 Validation Results for Time and Distance Standards (NAV)

Validation Results	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Indicators Identified	81	84	54	78	81	84	78	75	84
High Confidence (90.0% to 100%)	81	63	50	78	81	84	63	75	81
Moderate Confidence (51.0% to 89.9%)	0	21	0	0	0	0	15	0	0
Low Confidence (10.0% to 50.9%)	0	0	0	0	0	0	0	0	0
No Confidence (0.0% to 9.9%)	0	0	0	0	0	0	0	0	0
Could Not Be Validated	0	0	4	0	0	0	0	0	3

Telephone Surveys and Provider Directory Validations. Qlarant evaluated network adequacy against COMAR standards to ensure timely access to necessary care and in-network providers. MY 2025's sample included 2,060 PCPs to monitor available coverage for current HealthChoice enrollees. Successful contact yielded a response rate of 61.6%, which represents 1,268 PCPs. Qlarant surveyors verified:

- Accuracy of online directories, including telephone number and address;
- Provider acceptance of the MCO listed in the online directory;
- Provider practice acceptance of new Medicaid patients;
- First availability for routine care appointments; and
- First availability for urgent care appointments.

MDH established MY 2025's minimum compliance scores as 80% to ensure MCOs are complying with all state and federal regulations. MCOs not achieving the minimum compliance score are required to submit a CAP, which details proposed actions to correct any deficiencies identified during MY 2025 NAV activities. Required CAPs for the accuracy of online provider directories or compliance with routine and urgent care appointment timeframes addressed areas of noncompliance and were calculated by individual requirements. Six MCOs (ABH, JMS, KPMAS, PPMCO, UHC, and WPM) should improve compliance rates with successfully implemented CAPs. The following table identifies the number of quarterly and annual CAPs required by each MCO compared to the number of CAPs reviewed, with those successfully closed, and identifies any remaining CAP opportunities.

Table 7. MY 2025 Total CAP Summary per MCO (NAV)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Annual MY 2025 CAPs Required	0	0	1	0	0	0	2	1	0
Total Annual MY 2024 CAPs Closed	1*	1	0	1*	0	0	0	0	1*
MY 2024 to MY 2025 CAP Comparison	∅	↓	↑	∅	∅	∅	↑	↑	∅
Total Quarterly MY 2025 CAPs Required	1	0	0	2	0	0	0	0	1

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Quarterly MY 2024 CAPs Closed	0	0	0	0	0	0	0	0	0
Remaining Quarterly CAP Opportunities	↑	∅	∅	↑	∅	∅	∅	∅	↑

Green and ↓ = positive improvement (decrease in CAPs); Pink and ↑ = negative increase in CAPs; White and ∅ = no change in required CAPs.

*Indicates annual CAP progressed to a quarterly CAP.

Encounter Data Validation. EDV ensures the overall validity and reliability of encounter data. Qlarant conducts a medical record review on a sample of inpatient, outpatient, and office visit encounters to confirm the accuracy of codes. MDH established MY 2024's compliance threshold as 90% for each encounter type reviewed. Validation of encounter data provides MDH with a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs. UHC is the only MCO that was required to submit a CAP because of its MY 2024 compliance for inpatient encounters.

Table 8. MY 2024 MCO and HealthChoice Results by Encounter Type (EDV)

Encounter Type	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Inpatient	100%	100%	100%	100%	98%	99%	99%	88%	100%	98%
Outpatient	95%	98%	100%	100%	100%	99%	98%	99%	100%	99%
Office Visit	95%	93%	90%	97%	96%	94%	97%	95%	94%	95%

Note: Values reported are rounded to the nearest percentage for reporting only.

Red font denotes a CAP requirement for components scoring below the 90% minimum compliance score.

EPSDT Medical Record Reviews. The EPSDT program is a federally mandated Medicaid program that monitors physical and mental health conditions in children and adolescents through 20 years of age, as defined by the Omnibus Budget Reconciliation Act of 1989. Review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. For MY 2024, nurse reviewers conducted medical record reviews onsite at the provider offices or MCO headquarters, except for providers with five or fewer patients in the sample (singles).

Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs provided by Hilltop. For MY 2024, there was a total sample of 2,651 preventive care encounters across all MCOs.

MDH established the minimum compliance score for MY 2024 as 80% for the following components:

- Health and Developmental History (HX)
- Comprehensive Physical Examination (PE)
- Laboratory Tests/At-Risk Screenings (LAB)
- Immunizations (IMM)
- Health Education/Anticipatory Guidance (HED)

Qlarant evaluated CAPs by component instead of individual element. Results of the MY 2024 EPSDT medical record reviews indicate required CAPs along with a focused provider education project for two calendar years per MDH's Performance Monitoring Policy, for two MCOs (MPC and UHC) for the *Laboratory Tests/At-Risk Screenings* component, as demonstrated in the table below. CAPs are required to address noncompliance, which should improve compliance rates if successfully implemented.

Table 9. MY 2024 Total CAPs per MCO (EPSDT)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # of MY 2022 CAPs	0	0	0	0	0	0	1	0	0
Total # of MY 2023 CAPs	1	1	0	0	1	1	1*	1	1
Total # of MY 2024 CAPs	0	0	0	0	1*	0	0	1*	0
MY 2023 to MY 2024 CAP Comparison	↓	↓	∅	∅	↑	↓	↓	↑	↓

* Score fell below the minimum compliance score for multiple years and requires a CAP along with a focused provider education project per MDH's Performance Monitoring Policy.

Green and ↓ = positive improvement (decrease in CAPs); Pink and ↑ = negative increase in CAPs; White and ∅ = no change in required CAPs.

Consumer Report Card. Developing a CRC assists Medicaid enrollees in comparing and selecting an MCO from available health plans in the HealthChoice program. Information in the CRC includes performance measures from the HEDIS, the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] survey, and Maryland's encounter data measures. Annually, Qlarant develops the CRC to reflect the data reported from MCOs during the previous measurement year. The 2025 CRC results and star rating comparison from the 2024 CRC follow, based on HEDIS MY 2022 and 2023 data available in 2024.

Table 10. 2025 Results (CRC)

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Care	★	★	★★★	★	★★★	★★★	★★★	★★★	★★★
Doctor Communication and Service	★★	★★	★★	★★	★★	★★	★★	★★	★★
Keeping Kids Healthy	★	★	★★★	★★★	★	★	★★	★★★	★★★
Care for Kids with Chronic Illness	★	★★	NA	★★	★★★	★★	★★★	★	★★
Pregnancy and Infant Care	★	★★	★★	★★★	★★	★	★★	★	★★
Keeping Adults Healthy	★	★★	★★★	★★★	★★	★	★	★★	★

★★★ Above HealthChoice Average; ★★ HealthChoice Average; ★ Below HealthChoice Average; NA = Not Applicable

Table 11. Star Rating Changes from 2024 to 2025 (CRC)

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Care	∅	↓	∅	∅	∅	↑	∅	↑	↑
Doctor Communication and Service	↑	∅	↓	↑	↓	↑	↓	∅	∅
Keeping Kids Healthy	∅	∅	∅	∅	∅	∅	∅	↑	∅

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Care for Kids with Chronic Illness	↑ ^N	∅	NA	↑ ^N	∅	∅	↓	∅	∅
Pregnancy and Infant Care	∅	∅	↓	∅	∅	↓	∅	∅	∅
Keeping Adults Healthy	∅	∅	∅	∅	∅	∅	∅	∅	∅

Green and ↑ = improvement from MY 2022; Pink and ↓ = decline from MY 2022; White and ∅ = no change from MY 2022; Gray and NA = reported as Not Applicable for both 2024 and 2025

^N MCO evaluated in 2025 CRC, but not in the 2024 CRC.

Grievances, Appeals, and Denials Focused Study. Qlarant assessed MCO compliance with federal and state regulations governing requirements and timeliness of notices for enrollee and provider grievances, enrollee appeals, pre-service authorization requests, and adverse determinations to ensure HealthChoice enrollees are not denied access to medically necessary services and supports. MY 2024 GAD review conclusions were drawn from MCO-reported compliance data and from GAD record review findings. MCOs submitted GAD reports quarterly for the first three quarters of MY 2024, while the fourth quarter covered an annual submission. Annual record reviews involved evaluating MCO compliance with GAD processing requirements, timeliness of notifications to enrollees, letter content requirements, and ease of understanding communications/letters to enrollees. The table below compares the number of opportunities for improvement identified across the MCOs.

Table 12. Comparison of GAD Opportunities for Improvement from MY 2022 to MY 2024 (GAD)

Improvement Opportunities Comparison	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # of Opportunities MY 2022	2	11	0	7	2	0	4	1	8
Total # of Opportunities MY 2023	1	2	2	1	3	1	5	6	3
Total # of Opportunities MY 2024	0	1	1	3	1	2	5	8	2
MY 2022 to MY 2024 Comparison	-2	-10	+1	-4	-1	+2	+1	+7	-6
MY 2023 to MY 2024 Comparison	-1	-1	-1	+2	-2	+1	0	+2	-1

Healthcare Effectiveness Data and Information Set

MetaStar's Scope

MDH contracted with MetaStar, a National Committee for Quality Assurance (NCQA)-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice MCOs and to summarize the results. For HEDIS MY 2024, MDH required HealthChoice MCOs to report the complete HEDIS measure set for services rendered in calendar year 2024 to HealthChoice enrollees. These measures provide meaningful MCO comparative information, and they evaluate performance relative to MDH's priorities and goals.

Additional Information

For additional findings and comprehensive details associated with the MY 2024 HEDIS audits, please access the link to MetaStar's *Statewide Analysis Report for HealthChoice Participating Organizations' HEDIS MY 2024 Results* in [Appendix E](#). [Appendix A](#) includes informed conclusions from the HEDIS audits related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Consumer Assessment of Healthcare Providers and Systems

The Center for Study of Services' Scope

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® 5.1H Member Experience Surveys. The purpose of the survey is to assess enrollees' experience with their health plan and healthcare. The overall goal of the survey is to provide actionable performance feedback to help each health plan improve the enrollee experience.

The CSS administered the Adult and Child Medicaid versions of the CAHPS Health Plan Survey for the population of children with chronic conditions on behalf of the HealthChoice MCOs and MDH between February 6 and May 12, 2025, and submitted survey results to NCQA on May 23, 2025.

Additional Information

For additional findings and comprehensive details associated with the 2025 Adult and Child CAHPS results, please access the link to The Center for Study of Services' *State of Maryland Analysis Report for HealthChoice Managed Care Organizations Adult and Child Populations 2025 CAHPS® 5.1H Member Experience Survey* in [Appendix E](#). [Appendix A](#) includes informed conclusions from the CAHPS surveys related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

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. Assessments incorporated national standards to prioritize a health equity focus and address health outcomes for HealthChoice enrollees. Review activities for MYs 2023, 2024, and 2025 provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Maryland Medicaid managed care enrollees.

2025 Annual Technical Report

Measurement Years 2023, 2024, and 2025

Introduction

Background

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible enrollees by contracted managed care organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. Operational since June 1997 under the authority of an 1115 waiver of the Social Security Act, HealthChoice's guiding principle is to provide quality healthcare that is equitable, 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 the MCOs comply with initiatives established in the Code of Federal Regulations (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 (EQR) and Centers for Medicare & 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.

Quality characteristics of each MCO evaluated are included in the profiles below; no MCO was exempt from the EQR for the measurement years (MYs) 2023, 2024, and 2025 included in this Annual Technical Report (ATR) for the HealthChoice program. MDH requires MCOs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation. Each of the nine MCOs included in the HealthChoice Program are identified below:

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield Community Health Plan (CFCHP)
- 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)
- United Healthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

Table 13. MY 2024 MCO Profiles

Profiles	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Plan Type	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Populations Served	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
Managed Care Authority	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]
Contracted Since	2019	2013	1997	2014	1997	1997	1997	1997	1999
Enrollment	58,702	82,516	27,105	92,724	208,738	87,375	307,813	145,885	278,042
NCQA Accreditation Status	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Suspended	Accredited	Accredited

Source: [HealthChoice Quality Strategy 2022-2024](#)

MDH strives to ensure the delivery of high-quality, accessible care for managed care program enrollees. The HealthChoice Quality Strategy identifies five broad managed care program goals.

- Improve access to health care for the Medicaid population
- Improve the quality of health services delivered
- Provide patient-focused, comprehensive, and coordinated care through the medical home
- Emphasize health promotion and disease prevention
- Expand coverage through resources generated through managed care efficiencies

To achieve these overarching goals, MDH has identified three specific goals and measurable objectives in the table below.

Table 14. HealthChoice Program Goals and Objectives

Goal	Objective
Improve HealthChoice aggregate performance on Medicaid Healthcare Effectiveness Data and Information Set (HEDIS) [®] measures by reaching or exceeding the pre-pandemic HealthChoice aggregate by MY 2024.	1. Increase the number of HEDIS measures that meet or exceed the HealthChoice aggregate achieved in MY 2018 or MY 2019, whichever is highest, by MY 2024. 2. Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Means by MY 2024.
Improve overall health outcomes for HealthChoice enrollees through expanding the network of available provider types, creating targeted quality and operational initiatives to enhance enrollee access to care, and promoting health service delivery innovation.	1. Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures by three percentage points no later than MY 2024. 2. Improve the HealthChoice aggregate for measures tracking chronic health outcomes by MY 2024.
Ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities.	1. Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review (SPR) standards by MY 2024. 2. Increase the HealthChoice aggregate scores to at least 80% for all Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Medical Record Review (MRR) components by MY 2024. 3. Increase the HealthChoice aggregate scores to at least 85% for all network adequacy validation (NAV) activities by MY 2024. 4. Increase the HealthChoice aggregate scores to at least 90% for encounter data validation (EDV) by MY 2024. 5. Increase the HealthChoice aggregate to minimum compliance for each element of review for grievances, appeals, and pre-service determinations (GAD) by MY 2024.

The [“State Recommendations”](#) section in this report includes recommendations on how MDH can address quality strategy goals.

Purpose

Federal regulations require states contracting with MCOs to conduct annual, independent reviews of the managed care program. To meet these requirements, MDH 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 (required by CMS) and optional (chosen by individual states) activities following CMS-developed EQR protocols. Qlarant completed the following EQR activities in MYs 2023, 2024, and 2025 to evaluate MCO performance for MY 2024:

- Performance Improvement Project (PIPs) Validation
- Performance Measure Validation (PMV)
- SPR
- NAV

Qlarant conducted optional activities that include:

- EDV
- EPSDT MRRs
- Development and production of an annual Consumer Report Card (CRC)
- Quarterly focused reviews of MCO 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 how conclusions were drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. This ATR serves as Qlarant's report to MDH on the assessment of MY 2024 MCO performance, describes EQR methodologies for completing activities, provides compliance results, and analyzes performance. Additionally, included is an overview of the quality, access, and timeliness of health care services provided to Maryland's HealthChoice enrollees and recommendations for improvement, which may positively impact enrollee outcomes, if implemented.

Performance Improvement Project Validation

Objective

PIPs are designed to achieve and sustain improvement in clinical outcomes, administrative processes, or enrollee satisfaction. PIPs use a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying root causes, barriers, and implementing targeted interventions. Projects must be designed, conducted, and reported in a methodologically sound manner. PIP review and validation assesses the level of improvement across MCOs and provides MDH and other stakeholders with confidence in project results. Qlarant additionally assesses whether MCOs meet state-specific requirements for incorporating national standards for Culturally and Linguistically Appropriate Services (CLAS) to prioritize health equity for HealthChoice enrollees.

Methodology

PIP Topics

HealthChoice MCOs conduct two PIPs annually. To align with statewide public health and the specific Medicaid innovation initiatives in Maryland's Statewide Integrated Health Improvement Strategy (SIHIS), MCOs completed perinatal PIPs related to the Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP) topics to reduce severe morbidity and address preventive care services in early childhood. HEDIS performance measures were followed for each PIP.

MDH provided a list of strategies for the MCOs to choose from for each PIP topic. MCOs selected PIP strategies most appropriate for their enrollee populations and available resources, which were required to include a health equity focus to address health outcomes among the most disparate populations by conducting disparity analyses, including enrollee feedback, and examining resources.

Table 15. MY 2024 MDH-Selected Topics (PIP)

MY 2024 PIPs	Prenatal Care PIP	Postpartum Care-Related PIP
Topic	Timeliness of Prenatal Care and Identification of High-Risk Pregnancies	Maternal Health and Infant/Toddler Care During the Postpartum Period
Performance Measure(s)	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	- Prenatal and Postpartum Care: Postpartum Care (PPC-AD) - Well-Child Visits in the First 30 Months of Life (W30: 0-15 Months and W30: 15-30 Months) - Childhood Immunization Status: Combo 3 (CIS-3)
Aim	Will the implementation of targeted interventions focused on enrollees, providers, and the MCOs improve and sustain annual HEDIS performance rates in the area of Timeliness of Prenatal Care?	Will the implementation of targeted interventions focused on enrollees, providers, and the MCOs improve and sustain annual HEDIS performance rates in the area of Postpartum Care; Well-Child Visits in the First 30 Months of Life; and/or Childhood Immunization Status?
State-Specific Strategies	The prenatal care PIP topic consists of one mandatory strategy: <i>Improve completion and use of the Maryland Prenatal Risk Assessment (MPRA)</i> . MCOs were required to select two additional PIP strategies most appropriate to their enrollee populations and available resources.	The postpartum care-related PIP topic focused on two strategies selected by the MCO. MCOs were required to select PIP strategies most appropriate for their enrollee populations and available resources.

Introduction

Qlarant uses the [CMS EQR Protocol 1 – Validation of Performance Improvement Projects](#) as a guideline in PIP review activities and to verify that the MCOs used sound methodology in designing, implementing, analyzing, and reporting PIP activities. This section describes the MY 2024 validation processes used, including the use of the rapid cycle PIP process.

Description of Data Obtained. During remeasurement year 2024, MCOs focused on addressing root causes and barriers to successful implementation, modifying interventions, and studying outcomes.

Technical Methods of Data Collection and Analysis. Using the nine steps of the CMS EQR Protocol 1 as a guideline, MCOs submitted PIP progress and updates on a quarterly basis for Qlarant and MDH to provide real-time feedback and guidance following the rapid cycle and Plan, Do, Study, Act Model of Quality Improvement (PDSA) processes.

Timeline. Qlarant conducted PIP activities from January 2025 to March 2026 for MY 2024 PIP data.

PIP Validation

Qlarant reviews each PIP to assess each MCO's PIP methodology and to perform an annual validation of PIP results. Qlarant's approach to the nine PIP review steps is outlined below.

1. **Review the selected PIP topic.** MDH selected the PIP topic.
2. **Review the PIP aim statement.** MDH provided the aim statement to align with statewide public health and Medicaid innovation initiatives. Strategies and process metrics were additionally provided to the MCOs.
3. **Review the identified PIP population, selected PIP variables, and performance measures.** Qlarant executed this step according to CMS EQR Protocol 1 and cross-walked our approach in this step:
 - a. **Population:** Qlarant determined whether the MCO identified the PIP population in congruence with the aim statement.
 - b. **PIP Variables:** Qlarant assessed whether the selected PIP variables were appropriate for measuring and tracking improvement.
 - c. **Performance Measures:** Qlarant assessed whether performance measures were objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on enrollee outcomes.
4. **Review the sampling method.** This step is required only when the MCO studies a sample of the entire population. Qlarant assessed the appropriateness of the MCO's sampling technique.
5. **Review the data collection procedures.** Qlarant evaluated the validity and reliability of MCO procedures used to collect the data displaying PIP measurements. Qlarant executed this step according to the CMS EQR Protocol 1.

6. **Review the data analysis and interpretation of PIP results.** Qlarant assessed the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used and if each MCO's analysis and interpretation were accurate. A comprehensive quantitative and qualitative analysis is required for each project indicator. The quantitative analysis compares current performance to baseline, assessed previous measurements, and evaluated performance against goals/benchmarks. The qualitative analysis provides an assessment of interventions and evaluates the project's level of success and identifies root causes and barriers. Each intervention utilizes the continuous quality improvement process using the PDSA cycle to determine whether the intervention is achieving the desired outcome. This analysis reflects the study findings and includes a description of the rationale for continuing, discontinuing, or altering the planned activity.
7. **Assess the improvement interventions.** Qlarant assessed the appropriateness of interventions for achieving improvement. Each intervention is assessed to ensure that barriers are addressed. Interventions must be multifaceted and produce impactful and sustainable change. Effective interventions use specific, measurable, achievable, relevant, and time-oriented (SMART) objectives designed for the priority population. Interventions also use upstream approaches, such as policy reforms, workflow changes, and resource investments.
8. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluated improvement by validating statistical significance testing results and evaluating improvement compared to baseline performance. Improvement should also connect to interventions and desired outcomes, as opposed to an unrelated occurrence or solely a participation tally. This assessment is correlated to Step 8 (Improvement Strategies). If interventions are assessed as reasonable and expected to improve outcomes, then the improvement is correlated with the project's interventions. Sustained improvement is assessed after the second remeasurement has been reported. Results are compared to baseline to confirm consistent and sustained improvement. It should be noted that MCOs are only scored on the improvement of the HEDIS measure rates that align with the MCO's selected strategies.
9. **Assess state-specific strategies.** MDH and Qlarant added this step to evaluate evidence provided by the MCOs to determine if interventions were modified to improve the effectiveness of each MCO's strategies, based on process metric feedback. Improvement strategies must identify and prioritize enrollees specific to the selected strategies.

Rapid Cycle Process

All PIPs use the Rapid Cycle PIP process to provide MCOs with a quality improvement method that identifies, implements, and measures changes over quarterly periods. This PIP process is continuous and aligns with the CMS EQR Protocol 1 to allow the MCOs an opportunity to monitor their improvement efforts over shorter time periods. Frequent monitoring allows for quick modifications when needed. The goal is for the MCOs to improve performance efficiently and sustain improvement, resulting in a long-term, positive impact on enrollee health outcomes.

Qlarant assists the MCOs in the Rapid Cycle PIP process by providing quarterly reporting templates and quarterly PIP assessments, making recommendations, providing quarterly technical assistance as requested by MCOs, and breaking down the process into manageable steps based on the PIP development and implementation requirements:

1. Develop an appropriate project rationale based on supporting MCO data.
2. Identify performance measures that address the project rationale and reflect the study question/aim statement. Qlarant's team ensures MCOs have the appropriate performance measures and data collection methodologies to facilitate accurate and valid performance measure reporting.
3. Identify enrollee, provider, and MCO barriers and conduct a root cause analysis.
4. Develop improvement processes and interventions that include key stakeholders and address the identified root cause. The interventions should support and apply the selected strategies in a strategic, systemic, and sustainable way.
5. Measure, assess, and analyze the impact of the interventions. MCOs must measure performance frequently, such as on a monthly or quarterly basis. It is critical to study intervention outcomes to determine which interventions may be effective and which interventions may need to be modified, replaced, or eliminated using performance measure results. The MCO should be able to assess how the intervention impacts the study indicator(s).

PIP Scoring

For each PIP, Qlarant generates the following validation ratings:

- **Methodology Validation Rating.** The methodology validation rating refers to Qlarant's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. Elements assessed in PIP steps 1 to 7 are used to calculate the methodology validation score.
- **Significant and Sustained Improvement Validation Rating.** The significant and sustained improvement validation rating refers to Qlarant's overall confidence that the PIP produced evidence of significant improvement, based on performance measure results. Elements assessed in step 8 are used to calculate the significant improvement validation score.
- **Overall Validation Rating.** The overall validation rating refers to Qlarant's overall confidence in the MCO's PIP process and results. All elements in steps 1 to 9 are used to calculate the overall validation score.

Qlarant rates each step as *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, or *Not Applicable (NA)*, which results in an assigned score. A final assessment is made for all nine steps, with numeric scores provided for each component and step of the validation process. Each assessed component could result in varying total points due to the determination of components as NA for individual MCOs. Descriptions for each determination and the associated score include:

- **Met.** All required components are present (100%).
- **Partially Met.** At least one, but not all, components are present (total percentage varies).
- **Unmet.** None of the required components are present (0%).
- **Not Applicable.** None of the required components are applicable (NA).

Qlarant PIP reviewers evaluate the results of each step in the review process by answering a series of applicable questions, consistent with CMS EQR Protocol 1 requirements. Reviewers sought additional information and/or corrections from MCOs, when needed, during quarterly evaluations in preparation for the annual review.

The overall validation score is the sum of all the step scores used to evaluate whether the PIP is designed, conducted, and reported in a sound manner, and determines the degree of confidence MDH can have in the reported results. Qlarant evaluates confidence levels based on the PIP validation scores. Validation ratings for both an overall confidence of adherence to methodology and an overall confidence of significant and sustained improvement include:

- **High confidence (High)** in MCO compliance: 90% to 100%
- **Moderate confidence (Moderate)** in MCO compliance: 75% to 89%
- **Low confidence (Low)** in MCO compliance: 60% to 74%
- **No confidence (Not Credible)** in MCO compliance: 59% or lower

Qlarant utilizes a diamond rating system to compare each MCO's PIP performance to NCQA benchmarks.

- Four diamonds (◆◆◆◆) indicate the MCO rate meets or exceeds the NCQA Quality Compass ninetieth percentile.
- Three diamonds (◆◆◆) indicate the MCO rate meets or exceeds the NCQA Quality Compass seventy-fifth percentile but is below the ninetieth percentile.
- Two diamonds (◆◆) indicate the MCO rate meets or exceeds the NCQA Quality Compass fiftieth percentile but is below the seventy-fifth percentile.
- One diamond (◆) indicates the MCO rate is below the NCQA Quality Compass fiftieth percentile.

Results

Validation results and findings for MY 2024's performance are captured in the results section for each PIP topic. Each MCO's PIPs were reviewed against all applicable components contained within the nine steps. MCOs received recommendations for each step that did not achieve a *Met* rating. Aggregate and individual recommendations applicable to MCOs follow the results in this report. NCQA recommends considering HEDIS trending between MY 2023 and previous MYs with caution due to clarifications for continuous enrollment requirements for the PPC-CH numerator provided in the [HEDIS MY 2023 Trending Memo](#).

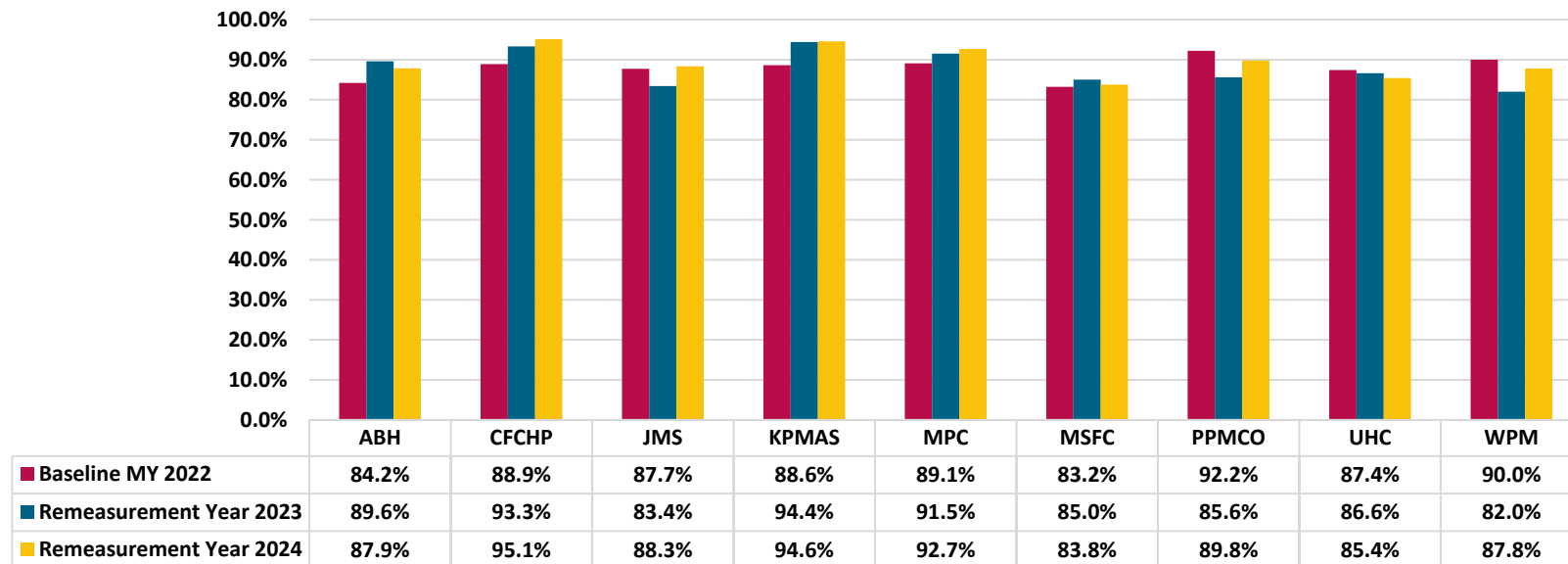
Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP)

Purpose. Prenatal Care PIPs focused on the overarching goal of increasing the percentage of pregnant enrollees engaging with timely prenatal care visits during MY 2024, according to the HEDIS PPC-CH measure specifications. The HEDIS PPC-CH measure assesses the access to prenatal care by the percentage of deliveries in which enrollees had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

Prenatal Care PIP Indicators Results. This section represents data collection results from MY 2024 as the second remeasurement year for the Prenatal Care PIP. Below, figure(s) represent indicator rates for all MCOs, and table(s) compare indicator rates to the HEDIS 2024 NCQA Quality Compass Medicaid benchmarks.

The MCOs' prenatal care rates for MY 2024 ranged from 83.8% (MSFC) to 95.1% (CFCHP). ABH, CFCHP, JMS, KPMAS, MPC, and MSFC's MY 2024 rates increased in comparison to the baseline MY 2022, with the greatest increase of 6.2 percentage points being for CFCHP. PPMCO, UHC, and WPM's MY 2024 rates decreased in comparison to the baseline rates in MY 2022, with the greatest decrease of 2.4 percentage points being for PPMCO.

Figure 1. MY 2024 Indicator Rates (Prenatal Care PIP)



The HealthChoice Aggregate for each PIP cycle is: Baseline MY 2022: 87.9%, Remeasurement Year 2023: 87.9%, and Remeasurement Year 2024: 89.5%.

PIP Validation Step Results. This section represents data collection results for MY 2024 as the second remeasurement year for the Prenatal Care PIP. MCOs' total points available for scoring varies due to the determination of components as *NA* for individual MCOs. All MCOs were given a rating of *NA* for Step 2 (Aim Statement), since MDH provided the aim statement. 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 measure findings for the selected indicators. The following table identifies the validation rating and the corresponding level of confidence that Qlarant has assigned for each MCO's PIPs for MY 2024.

Overall PIP Validation Rating. Eight of the nine MCOs' performances resulted in a confidence level of *High Confidence* for the Overall PIP Validation Rating, ranging from 91.0% (UHC) to 100% (MPC). The remaining MCO's performance, WPM's (88.4%), resulted in a confidence level of *Moderate Confidence*.

Methodology Validation Rating. Eight of the nine MCOs' performances resulted in a confidence level of *High Confidence* for the Methodology Validation Rating, ranging from 96.4% (KPMAS) to 100% (ABH, CFCHP, JMS, MPC, MSFC, PPMCO, and UHC). WPM's (88.9%) performance resulted in a confidence level of *Moderate Confidence*.

Significant and Sustained Improvement Validation Rating. MPC (100%) was the only MCO with performance that resulted in a confidence level of *High Confidence* for the Significant and Sustained Improvement Validation Rating. Three of the nine MCOs' performances resulted in a confidence level of *Moderate Confidence* at 80.0% (CFCHP, KPMAS, and WPM). ABH (60.0%) was the only MCO with performance that resulted in a confidence level of *Low Confidence*. Four of the nine MCOs had performance scores resulting in a confidence level of *No Confidence*: JMS (40.0%), MSFC (20.0%), PPMCO (40.0%), and UHC (20.0%).

Table 16. MY 2024 Remeasurement Validation Rating and Confidence Levels (Prenatal Care PIP)

Step/Description	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	M	M	M	M	M	M
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	M	M	M	M	M	PM	M	M	M
Step 4. Sampling Method	NA	M	NA	M	M	M	NA	NA	M
Step 5. Data Collection Procedures	M	M	M	M	M	M	M	M	M
Step 6. Data Analysis and Interpretation of Results	M	M	M	PM	M	M	M	M	M
Step 7. Improvement Strategies (Interventions)	M	M	M	M	M	M	M	PM	PM
Step 8. Significant and Sustained Improvement	PM	PM	PM	PM	M	PM	PM	PM	PM
Step 9. State-Specific Strategies	M	M	M	M	M	M	M	M	M
Methodology Validation Rating	100%	100%	100%	96.4%	100%	100%	100%	100%	88.9%
Significant and Sustained Improvement	60.0%	80.0%	40.0%	80.0%	100%	20.0%	40.0%	20.0%	80.0%
Overall PIP Validation Rating	95.7%	98.0%	93.6%	94.9%	100%	91.8%	93.5%	91.0%	88.4%

Validation rating percentages rounded to the nearest tenth for reporting purposes.

Green = *High Confidence*, **Yellow** = *Moderate Confidence*, **Gold** = *Low Confidence*, **Pink** = *No Confidence* M = *Met*, PM = *Partially Met*, NA = *Not Applicable*

Indicator Rate Performance – HealthChoice Performance. Below, figure(s) represent trended indicator rates, and table(s) compare indicator rates to the 2024 NCQA Quality Compass Medicaid HEDIS benchmarks. The MCOs’ prenatal care rates for MY 2024 ranged from 83.8% (MSFC) to 95.1% (CFCHP). ABH’s, CFCHP’s, JMS’s, KPMAS’s, MPC’s, and MSFC’s performance rate increased in comparison to MY 2022’s baseline performance rate. PPMCO’s, UHC’s, and WPM’s performance rate decreased in comparison to MY 2022’s baseline performance rate.

Indicator Rate Performance Compared to National Benchmarks. MCOs’ performance rates for prenatal care varied in comparison to the MY 2024 national benchmarks. CFCHP (95.1%), KPMAS (94.6%), and MPC’s (92.7%) performance met or exceeded the ninetieth percentile. PPMCO (89.8%) met or exceeded the seventy-fifth percentile. ABH (87.9%), JMS (88.3%), and WPM (87.8%) met or exceeded the fiftieth percentile. MSFC (83.8%) and UHC (85.4%) fell below the fiftieth percentile.

Table 17. MY 2024 Remeasurement Performance Comparison to NCQA's Quality Compass (Prenatal Care PIP)

MY 2024 HealthChoice Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Measure Rate	87.9%	95.1%	88.3%	94.6%	92.7%	83.8%	89.8%	85.4%	87.8%
Qlarant Diamond Rating	◆◆	◆◆◆◆	◆◆	◆◆◆◆	◆◆◆◆	◆	◆◆◆	◆	◆◆

Measure rate percentages rounded to the nearest tenth for reporting purposes.

◆◆◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass ninetieth percentile. ◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass seventy-fifth percentile but is below the ninetieth percentile. ◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass fiftieth percentile but is below the seventy-fifth percentile. ◆ indicate the MCO rate is below the NCQA Quality Compass fiftieth percentile.

Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP)

Purpose. Postpartum Care-Related PIPs focused on the improvement of specific postpartum care-related HEDIS measure rates that correlated with the individual MCO’s selected strategies. The MCOs’ selected strategies and correlating HEDIS measures are indicated in the table below.

Table 18. MY 2024 MCO-Selected Strategies and Correlating HEDIS Measures (Postpartum Care-Related PIP)

HEDIS Measure/Selected Strategy	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
PPC-AD: Increase engagement throughout the 12-month coverage period	Yes	Yes	No	No	No	No	No	Yes	No
PPC-AD: Clinic-community linkages on behavioral health referrals and parenting supports	No	No	No	No	No	No	No	No	Yes
PPC-AD: Implement an electronic postpartum depression screening tool	No	No	No	Yes	No	No	Yes	No	No
W30: Promote WCV through engagement with doulas/home visiting services (HVS)	Yes	No	Yes	No	Yes	No	No	No	Yes
W30: Value-added benefits for well child care	No	No	No	Yes	No	Yes	No	No	No

HEDIS Measure/Selected Strategy	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
CIS-3: Improve immunization rates	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No

Yes and blue = MCO selected strategy; No and gray = MCO did not select strategy

PIP Validation Step Results. This section represents data collection results for MY 2024 as the second remeasurement year for the Postpartum Care-Related PIP. MCOs' total points available for scoring vary due to the determination of components as NA for individual MCOs. All MCOs were given a rating of NA for Step 2 (Aim Statement), since MDH provided the aim statement. An assessment of the validity and reliability of the PIP study design reflects a detailed review of each MCO's PIPs and audited HEDIS measure findings for the selected indicators. The following table identifies the validation rating and the corresponding level of confidence Qlarant has assigned to each MCO's PIPs for MY 2024.

Methodology Validation Rating. Eight of the nine MCOs' performances resulted in a confidence level of *High Confidence*, ranging from 91.8% (CFCHP) to 100% (ABH, JMS, MPC, MSFC, and PPMCO). UHC's performance resulted in a confidence level of *Moderate Confidence* at 84.8%.

Significant and Sustained Improvement Validation Rating. Five of the nine MCOs' performances resulted in a confidence level of *High Confidence*, ranging at 100% (ABH, MPC, MSFC, PPMCO, and WPM). Two MCOs' performances resulted in a confidence level of *Moderate Confidence* at 80.0% (CFCHP and KPMAS). JMS and UHC's performance resulted in a confidence level of *Low Confidence* at 60.0%.

Overall Validation Rating. Eight of the nine MCOs' performances resulted in a confidence level of *High Confidence*, ranging from 90.9% (CFCHP) to 100% (ABH, MPC, MSFC, and PPMCO). UHC's performance resulted in a confidence level of *Moderate Confidence* at 82.8%.

Table 19. MY 2024 Validation Rating and Confidence Levels (Postpartum Care-Related PIP)

Step/Description	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	M	M	M	M	M	M
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	M	M	M	M	M	M	M	M	M
Step 4. Sampling Method	NA	M	NA	M	M	M	NA	NA	M
Step 5. Data Collection Procedures	M	M	M	M	M	M	M	M	M
Step 6. Data Analysis and Interpretation of Results	M	PM	M	PM	M	M	M	PM	M
Step 7. Improvement Strategies (Interventions)	M	PM	M	M	M	M	M	PM	PM
Step 8. Significant and Sustained Improvement	M	PM	PM	PM	M	M	M	PM	M
Step 9. State-Specific Strategies	M	M	M	M	M	M	M	M	M
Methodology Validation Rating	100%	91.8%	100%	96.5%	100%	100%	100%	84.8%	94.0%
Significant and Sustained Improvement Validation Rating	100%	80.0%	60.0%	80.0%	100%	100%	100%	60.0%	100%
Overall Validation Rating	100%	90.9%	95.7%	95.0%	100%	100%	100%	82.8%	94.9%

Validation rating percentages rounded to the nearest tenth for reporting purposes.

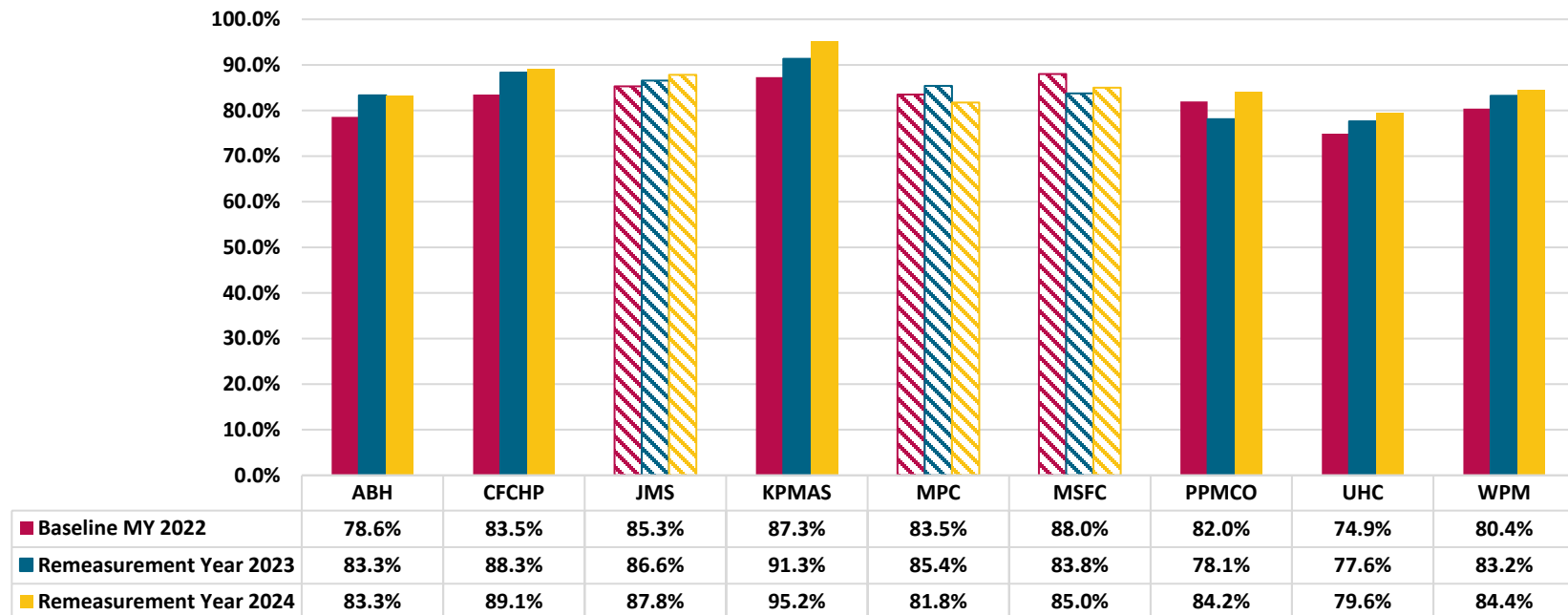
Green= High Confidence, Yellow= Moderate Confidence, Gold= Low Confidence, Pink= No Confidence. M= Met, PM= Partially Met, NA= Not Applicable.

Indicator Rate Performance – HealthChoice Performance. This section represents data collection results for MY 2024 as the second remeasurement year for the Postpartum Care-Related PIP. Below, figures represent indicator rates for all MCOs, and the tables compare indicator rates to the 2024 NCQA Quality Compass Medicaid HEDIS benchmarks.

Postpartum Care. The MY 2024 rates for MCOs who selected strategies for PPC-AD ranged from 79.6% (UHC) to 95.2% (KPMAS). All MCOs increased performance rates from the baseline MY 2022 to MY 2024, with the most significant increase of 7.9 percentage points for KPMAS (87.3% to 95.2%).

The MY 2024 rates for MCOs who did not select strategies for PPC-AD were 87.8% (JMS), 81.8% (MPC), and 85.0% (MSFC). JMS increased its performance rate from baseline MY 2022 to MY 2024 by 2.5 percentage points. MPC and MSFC decreased their performance rates from baseline MY 2022 to MY 2024 by 1.7 and 3 percentage points, respectively.

Figure 2. MY 2024 PPC-AD Indicator Rates (Postpartum Care-Related PIP)

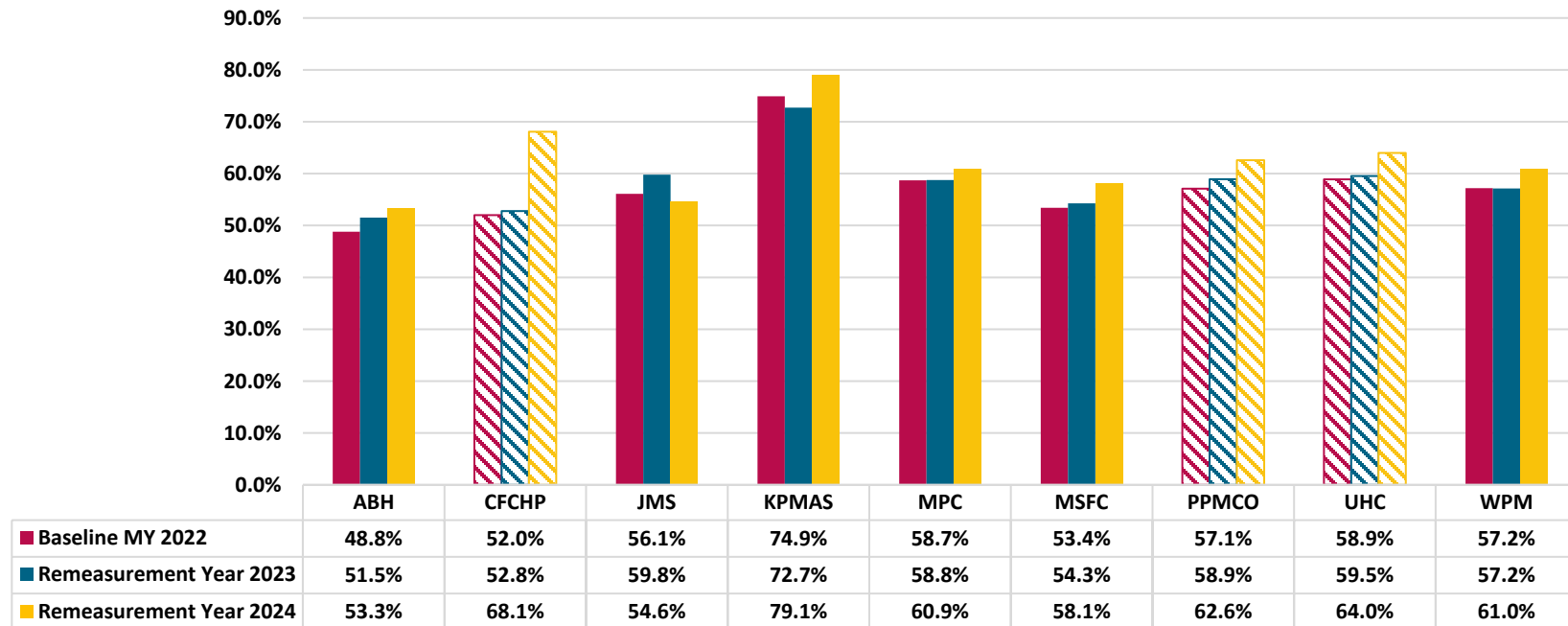


Solid bars represent MCOs that selected a PPC-AD HEDIS rate strategy. Striped bars represent MCOs that did not select a PPC-AD HEDIS rate strategy.

Well-Child Visits (0-15 Months). The MY 2024 rates for MCOs who selected strategies for W30 (0-15 Months) ranged from 53.3% (ABH) to 79.1% (KPMAS). All MCOs except JMS increased performance rates from the baseline MY 2022 to MY 2024. JMS' performance rate decreased by 1.5 percentage points from baseline MY 2022 (56.1%) to MY 2024 (54.6%).

The MY 2024 rates for MCOs who did not select strategies for W30 (0-15 Months) were 68.1% (CFCHP), 62.6% (PPMCO), and 64.0% (UHC). All three MCOs increased their performance rate from baseline MY 2022 to MY 2024 by 16.1, 5.5, and 5.1 percentage points, respectively.

Figure 3. MY 2024 W30: 0-15 Months Indicator Rates (Postpartum Care-Related PIP)

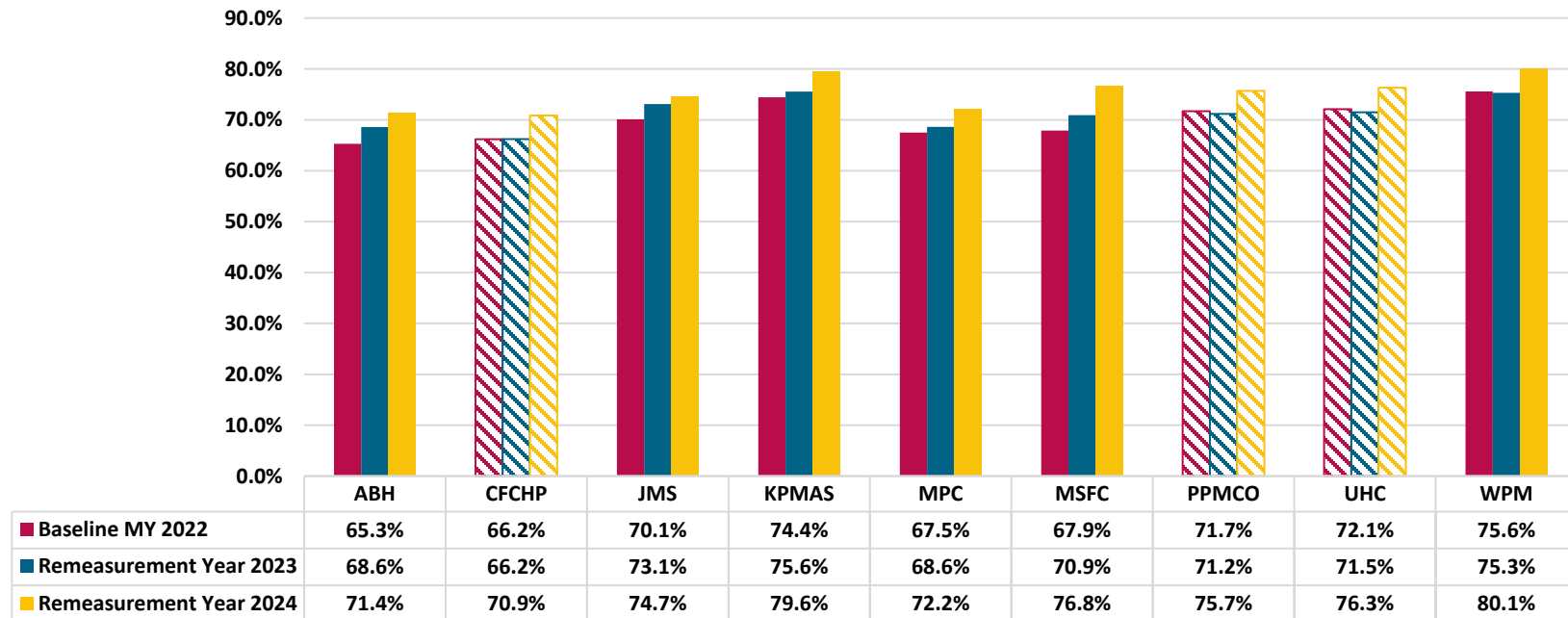


Solid bars represent MCOs that selected a W30 HEDIS rate strategy. Striped bars represent MCOs that did not select a W30 HEDIS rate strategy.

Well-Child Visits (15-30 Months). The MY 2024 rates for MCOs who selected strategies for W30 (15-30 Months) ranged from 71.4% (ABH) to 80.1% (WPM). All MCOs' performance rates increased from the baseline MY 2022 to MY 2024, with the most significant increase of 8.9 percentage points for MSFC (67.9% to 76.8%).

The MY 2024 rates for MCOs who did not select strategies for W30 (15-30 Months) were 70.9% (CFCHP), 75.7% (PPMCO), and 76.3% (UHC). All three MCOs increased their performance rate from baseline MY 2022 to MY 2024 by 4.7, 4, and 4.2 percentage points, respectively.

Figure 4. MY 2024 W30: 15-30 Months Indicator Rates (Postpartum Care-Related PIP)

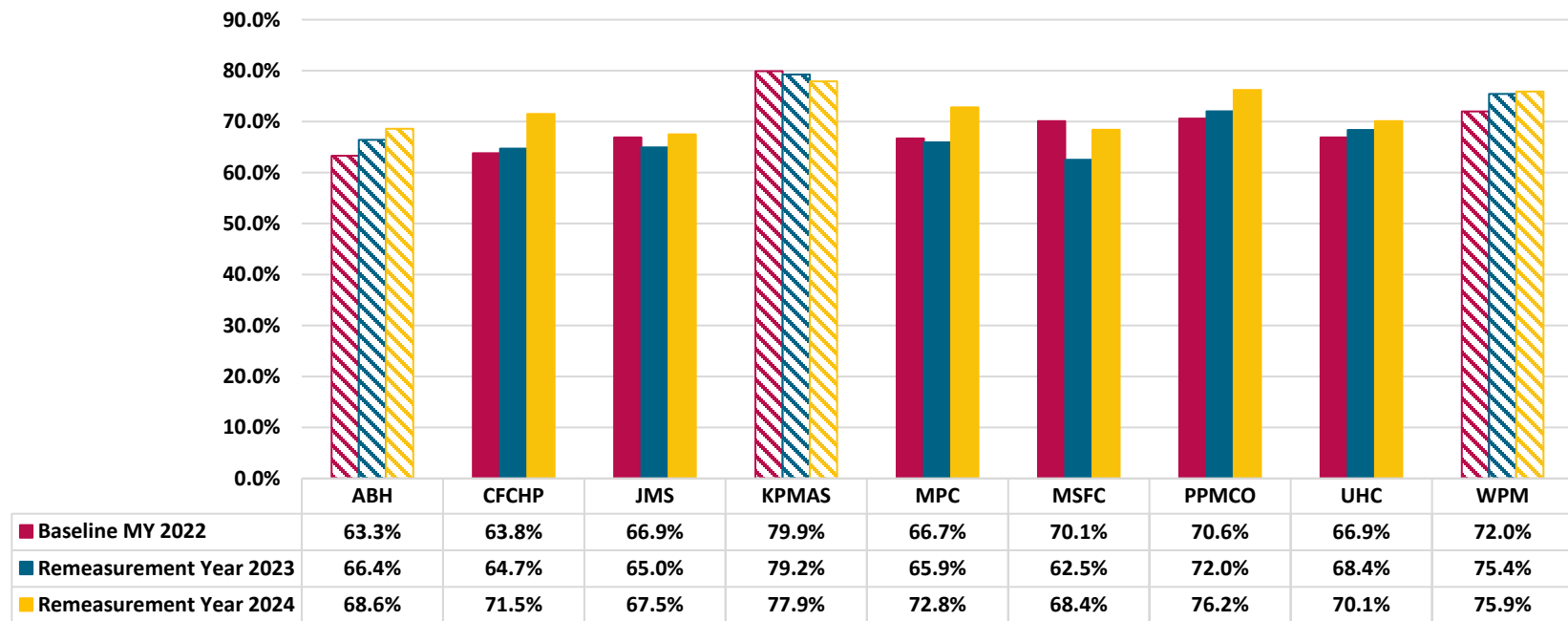


Solid bars represent MCOs that selected a W30 HEDIS rate strategy. Striped bars represent MCOs that did not select a W30 HEDIS rate strategy.

Childhood Immunization Status. The MY 2024 rates for MCOs who selected strategies for CIS-3 ranged from 67.5% (JMS) to 76.2% (PPMCO). All MCOs except for MSFC increased performance rates from the baseline MY 2022 to MY 2024, with the most significant increase of 7.7 percentage points for CFCHP (63.8% to 71.5%). MSFC's performance rate decreased by 1.7 percentage points from the baseline MY 2022 to MY 2024.

The MY 2024 rates for MCOs who did not select strategies for CIS-3 were 68.6% (ABH), 77.9% (KPMAS), and 75.9% (WPM). ABH and WPM increased their performance rates from baseline MY 2022 to MY 2024 by 5.3 and 3.9 percentage points, respectively. KPMAS decreased its performance rate from baseline MY 2022 to MY 2024 by two percentage points.

Figure 5. MY 2024 CIS-3 Indicator Rates (Postpartum Care-Related PIP)



Solid bars represent MCOs that selected a CIS-3 HEDIS rate strategy. Striped bars represent MCOs that did not select a CIS-3 HEDIS rate strategy.

Indicator Rate Performance Compared to National Benchmarks.

PPC-AD. For the MY 2024 PPC-AD measure, CFCHP (89.1%) and KPMAS (95.2%) performed within the ninetieth percentile. JMS (87.8%) performed within the seventy-fifth percentile. ABH (83.3%), MSFC (85.0%), PPMCO (84.2%), and WPM (84.4%) performed within the fiftieth percentile. MPC (81.8%) and UHC (79.6%) performed below the fiftieth percentile.

W30 (0-15 Months). For the MY 2024 W30 (0-15 Months) measure, KPMAS (79.1%) performed within the ninetieth percentile. CFCHP (68.1%) performed within the seventy-fifth percentile. UHC (64.0%) performed within the fiftieth percentile. ABH (53.3%), JMS (54.6%), MPC (60.9%), MSFC (58.1%), PPMCO (62.6%), and WPM (61.0%) performed below the fiftieth percentile.

W30 (15-30 Months). For the MY 2024 W30 (15-30 Months) measure, KPMAS (79.6%) and WPM (80.1%) performed within the seventy-fifth percentile. JMS (74.7%), MSFC (76.8%), PPMCO (75.7%), and UHC (76.3%) performed within the fiftieth percentile. ABH (71.4%), CFCHP (70.9%), and MPC (72.2%) performed below the fiftieth percentile.

CIS-3. For the MY 2024 CIS-3 measure, KPMAS (77.9%), PPMCO (76.2%), and WPM (75.9%) performed within the ninetieth percentile. MPC (72.8%) performed within the seventy-fifth percentile. ABH (68.6%), CFCHP (71.5%), JMS (67.5%), MSFC (68.4%), and UHC (70.1%) performed within the fiftieth percentile.

Table 20. MY 2024 Remeasurement Performance Comparison to NCQA's Quality Compass (Postpartum Care-Related PIP)

MCO Rate Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
PPC-AD Rate	83.3%	89.1%	87.8%	95.2%	81.8%	85.0%	84.2%	79.6%	84.4%
Diamond Rating	◆◆	◆◆◆◆	◆◆◆	◆◆◆◆	◆	◆◆	◆◆	◆	◆◆
W30 (0-15 Months) Rate	53.3%	68.1%	54.6%	79.1%	60.9%	58.1%	62.6%	64.0%	61.0%
Diamond Rating	◆	◆◆◆	◆	◆◆◆◆	◆	◆	◆	◆◆	◆
W30 (15-30 Months) Rate	71.4%	70.9%	74.7%	79.6%	72.2%	76.8%	75.7%	76.3%	80.1%
Diamond Rating	◆	◆	◆◆	◆◆◆	◆	◆◆	◆◆	◆◆	◆◆◆
CIS-3 Rate	68.6%	71.5%	67.5%	77.9%	72.8%	68.4%	76.2%	70.1%	75.9%
Diamond Rating	◆◆	◆◆	◆◆	◆◆◆◆	◆◆◆	◆◆	◆◆◆◆	◆◆	◆◆◆◆

Measure rate percentages rounded to the nearest tenth for reporting purposes.

Blue= MCO selected strategies that align with the HEDIS rate. **Gray**= MCO did not select strategies that align with the HEDIS rate.

◆◆◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass ninetieth percentile. ◆◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass seventy-fifth percentile but is below the ninetieth percentile. ◆◆ indicate the MCO rate meets or exceeds the NCQA Quality Compass fiftieth percentile but is below the seventy-fifth percentile. ◆ indicate the MCO rate is below the NCQA Quality Compass fiftieth percentile.

Conclusion

Overall analysis of PIP strategies and interventions submitted by MCOs enhances HEDIS measure rates and plans for quality assessment and performance improvement programs. Three of the nine MCOs (CFCHP, KPMAS, and MPC) performed at levels of *High Confidence* and *Moderate Confidence* for both the prenatal care and postpartum care-related PIP topics during MY 2024 for Methodology, Significant Improvement, and Overall Validation Ratings. All MCOs except for UHC and WPM performed at *High Confidence* levels for the overall validation of both PIP topics. WPM was the only MCO that performed at a *Moderate Confidence* level for the overall validation of the prenatal care-related PIP topic during MY 2024. UHC was the only MCO that performed at a *Moderate Confidence* level for the overall validation of the postpartum care-related PIP topic during MY 2024.

The following tables provide overall conclusions for MCO performance for the prenatal care and postpartum care-related PIP topics during the MY 2024 remeasurement year, respectively.

Prenatal Care PIP Conclusions.

Methodology Rating. Eight of the nine MCOs performed at *High Confidence* levels at 100% (ABH, CFCHP, JMS, MPC, MSFC, PPMCO, and UHC) and 96.4% (KPMAS). WPM performed at a *Moderate Confidence* level of 88.9%.

Significant and Sustained Improvement Validation Rating. MPC (100%) was the only MCO that performed at a *High Confidence* level. Three of the nine MCOs performed at a *Moderate Confidence* level at 80.0% (CFCHP, KPMAS, and WPM). ABH (60.0%) was the only MCO that performed at a *Low Confidence* level. Four of the nine MCOs performed at a *No Confidence* level (JMS and PPMCO at 40.0%, MSFC and UHC at 20.0%).

Overall Improvement Validation Rating. Eight of the nine MCOs performed at a *High Confidence* level, ranging from 91.0% (UHC) to 100% (MPC). WPM was the only MCO to perform at a *Moderate Confidence* level (88.4%).

Any HEDIS Rate Improvement. All MCOs, except for UHC, demonstrated HEDIS rate improvement.

Any Statistically Significant Improvement in HEDIS Rate. Four of the nine MCOs (CFCHP, KPMAS, MPC, and WPM) demonstrated statistically significant improvement in the HEDIS rate.

Any Sustained Improvement in HEDIS Rate. Three of the nine MCOs (CFCHP, KPMAS, and MPC) demonstrated sustained improvement in the HEDIS rate for MY 2024. ABH, JMS, MSFC, PPMCO, UHC, and WPM did not demonstrate sustained improvement in the HEDIS rate for MY 2024.

Table 21. MY 2024 Remeasurement Overall Performance (Prenatal Care PIP)

Prenatal Care PIP	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Any HEDIS Rate Improvement? (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Any Statistically Significant Improvement in HEDIS rate? (Yes/No)	No	Yes	No	Yes	Yes	No	No	No	Yes
Any Sustained Improvement in HEDIS rate? (Yes/No/NA)	No	Yes	No	Yes	Yes	No	No	No	No
Methodology Validation Rating (%)	100%	100%	100%	96.4%	100%	100%	100%	100%	88.9%
Significant and Sustained Improvement Validation Rating (%)	60.0%	80.0%	40.0%	80.0%	100%	20.0%	40.0%	20.0%	80.0%
Overall Validation Rating (%)	95.7%	98.0%	93.6%	94.9%	100%	91.8%	93.5%	91.0%	88.4%

Yes and blue= MCO selected strategies that align with the HEDIS rate. **No and gray=** MCO did not select strategies that align with the HEDIS rate.

Green= High Confidence, **Yellow=** Moderate Confidence, **Gold=** Low Confidence, **Pink=** No Confidence

Postpartum Care-Related Conclusions.

Methodology Rating. Eight of the nine MCOs performed at a *High Confidence* level of 100% (ABH, JMS, MPC, MSFC, and PPMCO), 91.8% (CFCHP), 96.5% (KPMAS), and 94.0% (WPM). One of the nine MCOs performed at a *Moderate Confidence* level of 84.8% (UHC).

Significant and Sustained Improvement Validation Rating. Five of the nine MCOs performed at a *High Confidence* level of 100% (ABH, MPC, MSFC, PPMCO, and WPM). Two of the nine MCOs performed at a *Moderate Confidence* level of 80.0% (CFCHP and KPMAS). Two of the nine MCOs performed at a *Low Confidence* level of 60.0% (JMS and UHC).

Overall Improvement Validation Rating. Eight of the nine MCOs performed at a *High Confidence* level of 100% (ABH, MPC, MSFC, and PPMCO), 90.9% (CFCHP), 95.7% (JMS), 95.0% (KPMAS), and 94.9% (WPM). One of nine MCOs performed at a *Moderate Confidence* level at 82.8% (UHC).

Any HEDIS Rate Improvement. All MCOs with selected strategies for the PPC-AD measure demonstrated HEDIS rate improvement (ABH, CFCHP, KPMAS, PPMCO, UHC, and WPM). All MCOs with selected strategies for the W30 measure demonstrated HEDIS rate improvement (ABH, JMS, KPMAS, MPC, MSFC, and WPM). All MCOs with selected strategies for the CIS-3 measure demonstrated HEDIS rate improvement except for MSFC.

Any Statistically Significant Improvement in HEDIS Rate. Seven of the nine MCOs demonstrated statistically significant improvement in the HEDIS rates (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, and WPM). Two of the nine MCOs did not demonstrate statistically significant improvement in the HEDIS rates (JMS and UHC).

Any Sustained Improvement in HEDIS Rate? All nine MCOs demonstrated sustained improvement in one or more HEDIS rates.

Table 22. MY 2024 Remeasurement Overall Performance (Postpartum Care-Related PIP)

Postpartum Care-Related PIP	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Any PPC-AD HEDIS rate improvement? (Yes/No/NA)	Yes	Yes	NA	Yes	NA	NA	Yes	Yes	Yes
Any W30 HEDIS rate improvement? (Yes/No/NA)	Yes	NA	Yes	Yes	Yes	Yes	NA	NA	Yes
Any CIS-3 HEDIS rate improvement? (Yes/No/NA)	NA	Yes	Yes	NA	Yes	No	Yes	Yes	NA
Any statistically significant improvement in HEDIS rate? (Yes/No/NA)	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Any sustained improvement in HEDIS rate? (Yes/No/NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Methodology Validation Rating (%)	100%	91.8%	100%	96.5%	100%	100%	100%	84.8%	94.0%
Significant and Sustained Improvement Validation Rating (%)	100%	80.0%	60.0%	80.0%	100%	100%	100%	60.0%	100%
Overall Validation Rating (%)	100%	90.9%	95.7%	95.0%	100%	100%	100%	82.8%	94.9%

Validation rating percentages rounded to the nearest tenth for reporting purposes.

Yes and blue= MCO selected strategies that align with the HEDIS rate. **No and gray=** MCO did not select strategies that align with the HEDIS rate. **NA=** No Applicable, MCO did not select related strategies

Green= High Confidence, **Yellow=** Moderate Confidence, **Pink=** No Confidence

Quality Strategy Highlights

To achieve MDH's goal of delivering high-quality, accessible care to managed care enrollees, MDH developed a framework to focus on quality improvement efforts for the HealthChoice program. MDH set task goals for increasing the PPC-CH, PPC-AD, and CIS-3 measure rates for all MCOs in the HealthChoice Quality Strategy for 2022-2024. Expectations are set according to the ninetieth percentile: MCOs performing within the ninetieth percentile are expected to maintain performance within the ninetieth percentile, and MCOs performing below the ninetieth percentile are expected to improve the baseline MY 2022 measure rates by five percent over the life of the PIP. The table below identifies specific HealthChoice performance metrics for these three measures.

Table 23. MY 2024 HealthChoice Performance Against Quality Strategy Targets (PIP)

Performance Measure	Quality Strategy	HealthChoice Aggregate Performance	Percentage Point Progress
PIP Topic	MY 2024 Targets	Remeasurement MY 2024	Value (↑, ↓, or NA)
Prenatal Care PIP: PPC-CH	88.2%	89.5%	1.3 ↑
Postpartum Care-Related PIP: PPC-AD	81.3%	85.6%	4.3 ↑
Postpartum Care-Related PIP: W30 (0-15 Months)	NA	62.4%	NA
Postpartum Care-Related PIP: W30 (15-30 Months)	NA	75.3%	NA

Performance Measure	Quality Strategy	HealthChoice Aggregate Performance	Percentage Point Progress
PIP Topic	MY 2024 Targets	Remeasurement MY 2024	Value (↑, ↓, or NA)
Postpartum Care-Related PIP: CIS-3	77.4%	72.1%	-5.3 ↓

NA (Not Applicable): The MDH Quality Strategy did not identify quality strategy targets for the W30 measures because it was baseline at the time of issuance, so there was not a specific target for MY 2024.

Source: [HealthChoice Quality Strategy 2022-2024](#)

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of MY 2024 PIP validations. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024's PIP validations:

- MCOs demonstrate **quality** by ensuring that strategic, systemic, and impactful interventions are developed and implemented to improve the quality of care enrollees receive in the areas of perinatal healthcare and preventive care for infants and toddlers. Interventions were required to have a health equity focus by overcoming barriers related to timely prenatal care, postpartum care, and/or preventive care for infants and toddlers for disparate populations with the incorporation of each component of the CLAS Standards.
- MCOs demonstrate **access (or accessibility)** by ensuring that interventions assess and reassess barriers and root causes related to timely prenatal care, postpartum care, and/or preventive care for infants and toddlers. Using the PDSA cycle, MCOs review and modify interventions, as needed, on a quarterly basis. Interventions were required to address barriers to ensure adequate access to timely prenatal and postpartum care services for all enrollees, such as HVS), doula services, and enhanced case management for enrollees with substance use disorder.
- MCOs demonstrate **timeliness** by ensuring that interventions address barriers related to the timeliness of prenatal care, postpartum care, and/or preventive care for infants and toddlers. Following a PDSA cycle, MCOs modified interventions to ensure enrollee engagement. MCOs followed through with prenatal and postpartum care, such as following the American College of Obstetricians and Gynecologists' recommendations for timely postpartum care visits and the childhood immunization status schedule.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2024 PIP validations and identify positive (↑), negative (↓), or not applicable (NA) assessments of aggregate MCO performance.

Table 24. MY 2024 Strengths, Improvements, and Recommendations (PIP)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	Strengths: For MY 2024, all MCOs performed at confidence levels of <i>High</i> and <i>Moderate Confidence</i> for the overall validation rating. ABH, CFCHP, JMS, KPMAS, MPC, MSFC, and PPMCO performed at a <i>High Confidence</i> level for the overall validation of both PIP topics.	↑
Quality and Access	Improvements: - Reported performance improvement included incorporating CLAS within the interventions for both PIP topics. - Conducted root cause analyses to overcome barriers for the enrollee, provider, and MCO. - Reported measures appropriately for both PIP topics.	↑
Quality	Opportunities: - Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions. - Utilize the same methodology as the baseline year.	↓
Quality, Access, and Timeliness	Recommendations: - Ensure evidence-based sources are relevant and describe how the proven-successful methodology in the source is being incorporated within the intervention. - Ensure the template is not altered and ensure all questions are answered thoroughly. - Review and identify confounding variables that could have an obvious impact on outcomes. - Conduct root cause analyses when statistically significant improvement of HEDIS rates was not demonstrated as a direct result of implemented interventions. - Assess the impact of interventions on health equity and modify as needed to further incorporate each component of the CLAS standards on an interventional level. Utilize enrollee and provider feedback to conduct a barrier analysis. Enrollee and provider feedback should also be incorporated in the design of the interventions to overcome barriers while prioritizing the disparate population to improve healthcare outcomes. - Continue to modify interventions as needed to address barriers to timeliness of prenatal and postpartum/infant and toddler care. - Review the provided aim statement in the quarterly templates or PIP Orientation Manual.	NA

Green and ↑ = Domain experienced a positive impact from MCOs' performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Additional Information

For additional findings and comprehensive details associated with the MY 2024 PIP validation, please access the link to the MY 2024 PIP Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the PIP validation related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Performance Measure Validation

Objective

Performance measures assist in monitoring the performance of individual MCOs at a point in time, tracking performance over time, and comparing performance among MCOs. The PMV activity evaluates the accuracy and reliability of measures produced and reported by each MCO and determines the extent to which each MCO followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates are essential to ascertain whether each MCO's quality improvement efforts have resulted in improved health outcomes. The validation process further allows MDH to have confidence in MCO measure results.

MDH utilizes Population Health Incentive Program (PHIP) activities as part of an incentive program designed to provide financial incentives to MCOs, based on their performance in standardized measures that demonstrate high-quality care. Analysis of select HEDIS and MDH-developed encounter measures to determine incentivized performance evaluates access to timely services to promote desired health outcomes.

Methodology

The PHIP activity consists of validations and source material from several collaborative vendors, as identified below:

- MDH contracted with MetaStar Inc., (MetaStar), an NCQA-Licensed Organization, to conduct HEDIS audits.
- MDH contracted with the Hilltop Institute at the University of Maryland, Baltimore County (Hilltop) to calculate PHIP encounter data measures.
- Qlarant validates the encounter data measures calculated by Hilltop and reports financial incentives, as provided by MDH.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set. More than 90% of national health plans utilize HEDIS performance measures to compare the performance of quality, access, and enrollee satisfaction. Providers, employers, consumers, and state purchasers of healthcare utilize aggregated

HEDIS rates to evaluate an MCO's ability to demonstrate an improvement in preventive health outreach to enrollees. MDH incorporates six HEDIS measures in PHIP activities, with the intent of improving MCO performance with incentives.

Description of Data Obtained. Qlarant received information from the sources below to satisfy validation requirements:

- MDH provided all the MetaStar data, Hilltop data, and benchmark percentiles for each MCO.
- MetaStar provided HEDIS Final Audit Reports and reports summarizing results from the NCQA HEDIS Compliance Audits^{TM1}.

Technical Methods of Data Collection and Analysis. HealthChoice MCOs are required to collect and report audited HEDIS data under Code of Maryland Regulations (COMAR) 10.67.04.03B(2). The PHIP program includes the following six measures:

- Asthma Medication Ratio (AMR): Ages 5-64
- Continued Opioid Use (COU): ≥31 days covered
- Glycemic Status Assessment for Patients with Diabetes (GSD): Poor HbA1c Control (>9%)
- Lead Screening in Children (LSC)
- Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
- Prenatal and Postpartum Care: Postpartum Care (PPC-AD)

MDH contracted with MetaStar to validate the six HEDIS measures and conduct the NCQA HEDIS Compliance Audits to ensure HEDIS data reported publicly by MCOs are accurate and reliable. The audit included a pre-visit teleconference; review of information system standards, HEDIS measure determination standards, and the HEDIS Record of Administration, Data Management, and Processes (Roadmap); medical record review validation (MRRV); and final audit opinion.

Pre-Visit Teleconference. MetaStar schedules a conference call two to four weeks prior to the audit visit to introduce key personnel, review the agenda, identify participants, and structure an approach to auditing data sources used for HEDIS.

HEDIS Roadmap Review. NCQA designed the Roadmap as a comprehensive instrument for collecting information from each MCO regarding structure, data collection, processing, and HEDIS reporting procedures. Each MCO completes and submits the Roadmap to MetaStar by January 31 of each reporting year. MetaStar reviews the Roadmap prior to the audit visit to make preliminary assessments regarding information system compliance and to identify areas requiring follow-up at the audit visit.

¹ NCQA HEDIS Compliance Audit TM is a trademark of the National Committee for Quality Assurance (NCQA).

Information Systems Standards. The audit visit portion of the HEDIS Compliance Audit expands upon information gleaned from the HEDIS Roadmap to enable MetaStar to make conclusions about each MCO's compliance with information system standards. These standards measure how each MCO collects, stores, analyzes, and reports medical, customer service, enrollee, practitioner, and vendor data; identify the minimum requirements for information systems and processes used in HEDIS data collection; and provide the foundation on which MetaStar assesses the organization's ability to report HEDIS data accurately, completely, and reliably. MetaStar reviews data collection and management processes, including the monitoring of vendors, to determine the soundness and completeness of data used for HEDIS reporting.

HEDIS Measure Determination Standards. MetaStar uses both pre-audit visit and post-audit visit activities to determine compliance with MDH standards and to assess each MCO's adherence to HEDIS technical specifications and report production protocols. Activities conducted during the audit process confirm that NCQA-certified measure software is used. All MCOs, except for KPMAS, continue to utilize certified measure software to produce HEDIS reports. Instead, KPMAS contracted directly with NCQA to evaluate and approve their internally developed measure production programming. MetaStar then reviews KPMAS' sampling protocols for the hybrid method. Later in the audit season, MetaStar reviews HEDIS results for algorithmic compliance and performs benchmark comparisons against NCQA-published means and percentiles.

MRRV. MetaStar's MRRV assesses the integrity of data obtained from medical records for any measures calculated using the hybrid method. MetaStar's audit team compares findings to each MCO's abstraction forms for a sample of positive numerator events. Part one of the validation may also include a review of a convenience sample of medical records to identify procedural errors early in the medical record abstraction process, enabling timely corrective action. This activity is optional and conducted based on NCQA standards and MetaStar's opinion. MetaStar's MRRV is an important component of the HEDIS Compliance Audit and ensures that reviews performed by each MCO or each MCO's contracted vendor meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, MetaStar selects hybrid measures from like-measure groupings for measure validation. MetaStar's MRRV tests medical records and the appropriate application of the HEDIS hybrid specifications (i.e., the enrollee is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

Final Audit Opinion. At the close of the audit, the auditor renders the Final Audit Opinion, which includes a Final Audit Statement, along with measure-specific rates/results, and comments.

MetaStar uses the following compliance designations when conducting the HEDIS audit:

- **Reportable (R).** The MCO submitted a reportable rate for the measure.
- **Not Applicable (NA).** The MCO followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate.
- **No Benefit (NB).** The MCO did not offer the health benefit required by the measure.
- **Not Reported (NR).** The MCO chose not to report the measure.

Timeline. MetaStar conducted MY 2024 PMV activities from January to December 2024.

HEDIS Measure Results – Comparing Previous Performance. The table below displays an analysis of change from comparisons of MY 2024's HEDIS measure results to MY 2023's results and indicates whether an MCO experienced a lower or higher change in HEDIS rates. Additional columns indicate changes in MARR (2024 rate minus 2023 rate) or National HEDIS Mean (NHM) (2023 rate minus 2022 rate). MetaStar's *Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2024 Results* report provided the information for the following table and excludes new measures or indicators with no trending history, HEDIS MY 2024 results that were reported as NA, or measures where the rates stayed the same from last year and did not increase or decrease. For measures where a lower rate indicates better performance (single asterisk), the number of lower-performing MCOs are indicated in the higher column and the number of higher-performing organizations in the lower column.

Table 25. MY 2024 Summary of MetaStar's HEDIS Measure Results (HEDIS)

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Cervical Cancer Screening (CCS)	↓	↑	↑	↑	↑	↑	↑	↑	↑	1	8		3.6%	↑	0.0%
Chlamydia Screening in Women (CHL), Total	↑	↑	↓	↑	↓	↑	↓	↑	↑	3	6		0.3%	↑	0.0%
Appropriate Testing for Pharyngitis (CWP)	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.5%	↑	0.0%
Childhood Immunization Status (CIS), Combo 10	↑	↑	↓	↓	↑	↑		↓	↓	4	4		-1.2%	↓	0.0%
Childhood Immunization Status (CIS), Combo 3	↑	↑	↑	↓	↑	↑	↑	↑	↑	1	8		3.2%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Childhood Immunization Status (CIS), Combo 7	↑	↑	↑	↓	↑	↑	↑	↑	↑	1	8		2.8%	↑	0.0%
Immunization for Adolescents (IMA), Combo 1 – Meningococcal, Tdap	↑	↑	↓	↑	↑	↑	↑	↓	↑	2	7		1.2%	↑	0.0%
Immunization for Adolescents (IMA), Combo 2 – HPV, Meningococcal, Tdap	↑	↑	↑	↑	↑	↑	↑	↓	↑	1	8		2.8%	↑	0.0%
Lead Screening in Children (LSC)	↑	↑	↓	↑	↑	↓	↑	↑	↑	2	7		3.0%	↑	0.0%
Topical Fluoride for Children (TFC)	↑	↑	↑		↑	↑	↑	↑	↑	0	8		0.2%	↑	0.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile Documentation, Total	↑	↓	↑	↑	↓	↑	↑	↑	↑	2	7		3.7%	↑	0.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Nutrition, Total	↑	↓	↑	↑	↓	↑	↑	↓	↓	4	5		1.9%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Physical Activity, Total	↑	↓	↑	↑	↓	↑	↑	↓	↓	4	5		1.5%	↑	0.0%
Appropriate Treatment for Upper Respiratory Infection (URI), Total	↑	↓	↓	↑	↑	↓	↓	↑	↑	4	5		0.1%	↑	0.0%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Total	↓	↓	↓	↑	↓	↓	↓	↓	↓	8	1		-1.7%	↓	0.0%
Risk of Continued Opioid Use (COU), 15 Days, Total*	↑	↑	↑	↑	↑	↑	↓	↑	↑	8	1	L	0.3%	↑	0.0%
Risk of Continued Opioid Use (COU), 31 Days, Total*	↑	↑	↓	↑	↑	↑	↑	↑	↑	8	1	L	0.3%	↑	0.0%
Use of Imaging Studies for Low Back Pain (LBP)	↑	↑	↓	↓	↓	↓	↓	↓	↓	7	2		-0.6%	↓	0.0%
Use of Opioids at High Dosage (HDO)*	↓	↓	↓	↑	↓	↑	↑	↑	↑	5	4	L	-0.1%	↓	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Use of Opioids From Multiple Providers (UOP), Multiple Pharmacies*	↓	↓	↓	↓	↓	↓	↓	↓	↓	0	9	L	-1.0%	↓	0.0%
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers*	↑	↑	↓	↑	↓	↓	↓	↓	↑	4	5	L	-0.4%	↓	0.0%
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers and Multiple Pharmacies*	↓	↓	↓	↓	↓	↓	↓	↓	↓	0	9	L	-0.6%	↓	0.0%
Asthma Medication Ratio (AMR), Total	↑	↓	↓	↓	↑	↓	↑	↑	↓	5	4		0.7%	↑	0.0%
Pharmacotherapy Management of COPD Exacerbation (PCE), Bronchodilator	↓	↓	↑	↑	↓	↓	↓	↓	↓	7	2		-2.5%	↓	0.0%
Pharmacotherapy Management of COPD Exacerbation (PCE), Systemic Corticosteroid	↓	↓	↑	↑	↓	↓	↑	↓	↓	6	3		-3.1%	↓	0.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	↑	↑	↑	↓	↑	↑	↑	↑	↑	1	8		4.6%	↑	0.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	↑	↑	↑	↓	↑	↑	↑	↑	↑	1	8		4.1%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Cardiac Rehabilitation – Achievement (CRE)	↓	↑		↓	↓	↑	↑	↑	↓	4	4		-0.2%	↓	0.0%
Cardiac Rehabilitation – Engagement1 (CRE)	↓	↑			↑	↑	↑	↑	↓	2	5		0.3%	↑	0.0%
Cardiac Rehabilitation – Engagement2 (CRE)	↓	↑	↓	↓	↓	↑	↑	↑	↓	5	4		-1.1%	↓	0.0%
Cardiac Rehabilitation – Initiation (CRE)		↓			↓	↑	↑	↑	↑	2	4		-0.1%	↓	0.0%
Controlling High Blood Pressure (CBP)	↑	↑	↓	↑	↑	↑	↑	↑	↓	2	7		3.9%	↑	0.0%
Statin Therapy for Patients with Cardiovascular Disease (SPC), Received Statin Therapy, Total	↓	↑	↓	↓	↓	↓	↓	↑	↓	7	2		-1.2%	↓	0.0%
Statin Therapy for Patients with Cardiovascular Disease (SPC), Statin Adherence 80%, Total	↑	↑	↓	↓	↓	↓	↑	↑	↑	4	5		2.6%	↑	0.0%
Prenatal and Postpartum Care (PPC) – Postpartum Care		↑	↑	↑	↓	↑	↑	↑	↑	1	7		1.4%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	↓	↑	↑	↑	↑	↓	↑	↓	↑	3	6		1.5%	↑	0.0%
Blood Pressure Control for Patients with Diabetes (BPD)	↑	↑	↓	↑	↑	↑	↑	↑	↑	1	8		4.6%	↑	0.0%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		↑	↓		↑	↑	↑	↑	↑	1	6		3.0%	↑	0.0%
Eye Exam for Patients with Diabetes (EED)	↑	↑	↑	↑	↑	↓	↑	↓	↓	3	6		3.0%	↑	0.0%
Glycemic Status Assessment for Patients with Diabetes (GSD), Control (<8.0%)	↑	↑	↑	↑	↑	↑	↑	↑	↓	1	8		1.4%	↑	0.0%
Glycemic Status Assessment for Patients with Diabetes (GSD), Poor Control (>9.0%)*	↓	↓	↓	↓	↓	↓	↓	↑	↑	2	7	L	-1.2%	↓	0.0%
Kidney Health Evaluation for Patients with Diabetes (KED)	↑	↑	↑	↑	↑	↑	↑	↓	↑	1	8		4.2%	↑	0.0%
Statin Therapy for Patients with Diabetes (SPD), Received Statin Therapy	↑	↑	↑	↑	↑	↑	↑	↓	↑	1	8		2.1%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Statin Therapy for Patients with Diabetes (SPD), Statin Adherence 80%	↑	↑	↓	↓	↓	↓	↑	↑	↑	4	5		-0.1%	↓	0.0%
Antibiotic Utilization for Respiratory Conditions (AXR)	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		1.9%	↑	0.0%
Child and Adolescent Well-Care Visits (WCV), 12-17 years	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.6%	↑	0.0%
Child and Adolescent Well-Care Visits (WCV), 18-21 years	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.6%	↑	0.0%
Child and Adolescent Well-Care Visits (WCV), 3-11 years	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		4.0%	↑	0.0%
Child and Adolescent Well-Care Visits (WCV), Total	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.9%	↑	0.0%
Plan All-Cause Readmissions (PCR) – Observed	↓	↑	↑	↑	↑	↓	↑	↑	↑	2	7		0.6%	↑	0.0%
Plan All-Cause Readmissions (PCR) – Observed/Expected*	↑	↑	↑	↑	↑	↑	↑	↑	↑	9	0	L	0.2%	↑	-8.88

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Well-Child Visits in the First 30 Months of Life (W30), 15 months	↑	↑	↓	↑	↑	↑	↑	↑	↑	1	8		4.0%	↑	0.0%
Well-Child Visits in the First 30 Months of Life (W30), 15-30 months	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		4.0%	↑	0.0%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SSA)		↑	↑	↓	↑		↓	↑	↓	3	4		-0.4%	↓	0.0%
Antidepressant Medication Management (AMM), Acute Phase		↓	↓	↑	↑		↓	↑	↑	3	4		-2.5%	↓	0.0%
Antidepressant Medication Management (AMM), Continuation Phase		↓	↓	↑	↑		↓	↑	↑	3	4		-4.0%	↓	0.0%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)		↑	↑	↑	↑		↑	↓	↑	1	6		1.2%	↑	0.0%
Diagnosed Mental Health Disorders (DMH), Total	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		2.0%	↑	0.0%
Diagnosed Substance Use Disorders (DSU), Total	↑	↑	↑	↓	↑	↑	↓	↑	↓	3	6		0.1%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Pharmacotherapy for Opioid Use Disorder (POD), Total		↓	↑		↑		↓	↓	↑	3	3		-3.3%	↓	0.0%
Adult Immunization Status (AIS-E), Influenza	↑	↑	↑	↓	↓	↓	↓	↓	↑	5	4		0.7%	↑	0.0%
Adult Immunization Status (AIS-E), Pneumococcal								↑		0	1		75.0%	↑	0.0%
Adult Immunization Status (AIS-E), TdTap	↑	↑	↑	↓	↑	↑	↑	↑	↑	1	8		4.2%	↑	0.0%
Adult Immunization Status (AIS-E), Zoster	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.7%	↑	0.0%
Breast Cancer Screening (BCS-E)	↑	↑	↓	↑	↓	↑	↑	↑	↑	2	7		1.7%	↑	0.0%
Cervical Cancer Screening (CCS-E)	↑					↑				0	2		12.3%	↑	0.0%
Colorectal Cancer Screening (COL-E)	↑					↑				0	2		14.5%	↑	0.0%

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Acute Phase	↑					↑				0	2		25.9%	↑	0.0%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Continuation Phase	↑					↑				0	2		29.2%	↑	0.0%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Blood Glucose and Cholesterol Total	↑									0	1		65.5%	↑	0.0%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Blood Glucose Total	↓									1	0		-24.5%	↓	0.0%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Cholesterol Total	↑									0	1		66.2%	↑	0.0%
Prenatal Immunization Status (PRS-E)	↑	↑	↑	↓	↑	↓	↑	↑	↑	2	7		2.1%	↑	0.0%

Source: MetaStar's Analysis Report HealthChoice Participating Organizations HEDIS MY 2024 Results

HealthChoice Aggregate Quality, Access, and Timeliness of Services. MetaStar identified strengths, improvements, and recommendations that summarize aggregate performance across MCOs, based on the results of the MY 2024 HEDIS compliance audit for PMV. Qlarant aligns these strengths, improvements, and/or recommendations to applicable domains in quality, access, and timeliness of services provided to enrollees; and identifies positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

MetaStar did not make any formal recommendations or observe any formal improvements from the MCOs and identified the following strengths in their "Implications and Discussion" section of the Statewide Executive Summary Report for HEDIS MY 2024.

Table 26. MY 2024 Strengths, Improvements, and Recommendations (HEDIS)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, Timeliness	Strengths: <i>MetaStar observed the following strengths:</i> • Eight of nine MCOs' rates were above the NHM for Glycemic Status Assessment for Patients with Diabetes (GSD) >9 indicator. • All nine MCOs scored above the NHM for Prenatal Care and Postpartum Care (PPC) Timeliness of Prenatal Care and Postpartum indicators, LBP, and W30 15-30 Months indicator. • In addition, for Lead Screening for Children (LSC), all nine MCOs benchmarked above the seventy-fifth percentile, and of those nine, three MCOs benchmarked above the ninetieth percentile. • Seven of nine MCO PPC Postpartum indicator rates benchmarked above the seventy-fifth percentile, and of those seven, three MCOs benchmarked above the ninetieth percentile. • Four of nine MCO PPC Timeliness of Prenatal Care indicator rates benchmarked above the seventy-fifth percentile, and of the four, three MCOs benchmarked above the ninetieth percentile.	↑

Green and ↑ = Domain experienced a positive impact from MCOs' performance.

Source: [MetaStar's Analysis Report HealthChoice Participating Organizations HEDIS MY 2024 Results](#)

Consumer Assessment of Healthcare Providers and Systems

Introduced by the Agency for Healthcare Research and Quality in the mid-1990s, the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] program encompasses the full range of standardized surveys that ask consumers 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. NCQA uses the Health Plan CAHPS survey in its Health Plan Accreditation Program as part of 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 readily compare the performance of health care plans.

Data Collection and Review. 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 5.1H Member Experience Surveys. CSS administered the 2025 Health Plan CAHPS Survey in accordance with the NCQA methodology detailed in HEDIS 2025, *Volume 3: Specifications for Survey Measures and Quality Assurance Plan for HEDIS 2025 Survey Measures*. Prior to sampling, CSS carefully inspected the enrollee file(s) and noted any errors or irregularities found (such as incomplete contact information or subscriber numbers). Once the quality assurance process had been completed, CSS processed enrollee addresses through the United States Postal Service National Change of Address service to ensure that the mailing addresses were up to date.

Timeline. CSS administered the Adult and Child Medicaid versions of the CAHPS Health Plan Survey for the population of children with chronic conditions on behalf of the HealthChoice MCOs and MDH between February 6 and May 12, 2025, and submitted survey results to NCQA on May 23, 2025.

The following tables summarize results of the CAHPS Health Plan Survey for the adult and child Medicaid populations and include CSS' observations about aggregate MCO performance across key HealthChoice survey measures relating to quality, access, and timeliness of care. CSS' observations about individual MCO performance are included in [Appendix A](#).

Table 27. Summary of Trends in Performance on Key HealthChoice Adult Medicaid Survey Measures (CAHPS)

Health Plan	Survey Year	2025 (MY 2024) NCQA Quality Compass National Average (All LOBs)	HealthChoice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Getting Needed Care (& Usually or Always)	2025	82.05%	79.10%	81.38%	79.57%	82.41%	73.00%	77.07%	82.18%	80.65%	81.13%	73.70%
	2024		10th	33rd	10th	33rd	<10th	10th	33rd	10th	33rd	<10th
	2023		79.70%	71.68%	80.41%	84.56%	75.09%	79.03%	85.82%	80.16%	76.56%	81.04%
Getting Care Quickly (% Usually or Always)	2025	81.57%	76.83%	76.80%	75.86%	83.08%	72.02%	76.94%	73.88%	82.24%	80.25%	69.92%
	2024		10th	10th	10th	33rd	<10th	10th	<10th	33rd	33rd	<10th
	2023		78.82%	72.28%	81.44%	82.15%	73.26%	79.99%	83.09%	79.83%	79.90%	76.88%
Rating of Personal Doctor (% 9 or 10)	2025	70.70%	64.68%	54.49%	65.64%	70.59%	64.53%	64.57%	64.04%	62.39%	64.84%	68.92%
	2024		10th	<10th	10th	33rd	<10th	<10th	<10th	<10th	10th	33rd
	2023		66.20%	60.43%	67.76%	70.00%	64.71%	65.56%	69.89%	65.12%	67.14%	63.84%
Rating of Specialist Seen Most Often (% 9 or 10)	2025	68.19%	64.57%	54.84%	65.33%	65.88%	65.74%	58.12%	62.18%	71.13%	69.06%	64.86%
	2024		10th	<10th	10th	10th	10th	<10th	<10th	67th	33rd	10th
	2023		65.34%	52.24%	63.01%	70.65%	69.86%	73.63%	67.59%	65.04%	62.14%	60.00%
Rating of All Health Care (% 9 or 10)	2025	57.72%	54.08%	48.92%	52.68%	54.30%	60.51%	48.30%	53.45%	58.26%	50.93%	57.71%
	2024		10th	<10th	10th	10th	67th	<10th	10th	33rd	<10th	33rd
	2023		54.46%	45.24%	55.91%	56.38%	58.57%	48.97%	55.84%	50.83%	63.25%	53.79%
			55.19%	50.49%	58.27%	43.81%	52.48%	52.34%	58.97%	54.55%	61.06%	65.05%

<10th 10th 33rd 67th 90th Color shading represents 2025 plan performance compared to the 2025 (MY 2024) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2025 plan rate indicates a statistically significant decrease from the Aggregate rate at the 95% confidence level.

↑↑ next to the 2025 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2025 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Table 28. Summary of Trends in Performance on Key HealthChoice Adult Medicaid Survey Measures (Continued) (CAHPS)

Health Plan	Survey Year	2025 (MY 2024) NCQA Quality Compass National Average (All LOBs)	HealthChoice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Rating of Health Plan (% 9 or 10)	2025	61.66%	56.89% 10th	49.32% <10th ● L	55.36% 10th	58.33% 10th ↑↑	60.00% 33rd ↑↑	52.79% <10th	62.35% 33rd H	55.52% 10th	56.17% 10th	61.13% 33rd
	2024		55.42%	49.47%	58.62%	57.08%	59.91%	47.93%	59.44%	48.44%	60.56%	56.44%
	2023		55.93%	48.00%	56.28%	47.64% ✓	52.86%	53.01%	65.99%	61.81%	59.22%	58.96%
Coordination of Care (% Usually or Always)	2025	85.94%	81.52% 10th	77.14% <10th ↓↓	82.84% 10th ↓↓	90.54% 90th H	75.49% <10th L	82.47% 10th	86.46% 33rd	80.87% <10th	82.20% 10th ↑↑	75.86% <10th ↓↓
	2024		84.57%	77.78%	90.28%	80.00%	91.07% ✓	88.89%	86.49%	84.21%	80.65%	82.89%
	2023		82.55%	81.82%	95.65% ✓	90.38%	75.71%	79.73%	78.33%	78.26%	79.69%	85.19%
Customer Service (% Usually or Always)	2025	89.27%	87.04% 10th	85.69% <10th ↑↑	85.68% <10th ↓↓	94.01% 90th ● H	86.15% 10th ↓↓	86.83% 10th ↓↓	93.20% 90th ↑↑	84.43% <10th	86.59% 10th	81.20% <10th L
	2024		92.56%	82.83%	89.57%	91.10%	88.55%	90.16%	91.76%	87.13%	89.10%	86.39%
	2023		91.78%	81.95%	90.89%	92.98%	90.70%	90.46%	86.61%	86.96%	87.21%	88.73%
How Well Doctors Communicate (% Usually or Always)	2025	93.37%	92.25% 10th	92.98% 33rd ↑↑	90.48% <10th ↓↓	96.47% 90th ↑↑	90.73% 10th H	90.25% <10th L	93.48% 33rd	93.33% 33rd	90.61% <10th ↑↑	93.02% 33rd ↑↑
	2024		92.56%	91.42%	96.00%	92.19%	90.87%	94.33%	94.82%	92.47%	88.65%	92.69%
	2023		91.78%	91.21%	96.58% ✓	91.42%	87.14%	93.99%	93.25%	93.56%	86.41%	92.31%
Shared Decision Making (% Yes)	2025	Measure not supported by NCQA	80.71% ↑↑	79.77% ↑↑	78.13%	83.79% ↑↑	75.95% ↓↓ L	80.16% ↓↓	90.10% H	83.08% ↑↑	78.22% ↑↑	77.24%
	2024		–	–	–	–	–	–	– ●	–	–	–
	2023		79.86%	79.17%	82.23%	81.49%	78.44%	80.95%	76.56% ✓	79.23%	76.91%	84.04%
			78.16%	70.39%	79.50%	80.26%	78.47%	82.59%	76.86% ✓	77.83%	75.54%	78.95%

<10th 10th 33rd 67th 90th Color shading represents 2025 plan performance compared to the 2025 (MY 2024) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2025 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

↑↑ ↓↓ next to the 2025 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2025 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Table 29. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC Survey Measures (CAHPS)

Health Plan	Survey Year	2025 (MY 2024) NCQA Quality Compass National Average (All LOBs)	HealthChoice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Getting Needed Care (% Usually or Always)	2025	83.95%	79.77%	78.37%	79.86%	83.59%	76.56%	84.52%	79.31%	82.70%	77.90%	75.81%
	2024		10th	10th	10th	33rd	<10th	33rd	10th	33rd	10th	<10th
	2023		79.92%	78.44%	80.56%	86.49%	74.92%	79.84%	76.77%	80.77%	82.19%	81.84%
Getting Care Quickly (% Usually or Always)	2025	86.20%	82.07%	83.93%	83.65%	82.68%	75.13%	88.01%	78.59%	83.27%	85.23%	79.19%
	2024		10th	10th	10th	10th	<10th	33rd	<10th	10th	33rd	10th
	2023		82.51%	81.83%	85.10%	89.88%	67.57%	84.52%	83.52%	83.13%	84.12%	83.74%
Rating of Personal Doctor (% Usually or Always)	2025	77.83%	75.90%	77.38%	72.69%	80.88%	75.17%	77.13%	72.89%	77.02%	76.27%	75.42%
	2024		10th	33rd	<10th	67th	10th	33rd	10th	33rd	10th	10th
	2023		75.42%	74.16%	74.22%	77.46%	77.37%	68.05%	75.33%	76.99%	75.39%	78.64%
Rating of Specialist Seen Most Often (% 9 or 10)	2025	73.21%	67.84%	66.67%	69.30%	69.35%	58.33%	71.11%	70.00%	70.31%	71.43%	63.30%
	2024		<10th	<10th	10th	10th	<10th	33rd	10th	10th	33rd	<10th
	2023		70.78%	74.67%	71.43%	71.43%	69.49%	67.12%	67.27%	69.74%	67.14%	77.27%
Rating of All Health Care (% 9 or 10)	2025	70.90%	70.84%	72.33%	67.74%	75.71%	65.66%	71.34%	72.17%	72.45%	69.25%	72.22%
	2024		33rd	33rd	10th	67th	10th	33rd	33rd	33rd	33rd	33rd
	2023		70.58%	66.41%	68.44%	70.21%	71.32%	65.95%	69.43%	72.96%	73.58%	75.86%
			67.84%	66.88%	62.30%	70.00%	64.39%	70.00%	63.64%	71.16%	71.07%	70.72%

<10th 10th 33rd 67th 90th Color shading represents 2025 plan performance compared to the 2025 (MY 2024) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2025 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

↑↑ next to the 2025 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2025 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Table 30. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC Survey Measures (Continued) (CAHPS)

Health Plan	Survey Year	2025 (MY 2024) NCQA Quality Compass National Average (All LOBs)	HealthChoice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Rating of Health Plan (% 9 or 10)	2025	71.80%	68.88% 10th	71.12% 33rd	69.49% 10th	66.67% 10th	66.79% 10th	65.15% 10th	68.72% 10th	71.76% 33rd	65.22% 10th	73.02% 33rd
	2024		69.65%	67.10%	73.09%	65.40%	66.14%	68.07%	66.67%	71.72%	67.23%	77.92%
	2023		66.83%	65.14%	63.02%	59.43%	65.82%	67.85%	62.50%	74.80%	67.09%	71.26%
Coordination of Care (% Usually or Always)	2025	84.90%	80.44% 10th	83.46% 33rd	79.01% <10th	80.52% 10th	79.29% 10th	82.48% 10th	81.62% 10th	77.05% <10th	84.25% 33rd	77.85% <10th
	2024		80.39%	77.14%	79.38%	87.88%	80.41%	80.56%	75.24%	80.99%	82.42%	81.95%
	2023		77.94%	79.37%	75.32%	80.00%	78.21%	75.00%	75.34%	81.91%	74.39%	82.72%
Customer Service (% Usually or Always)	2025	88.21%	85.68% 10th	84.60% <10th	84.49% <10th	89.08% 33rd	88.61% 33rd	86.40% 10th	82.06% <10th	84.66% 10th	87.36% 33rd	84.67% 10th
	2024		86.88%	81.03%	90.82%	93.02%	87.69%	81.17%	85.71%	84.58%	86.27%	89.61%
	2023		82.70%	76.79%	72.97%	91.69%	82.69%	80.71%	85.38%	86.21%	84.44%	85.09%
How Well Doctors Communicate (% Usually or Always)	2025	93.95%	91.72% 10th	92.37% 10th	91.54% 10th	93.66% 33rd	91.03% <10th	92.26% 10th	90.63% <10th	92.02% 10th	91.81% 10th	90.68% <10th
	2024		91.46%	90.01%	89.18%	94.02%	90.93%	91.38%	92.16%	93.72%	90.30%	91.22%
	2023		90.77%	89.59%	88.93%	93.22%	89.12%	92.91%	91.25%	92.84%	89.81%	89.84%
Shared Decision Making (% Yes)	2025	Measure not supported by NCQA	74.49% 10th	73.23% 10th	73.51% 10th	75.00% 10th	76.33% 10th	84.97% 10th	75.11% 10th	67.94% 10th	77.36% 10th	70.45% 10th
	2024		—	—	—	—	—	—	—	—	—	—
	2023		75.50%	74.74%	71.94%	87.62%	67.87%	68.47%	79.75%	76.16%	84.57%	72.64%
			75.87%	76.86%	81.82%	70.18%	76.68%	80.18%	68.62%	78.84%	74.29%	67.71%

Color shading represents 2025 plan performance compared to the 2025 (MY 2024) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2025 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

↑↑ next to the 2025 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2025 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Table 31. Summary of Trends in Performance on CCC Survey Measures (CAHPS)

Health Plan	Survey Year	2025 (MY 2024) NCQA Quality Compass National Average (All LOBs)	HealthChoice Average	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Prescription Medicines (% Usually or Always)	2025	90.51%	89.25% ↑↑ 10th	80.32% ● L <10th	89.36% 33rd	91.35% ↑↑ 33rd	89.19% 10th	88.77% 10th	89.33% 33rd	95.25% H 90th	86.09% <10th	91.18% 33rd
	2024		88.51%	85.84%	88.40%	90.91%	91.30%	87.67%	89.74%	89.13% ✓	85.20%	90.06%
	2023		88.35%	80.99%	89.06%	90.54%	84.21%	89.74%	87.86%	91.59%	86.59%	91.16%
Access to Specialized Services (% Usually or Always)	2025	74.52%	69.00% ↑↑ <10th	54.98% ↓↓ L <10th	71.11% ↑↑ 33rd	70.06% 10th	59.27% <10th	72.07% 33rd	76.22% ↑↑ 33rd	69.45% ↓↓ <10th	66.60% <10th	76.53% ↑↑ 33rd H
	2024		68.82%	64.88%	65.84%	72.45%	56.55%	70.13%	71.74%	70.18%	73.81%	69.55%
	2023		66.27%	65.26%	57.62%	60.97%	57.62%	71.11%	67.14%	74.13%	66.31%	65.74%
Getting Needed Information (% Usually or Always)	2025	91.02%	89.59% 10th	88.57% ↑↑ 10th	88.89% 10th	91.34% 33rd	85.71% ↑↑ <10th L	90.67% ↓↓ 33rd	86.28% <10th	93.61% ↑↑ 67th H	88.26% 10th	91.47% 33rd
	2024		87.82%	87.22%	83.25%	93.75%	83.57%	91.00%	85.57%	90.48%	88.71%	87.85%
	2023		88.02%	84.80%	88.81%	92.00%	79.51%	91.46%	89.58%	88.24% ✓	87.03%	89.74%
Personal Doctor Who Knows Child (% Yes)	2025	91.44%	90.40% 10th	90.87% 10th	91.40% ↑↑ 33rd	93.79% 67th H	87.55% <10th L	91.22% 33rd	90.14% 10th	91.34% ↑↑ 33rd	90.14% ↑↑ 10th	87.98% ↓↓ 10th
	2024		89.07%	88.84%	89.05%	88.36%	82.02%	90.99%	89.74%	90.71%	89.63%	89.03%
	2023		90.18%	90.08%	86.52%	94.72%	88.67%	91.56%	91.54%	90.06%	89.31%	90.88%
Coordination of Care for Children with Chronic Conditions (% Yes)	2025	74.91%	72.77% 10th	68.52% L <10th	74.45% ↑↑ 33rd	79.40% 90th H	73.24% ↑↑ 10th	71.08% ↑↑ 10th	77.41% ↑↑ 67th	74.05% 10th	68.53% <10th	72.16% 10th
	2024		73.63%	76.12%	71.55%	70.31%	68.97%	70.53%	74.32%	80.27%	69.94%	77.61%
	2023		70.15%	67.08%	68.78%	72.27%	64.29%	69.07%	71.72%	74.12%	68.06%	72.59%

<10th 10th 33rd 67th 90th Color shading represents 2025 plan performance compared to the 2025 (MY 2024) NCQA National Percentiles for all LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2025 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

↑↑ next to the 2025 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2025 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

HealthChoice Aggregate Quality, Access, and Timeliness of Services. CSS identified strengths and improvements by summarizing aggregate performance across MCOs, based on the results of the MY 2024 CAHPS surveys. Applicable domains in quality, access, or timeliness correspond to areas of impact identified from CSS. Qlarant corresponds these strengths and improvements to quality, access, and timeliness of services provided to enrollees; and identifies positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

Table 32. MY 2024 Strengths, Improvements, and Recommendations (CAHPS)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	Strengths: CSS observed the following strengths: Adult: For all measures, the HealthChoice Aggregate performed on par with the 2024 levels across the measure spectrum. No measures saw a statistically significant change from the 2024 or 2023 levels. Child: The HealthChoice Aggregate performed on par with the 2024 levels across the measure spectrum. Four non-CCC measures and two CCC measures saw a three-year positive trend.	↑
Quality, Access	Improvements: CSS observed the following improvements: Adult: There are no formal improvements from the previous measurement year for all MCOs for the adult survey. Child: Two MCOs (MPC and PPMCO) demonstrated statistically significant performance gains compared to the prior year for <i>Rating of Personal Doctor</i> and <i>Shared Decision Making</i>; and <i>Access to Prescription Medicines</i>, respectively.	↑
Quality, Access	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: - HealthChoice exhibited a consistent negative directional trend on the <i>Rating of All Health Care</i> measure, but it wasn't statistically significant. - For all measures, HealthChoice scored in the bottom third of the 2025 (MY 2024) NCQA Quality Compass Adult Medicaid percentile distribution. - Three MCOs (KPMAS, MPC, and UHC) demonstrated statistically significant declines in MCO performance compared to 2024 in <i>Coordination of Care</i>, <i>Rating of Specialist Seen Most Often</i>, and <i>Rating of All Health Care</i>, respectively. Child: - Most measures scored in the bottom third of the 2025 (MY 2024) NCQA Quality Compass Child Medicaid National distribution. Seven of the nine non-CCC measures and four of the five CCC measures were in the bottom third, and one (<i>Rating of All Health Care</i>) scored in the middle third.	↓

Green and ↑ = Domain experienced a positive impact from MCOs' performance. **Pink** and ↓ = Domain experienced a negative impact from MCOs' performance.

Source: [CSS' State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations' Adult and Child Populations 2025 CAHPS 5.1H Member Experience Survey](#)

Population Health Incentive Program

MDH selected HEDIS and state-specific performance measures for the PHIP program.

Description of Data Obtained. MCOs demonstrating high-quality care annually receive financial incentives according to COMAR 10.67.04.03-2. MDH designed PHIP to improve MCO performance by applying incentives to standardized measures of performance. Qlarant collaborates with MetaStar and Hilltop for validation activities for the MDH-specified set of performance measures.

Technical Methods of Data Collection and Analysis. Selected HEDIS measures are calculated and validated per *HEDIS Volume 2: Technical Specifications for Health Plans* and then compared to the nationally calculated Quality Compass percentiles (see Table 35 for HEDIS validation results). These percentiles are used as incentive benchmarks to determine if each MCO's quality improvement efforts have successfully resulted in improved health outcomes. For state-specific performance measures, MDH and Hilltop calculate percentiles for comparison across HealthChoice MCOs once Qlarant's validation is complete (see Table 34 for encounter data validation results).

MY 2024 PHIP rates were drawn from HEDIS and encounter data rates. The following table displays the selected PHIP measures for MY 2024.

Table 33. MY 2024 Measures (PHIP)

Performance Measure	Domain	Measure Source	Reporting Entity
Ambulatory Care Visits for Supplemental Security Income (SSI) Adults (MDH)	Access to Care	Encounter Data	MCO
Ambulatory Care Visits for SSI Children (MDH)	Access to Care	Encounter Data	MCO
Asthma Medication Ratio (AMR): Ages 5-64	Effectiveness of Care	HEDIS	MCO
Continued Opioid Use (COU): ≥31 days covered	Effectiveness of Care	HEDIS	MCO
Glycemic Status Assessment for Patients with Diabetes (GSD): Poor HbA1c Control (>9%) [^]	Effectiveness of Care	HEDIS	MCO
Lead Screening in Children (LSC)	Effectiveness of Care	HEDIS	MCO
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Access and Availability of Care	HEDIS	MCO
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Access and Availability of Care	HEDIS	MCO

[^] Previously Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%) during MY 2023.

Validation Methodology and Results

Encounter Data Measure Validation Methodology. PHIP encounter data measures were calculated by Hilltop. Hilltop used MCO encounter and fee-for-service data to calculate the following encounter data measures:

- Ambulatory Care Visits for SSI Adults
- Ambulatory Care Visits for SSI Children

Qlarant validated the encounter data measures by reviewing both data collection and processing systems, as well as the source code for each measure, to determine compliance with MDH's measure specifications. Qlarant used the following validation designations to characterize the findings:

- **Reportable (R).** The measure was compliant with state specifications.
- **Do Not Report (DNR).** The MCO rate was materially biased and should not be reported.
- **Not Applicable (NA).** The MCO was not required to report the measure.
- **Not Reportable (NR).** The measure was not reported because the MCO did not offer the required benefit.

Qlarant's Encounter Data Measure Validation Results. The table below displays MY 2024's encounter data measure validation results, validated by Qlarant.

Table 34. Qlarant's MY 2024 Encounter Data Measure Validation Results (PHIP)

Performance Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults	R	R	R	R	R	R	R	R	R
Ambulatory Care Visits for SSI Children	R	R	R	R	R	R	R	R	R

R = Reportable; the measure was compliant with state specifications.

MetaStar's HEDIS Measure Validation Results. The table below displays MY 2024's HEDIS data measure validation results, validated by MetaStar.

Table 35. MetaStar's MY 2024 HEDIS Measure Validation Results (PHIP)

Performance Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
AMR: Ages 5-64	R	R	R	R	R	R	R	R	R
COU: ≥31 days covered	R	R	R	R	R	R	R	R	R
GSD: Poor HbA1c Control (>9%)^	R	R	R	R	R	R	R	R	R
LSC	R	R	R	R	R	R	R	R	R
PPC-CH	R	R	R	R	R	R	R	R	R
PPC-AD	R	R	R	R	R	R	R	R	R

R = Reportable; the measure was compliant with state specifications.

^ Previously Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%) during MY 2023.

Financial Incentive Methodology. The financial rewards to MCOs are based on performance and improvements of HEDIS and non-HEDIS quality measures against objective benchmarks. Available funds will be allocated through two rounds of incentive payments:

- **Round 1.** Payments to plans are made from the allocated incentive funding, based on performance during MY 2024 and improvement from MY 2023. MCOs must demonstrate improvement of at least 0.5 percentage points in the measure compared to the previous measurement year. The amount will be determined by MDH budget allocations for the performance year under review. Round 1 incentives consist of two types of incentives: performance incentives (Tier 1) and improvement incentives (Tier 2).
- **Round 2.** Unallocated funds from Round 1 are redistributed among high-performing MCOs as additional incentives, up to a per-plan limit of 1% of the MCO's MY 2024 capitation as total payment from Round 1 and Round 2.

Round 1, Tier 1. Performance incentives reward MCOs for strong objective performance for each performance measure in the current measurement year. This objective assessment will be made by comparing individual MCO performance on each measure, as outlined below.

For each qualifying measure, applicable MCOs would receive up to 100% of the Round 1 incentives through performance on quality measures during MY 2024. Depending on the measure type, the following distribution approach would apply:

- **HEDIS Measures.** Distribution of national Medicaid health maintenance organization (HMO) scores for the measure during MY 2024 using the HEDIS Quality Compass percentiles.
- **Non-HEDIS Measures.** Distribution of Maryland MCO scores for the measure during MY 2024, as determined by Hilltop.

Each measure has a base value of one-eighth ($1/8$) of the available incentive dollars per plan, which is a percentage of each MCO's total capitation, not to exceed 1%, during MY 2024. MCOs are assigned one of the following four categories for each measure in Tier 1, based on MY 2024's score:

- **Superlative Performance.** Measurement scores at or above the ninetieth percentile of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, qualifying MCOs receive $1/8$ of 0.25 percent of capitation.
- **Very Strong Performance.** Measurement scores within the seventy-fifth to eighty-ninth percentiles (inclusive) of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, qualifying MCOs receive $2/3$ of $1/8$ of 0.25 percent of capitation.
- **Strong Performance.** Measurement scores within the fiftieth to seventy-fourth percentiles (inclusive) of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, qualifying MCOs receive $1/3$ of $1/8$ of 0.25 percent of capitation.
- **No Incentive for Performance.** Measurement scores below the fiftieth percentile of all Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). The MCO would not receive an incentive within this category.

Round 1, Tier 2. Improvement incentives reward year-over-year improvement and objectively strong improvement for MCOs that did not achieve superlative performance in the current measurement year. For each qualifying measure, applicable MCOs would receive up to one-third (1/3) of the Round 1 incentives through improvement for MCOs that do not earn full performance incentives. MCOs would receive 1/3 of the 1/8 of 1 percent capitation if the following requirements are met:

- The MCO demonstrated improvement of at least 0.5 percentage points in the measure from the previous year, AND
- The MCO's current MY 2024 score is greater than or equal to the fiftieth percentile of all Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS).

For any performance measures in which a lower score indicates stronger performance, year-over-year "improvement" is a reduction of at least 0.5 percentage points in the score for that measure.

Round 2 Incentives. In addition to Round 1 funding, in Round 2, unallocated program-wide funds from Round 1— that is, funds not disbursed from the total allocated to all MCOs in Round 1— would be redistributed among MCOs that meet the following qualifying criteria:

- The MCO earned more than 80% of possible Round 1 incentives, AND
- The MCO performed sufficiently on the HEDIS Performance Monitoring Policy requirements for the measurement year.

The incentive payments from Round 2 are not to exceed 1% of capitation in total across both rounds of incentives for any individual MCO. If the remaining funds from Round 1 are not sufficient to settle all qualifying MCOs up to 1% of capitation in Round 2, then the remaining funds will be disbursed proportionally among qualifying MCOs based on the amount of funding needed to achieve 1% of total capitation. If there are additional funds remaining after settling qualifying MCOs up to 1% of capitation across both rounds, then MDH may, within its discretion, make additional payments to MCOs that are below 1% of capitation based on improvement or performance, or place remaining funds into a non-lapsing pool.

Results

PHIP Model Parameters

The table below displays the total funding available for incentives for each MCO. Per MDH, the funding for PHIP incentives was based on 0.25% of total MCO capitation, or \$18,901,766.

Table 36. Total Available Funds (PHIP)

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Available for Incentives (based on % cap approved by DBM [^])	\$797,688	\$1,392,778	\$495,590	\$1,348,572	\$3,329,417	\$1,376,461	\$4,502,823	\$2,080,461	\$3,577,976
Max Payout for Each of the Measures (1/8 th of available cap)	\$99,711	\$174,097	\$61,949	\$168,572	\$416,177	\$172,058	\$562,853	\$260,058	\$447,247

[^] Department of Budget and Management

PHIP Performance Measure and Financial Incentive Results

This section identifies Tier 1 and Tier 2 incentive results.

Table 37. Tier 1 Performance Incentives: MY 2024 Benchmark Percentiles (PHIP)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	60.9%	75.1%	83.7%	73.3%	83.4%	79.6%	81.9%	76.2%	78.9%
Ambulatory Care Visits for SSI Children (MDH)	63.0%	72.5%	77.2%	78.6%	81.9%	71.8%	82.6%	77.3%	79.9%
AMR: Ages 5-64	61.2%	74.1%	76.4%	97.1%	81.3%	58.2%	77.6%	58.4%	51.2%
COU: ≥31 days covered [^]	3.5%	3.5%	4.3%	1.3%	4.7%	2.8%	3.8%	4.1%	2.7%
GSD: Poor HbA1c Control (>9%) [^]	31.4%	26.3%	29.4%	28.7%	28.5%	27.3%	33.3%	35.0%	36.0%
LSC	72.7%	75.4%	82.9%	86.6%	76.2%	71.5%	79.3%	74.9%	79.6%
PPC-CH	87.9%	95.1%	88.3%	94.6%	92.7%	83.8%	89.8%	85.4%	87.8%
PPC-AD	83.3%	89.1%	87.8%	95.2%	81.8%	85.0%	84.2%	79.6%	84.4%

Red = <fiftieth percentile (no incentive); **Yellow** = fiftieth to seventy-fourth percentile (strong); **Light green** = seventy-fifth to eighty-ninth percentile (very strong); **Dark green** = ninetieth percentile (superlative)

[^] A lower rate indicates better performance.

Table 38. Improvement Incentives (PHIP Tier 2)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	NO	NO	NO	NO	YES	YES	YES	NO	YES
Ambulatory Care Visits for SSI Children (MDH)	NO	NO	NO	YES	YES	NO	NO	YES	YES
AMR: Ages 5-64	NO	NO	NO	NO	NO	NO	NO	NO	NO
COU: ≥31 days covered^	NO	NO	NO	NO	NO	NO	NO	NO	NO
GSD: Poor HbA1c Control (>9%) ^	YES	NO	YES	NO	YES	YES	YES	NO	NO
LSC	YES	YES	NO	NO	YES	NO	YES	YES	NO
PPC-CH	NO	NO	YES	NO	NO	NO	YES	NO	YES
PPC-AD	NO	NO	NO	NO	NO	YES	YES	NO	YES

Yes and Blue = Improvement; No and Gray = No Improvement

^ A lower rate indicates better performance.

Performance incentives reward MCOs for strong objective performance on each performance measure. The tables below display the financial incentives for each MCO across the specified performance measures.

Round 1. The following table shows the dollars awarded per MCO, based on Tier 1 performance incentives in MY 2024.

Table 39. MY 2024 Performance Incentive Dollars Awarded (PHIP Tier 1)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	\$0	\$0	\$41,299	\$0	\$277,451	\$57,353	\$375,235	\$0	\$149,082
Ambulatory Care Visits for SSI Children (MDH)	\$0	\$0	\$20,650	\$56,191	\$277,451	\$0	\$375,235	\$86,686	\$149,082
AMR: Ages 5-64	\$0	\$116,065	\$41,299	\$168,572	\$416,177	\$0	\$562,853	\$0	\$0
COU: ≥31 days covered^	\$0	\$0	\$0	\$112,381	\$0	\$57,353	\$0	\$0	\$149,082
GSD: Poor HbA1c Control (>9%)^	\$33,237	\$174,097	\$41,299	\$112,381	\$277,451	\$114,705	\$187,618	\$0	\$0
LSC	\$66,474	\$116,065	\$61,949	\$168,572	\$277,451	\$114,705	\$375,235	\$173,372	\$447,247
PPC-CH	\$33,237	\$174,097	\$20,650	\$168,572	\$416,177	\$0	\$375,235	\$86,686	\$149,082
PPC-AD	\$66,474	\$174,097	\$61,949	\$168,572	\$138,726	\$114,705	\$375,235	\$0	\$298,165
TOTAL:	\$199,422	\$754,421	\$289,094	\$955,239	\$2,080,886	\$458,820	\$2,626,647	\$346,743	\$1,341,741

Red = < fiftieth percentile (no incentive); Yellow = fiftieth to seventy-fourth percentile (strong); Light green = seventy-fifth to eighty-ninth percentile (very strong); Dark green = ninetieth percentile (superlative)

^ A lower rate indicates better performance.

Table 40. MY 2024 Improvement Incentive Dollars Awarded (PHIP Tier 2)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	\$0	\$0	\$0	\$0	\$138,726	\$57,353	\$187,618	\$0	\$149,082
Ambulatory Care Visits for SSI Children (MDH)	\$0	\$0	\$0	\$56,191	\$138,726	\$0	\$0	\$86,686	\$149,082
AMR: Ages 5-64	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
COU: ≥31 days covered^	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
GSD: Poor HbA1c Control (>9%)^	\$33,237	\$0	\$20,650	\$0	\$138,726	\$57,353	\$187,618	\$0	\$0
LSC	\$33,237	\$58,032	\$0	\$0	\$138,726	\$0	\$187,618	\$86,686	\$0
PPC-CH	\$0	\$0	\$20,650	\$0	\$0	\$0	\$187,618	\$0	\$149,082
PPC-AD	\$0	\$0	\$0	\$0	\$0	\$57,353	\$187,618	\$0	\$149,082
TOTAL	\$66,474	\$58,032	\$41,299	\$56,191	\$554,903	\$172,058	\$938,088	\$173,372	\$596,329

Yes and Blue = Improvement; No and Gray = No Improvement

^ A lower rate indicates better performance.

Conclusion

PHIP is an incentive program designed to provide a financial reward to MCOs based on performance within certain measures, including both identified HEDIS measures and MDH-developed encounter measures. Round 1 is based on a two-tier review, looking at MCO performance and improvement within identified measures.

All nine MCOs received a Round 1, Tier 1 performance incentive and a Round 1, Tier 2 improvement incentive. No MCO received a Round 2 incentive. The remaining funds have been credited to a non-lapsing fund.

Table 41. MY 2024 Round 1 Incentive Award Summary (PHIP Tier 1 & Tier 2)

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Tier 1 – Performance Incentives	\$199,422	\$754,421	\$289,094	\$955,239	\$2,080,886	\$458,820	\$2,626,647	\$346,743	\$1,341,741	\$9,053,013
Tier 2 – Improvement Incentives	\$66,474	\$58,032	\$41,299	\$56,191	\$554,903	\$172,058	\$938,088	\$173,372	\$596,329	\$2,656,746
TOTAL INCENTIVES FOR ROUND 1	\$265,896	\$812,454	\$330,393	\$1,011,429	\$2,635,788	\$630,878	\$3,564,735	\$520,115	\$1,938,070	\$11,709,759
Maximum Possible Incentives from Round 1	\$797,688	\$1,392,778	\$495,590	\$1,348,572	\$3,329,417	\$1,376,461	\$4,502,823	\$2,080,461	\$3,577,976	\$18,901,766
Proportion of Potential Round 1 Incentives Earned	33%	58%	67%	75%	79%	46%	79%	25%	54%	62%

Summary. After Round 1 incentives were earned, \$7,192,007 of the total available incentive funding remained unallocated. Because no MCO qualified for Round 2 incentives, no Round 2 payments were made. MDH credited this remaining amount to a non-lapsing fund.

Table 42. MY 2024 Round 1 and Round 2 Incentives Awarded (PHIP Summary)

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Round 1 – Performance (Tier 1)	\$199,422	\$754,421	\$289,094	\$955,239	\$2,080,886	\$458,820	\$2,626,647	\$346,743	\$1,341,741	\$9,053,013
Round 1 – Improvement (Tier 2)	\$66,474	\$58,032	\$41,299	\$56,191	\$554,903	\$172,058	\$938,088	\$173,372	\$596,329	\$2,656,746
TOTAL INCENTIVES FOR ROUND 1	\$265,896	\$812,454	\$330,393	\$1,011,429	\$2,635,788	\$630,878	\$3,564,735	\$520,115	\$1,938,070	\$11,709,759
Round 2	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Incentives (Round 1 and Round 2)	\$265,896	\$812,454	\$330,393	\$1,011,429	\$2,635,788	\$630,878	\$3,564,735	\$520,115	\$1,938,070	\$11,709,759
Percent of 2024 Capitation Earned as Incentives	0.08%	0.15%	0.17%	0.19%	0.20%	0.11%	0.20%	0.06%	0.14%	0.15%

Quality Strategy Highlights

MDH set task goals for the following HEDIS measures in the HealthChoice Quality Strategy for 2022-2024 based on pre-COVID-19 public health emergency aggregate performance. Quality Strategy targets for the MDH-developed measures are currently in development. Specific HealthChoice performance metrics and targets are shown in the following table.

Table 43. MY 2024 Maryland Reportable Rate Against Quality Strategy Targets

Performance Measures	MDH Quality Strategy Targets for MY 2024	Maryland Average Reportable Rate (MARR)
AMR: Ages 5-64	70.6%	70.61%
COU: ≥31 days covered*	1.9%	3.40%
GSD: Poor HbA1c Control (>9%)*	36.9%	30.66%
LSC	82.8%	77.68%
PPC-CH	88.2%	89.48%
PPC-AD	81.3%	85.60%

Source: [HealthChoice Quality Strategy 2022-2024](#) and [MetaStar's MY 2024 HEDIS Statewide Executive Summary Report](#)

*A lower rate indicates better performance.

- Four of the six measures met or outperformed the quality strategy target for MY 2024; Asthma Medication Ratio: Ages 5-64 (70.61%), Glycemic Status Assessment for Patients with Diabetes: Poor HbA1c Control (>9%) (30.66%), Prenatal and Postpartum Care: Timeliness of Prenatal Care (89.48%), and Prenatal and Postpartum Care: Postpartum Care (85.60%).
- The Continued Opioid Use: ≥31 days covered measure (3.40%) did not meet the quality strategy target by 1.5 percentage points as a lower rate for this measure indicates better performance.
- The Lead Screening in Children (77.68%) measure fell below the quality strategy target by 5.12 percentage points.

Quality, Access, and Timeliness

MCOs must ensure that HealthChoice Program enrollees receive high-quality care that increases access to timely services and promotes desired health outcomes. Qlarant identified strengths, improvements, and recommendations summarizing aggregate performance across MCOs, based on PHIP validation activity results. These strengths, improvements, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees.

For MY 2024, the Glycemic Status Assessment for Patients with Diabetes: Poor HbA1c Control (>9%) and Lead Screening in Children measures demonstrated improved performance by most MCOs compared to the other measures. Tier 1 Performance Incentives were awarded to each MCO, ranging from a total of three measures (UHC) to a total of seven measures (JMS, KPMAS, MPC, and PPMCO). All MCOs received a Tier 1 Performance Incentive for the Lead Screening in Children measure. Additionally, Tier 2 Improvement Incentives were awarded to each MCO, ranging from a total of one measure (CFCHP and KPMAS) to a total of five measures (PPMCO).

Additional Information

For additional findings and comprehensive details associated with the MY 2024 PHIP validation, please access the link to the MY 2024 PHIP Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the PHIP validation related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Systems Performance Review

Objective

Conducting SPR provides an annual assessment of the structures, processes, and outcomes of each MCO's internal quality assurance program. Healthcare professionals with experience in managed care and quality improvement systems performed the annual SPR. Team members utilized a combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice. Qlarant's review team identifies, validates, quantifies, and monitors problem areas; and distinguishes and promotes best practices through compliance or systems review. MDH receives an independent assessment of MCO capabilities through the SPR, which can be used to promote accountability and improve quality-related processes and monitoring. MY 2024's SPR applied the system performance standards defined for MY 2024, and reviewed a sample of appeal, grievance, adverse determination, and credentialing records to assess compliance with applicable standards.

Methodology

Review Activities. MY 2024's comprehensive review activities included a pre-audit overview and survey, a comprehensive review, exit letters, reporting, and corrective action plans (CAPs).

- **Pre-audit Overview and Survey.** COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. Performance standards used to assess the MCOs' operational systems were developed through a review of COMAR 10.67.04.03B(1), federal regulations, and guidelines from other quality assurance accrediting bodies, such as the NCQA. Qlarant finalized the SPR standards for the orientation manual after considering all comments from each MCO's review of the draft standards and MDH's review and approval. MCOs were required to submit a completed pre-audit survey form and provide documentation, written plans, and policies and procedures for various processes, such as quality assurance and governance, delegation of activities, credentialing and recredentialing, enrollee rights, availability and accessibility, utilization review, continuity of care, health education, outreach, and fraud and abuse. MCOs demonstrated efficiency of their healthcare systems by providing written

documentation, committee minutes, work plans, reports, and other procedures identifying continuous quality improvement efforts undertaken by each MCO for these processes. Qlarant's SPR team reviewed documents provided prior to the comprehensive site review.

- **Comprehensive Reviews.** Comprehensive reviews are conducted as site reviews. Virtual reviews were an optional choice to in-person visits to each MCO's office of choice. Structured interviews with key MCO staff and a review of all relevant documentation needed to assess the standards occurred during the site visit. An exit conference with the MCO concluded the site visit to provide preliminary findings based on interviews and all documentation reviewed. Qlarant notified each MCO that an exit letter was forthcoming for all elements and components not meeting minimum compliance.
- **Exit Letters.** Each MCO received finalized exit letters sharing areas of noncompliance based on initial conclusions of Qlarant's SPR review team, and indicated, as necessary, a request for additional information not provided during the comprehensive review. After receiving the exit letter, the MCOs had the opportunity to submit any additional documentation to Qlarant.
- **Reports.** Additional documents received from the MCO in response to the exit letter were reviewed against the standard(s) to which they related. Qlarant made appropriate revisions to each MCO's draft report, documented findings and levels of compliance for each standard by element and component, and submitted draft results of the SPR to MDH for review. Upon MDH's approval, MCOs received a final report containing individual review findings and any required CAPs. Feedback provided to MDH and the MCOs sought to improve the care provided to HealthChoice enrollees.
- **CAPs.** After receiving the final report, each MCO responded to Qlarant with the required CAP(s). Each MCO had the opportunity to respond to any other issues contained in the report, request a consultation to clarify issues, or ask for technical assistance in preparing a CAP. Qlarant evaluates the content of all CAPs and determines a CAP adequate only if it addresses all required elements and components (such as timelines, action steps, or documented evidence).

Data Collection and Review. Documentation provided by the MCOs included policies and procedures; meeting minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; HEDIS and CAHPS results; operational performance reports; enrollee handbooks and materials; provider manuals, directories, and newsletters; and grievance, appeal, and adverse determination records.

Each element and component received a review determination for meeting compliance with performance standards (*Met* or *Met with Opportunity*) or for required CAPs because of not meeting compliance with performance standards (*Partially Met* or *Unmet*). Each element or component was provided equal weight. MCOs were held accountable for standards in their policies and procedures that were more restrictive than what was required by MDH. MDH had the discretion to change a finding to *Unmet* if the element or component received a *Partially Met* finding for more than one consecutive year.

Table 44. MY 2024 Validation Review Determinations (SPR)

Determination Category	Review Determination and Criteria
Performance Evaluation Status	Met (M). MCO achieved compliance with all requirements and scored minimum compliance with performance standards relating to grievances, appeals, and denials (95%) or minimum compliance for all other performance standards (100%).
	Met with Opportunity (MwO). MCO achieved compliance with requirements but demonstrated an opportunity to improve; CAP is not required.
	Partially Met (PM). Qlarant required a CAP from MCO.
	Unmet (UM). Qlarant required a CAP from MCO.
Review Inclusion Status	Baseline (B). Qlarant reviewed, but did not score the component, element, or standard.
	Deemed (D). Qlarant did not review the component, element, or standard as the MCO scored minimum compliance (100%) on the applicable NCQA standards.
	Not Applicable (NA). Qlarant did not review, as the component was not applicable.

Non-duplication Deeming. CMS permits states the opportunity to use information from a private accreditation review, such as an NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming. Non-duplication, as described in EQR protocols and 42 CFR §438.360, is intended to reduce administrative burden on the MCOs. This process eliminates the need to review the deemed regulation as part of the SPR, thus reducing the administrative burden on the MCO. To qualify for deeming, MDH established the following criteria:

- The MCO must be NCQA accredited with Health Plan Accreditation.
- The NCQA accreditation review standards were comparable to applicable standards established through EQR protocols.
- The MCO must provide evidence of the most recent NCQA audit, which includes a 100% assessment of the applicable standards.

Qlarant used the following resource to determine qualifications for deeming: NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards*² (Effective July 1, 2023, through June 30, 2024). [Appendix B](#) provides a crosswalk of the SPR standards in which MDH permitted deeming for MY 2024's comprehensive review.

Timeline. MY 2024's SPR timeline started in August 2024 by providing MCOs an opportunity to review and comment on standards, laws, and regulations applying to the upcoming review. Any comments forwarded from MCOs during their 45-day comment period were considered before submission of the "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" in September 2024. Site visits occurred from January through March 2025. After receiving exit letters at the conclusion of the site visits, MCOs had 10 business days to submit

² National Committee for Quality Assurance. (2023). *Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards*. Retrieved from the NCQA store.

any additional information. MCOs received final reports after MDH approved Qlarant's draft reports. Any required CAPs were due within 45 days of receiving final reports. Continued technical assistance occurred until the MCO submitted an acceptable CAP, if necessary.

Results

The following tables identify MCO performance resulting in opportunities for improvement and/or requiring corrective action before MY 2024's SPR across structural and operational standards.

Trending Analysis

Comprehensive Trending Analysis – Aggregate Scores. Maryland HealthChoice scores have remained consistent from MY 2018 to MY 2024 for Standards 1 and 8. There has been improvement demonstrated for Standards 2, 3, 4, 5, 6, 7, and 11, as well as consistent improvement in the HealthChoice composite score. Standard 9 had a slight decrease from MY 2018 to MY 2024, and Standard 10 had a slight decrease from MY 2018 to MY 2021; however, improved in MY 2024.

Table 45. HealthChoice Aggregate Scores At-A-Glance (SPR)

Standard	MY 2018	MY 2021	MY 2024
1: Systematic Process of Quality Assessment and Performance Improvement	100%	100%	100%
2: Accountability to the Governing Body*	93%	NA	97%
3: Oversight of Delegated Entities and Subcontractors	88%	95%	100%
4: Credentialing and Recredentialing	99%	99%	100%
5: Enrollee Rights	91%	96%	98%
6: Availability and Accessibility	86%	99%	100%
7: Utilization Review	93%	94%	95%
8: Continuity of Care	100%	100%	100%
9: Health Education Plan*	100%	NA	97%
10: Outreach Plan	100%	99%	100%
11: Fraud and Abuse	94%	98%	99%
12: Disenrollment Requirements and Limitations	NA	NA	BASILINE REVIEW
Composite Score	97%	98%	99%

NA – Not Applicable

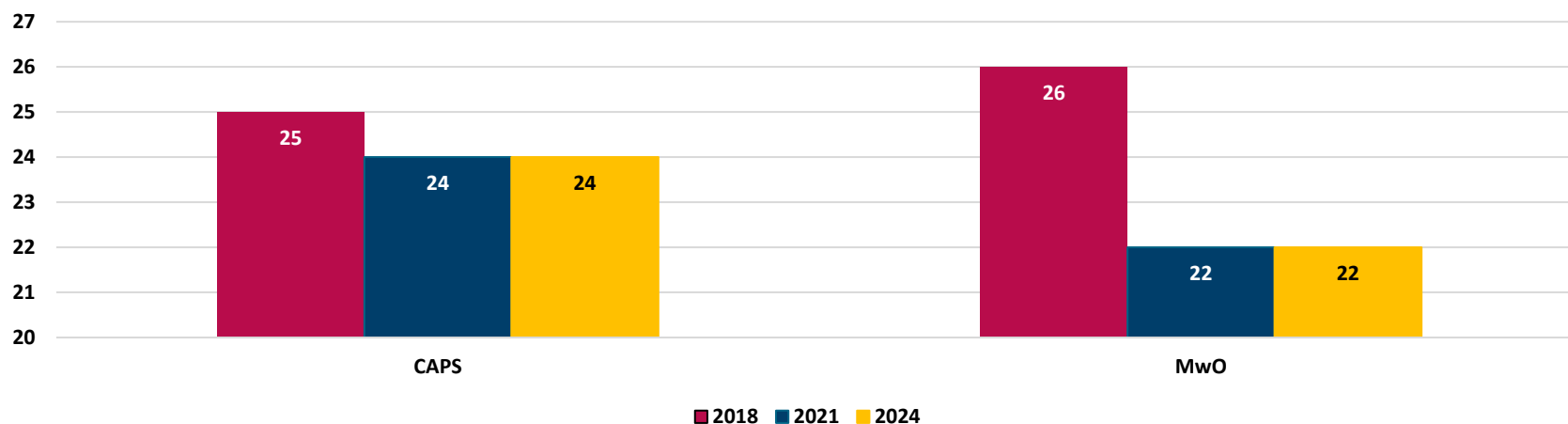
*Standards 2 and 9 were exempt from the MY 2021 SPR due to 100% MCO compliance in previous SPRs and were reviewed in the MY 2022 interim SPR.

Standard 12 (Disenrollment) was previously monitored by the State of Maryland and introduced to Qlarant's EQR review as a Baseline Review in MY 2024.

Comprehensive Trending Analysis – CAPs and MwOs. Trended results for the last three comprehensive reviews (MY 2018, MY 2021, and MY 2024) illustrate that the number of CAPs decreased from 25 to 24 CAPs across the MCOs. It should be noted that while the number of CAPs

decreased, the amount of *MwO* findings remained consistent across the MCOs (22), when MY 2024 is compared to MY 2021; and decreased by four when compared to MY 2018.

Figure 6. Three-Year Comprehensive Trending of CAPs and MwOs



Compliance Across Standards

Standards without Required Corrective Action or Recommended Improvements. All MCOs met the compliance score of 100% for Standard 6: Availability and Accessibility and Standard 10: Outreach Plan. No CAPs were required for Standard 12: Disenrollment Requirements and Limitations, as this standard was reviewed as a baseline year for all MCOs. Standard 12 will be reviewed and scored in the MY 2025 interim review.

Standards with Required Corrective Action and Recommended Improvements. *Standards with Recommended Improvements Only:* All MCOs met the compliance score for Standard 1: Systematic Process of Quality Assessment and Performance Improvement, Standard 3: Oversight of Delegated Entities and Subcontractors, and Standard 8: Continuity of Care; however, Qlarant identified recommendations for improvement for several MCOs within these standards. PPMCO received *MwO* findings for three standards (Standard 1, 3, and 8), while MPC received a *MwO* finding for one standard (Standard 8). ***Standards with Required Corrective Action Only.*** Standard 2: Accountability to the Governing Body and Standard 4: Credentialing and Recredentialing both required corrective action based on *PM* or *UM* findings. MSFC received *UM* findings in Standard 2, while ABH received *PM* findings in Standard 4. ***Standards with Mixed Results.*** Four standards (Standard 5: Enrollee Rights, Standard

7: Utilization Review, Standard 9: Health Education Plan, and Standard 11: Fraud and Abuse) received a mix of *PM*, *UM*, and *MwO* findings. Eight MCOs (excluding JMS) are required to submit CAPs based on *PM* findings and five MCOs received *MwO* findings for Standard 5. For Standard 7, seven MCOs (ABH, CFCHP, KPMAS, MSFC, PPMCO, UHC and WPM) are required to submit annual CAPs, with quarterly CAPs required for two MCOs (CFCHP and WPM) for multiple years of not meeting requirements to improve. CFCHP has not met requirements for 7.7c for 2 consecutive years and 7.7e for 3 consecutive years. WPM has not met requirements for 7.7c for 3 consecutive years. Seven MCOs (excluding JMS and UHC) received *MwO* findings for Standard 7. Four MCOs (KPMAS, MSFC, UHC, and WPM) are required to submit CAPs and three MCOs (ABH, MPC, and PPMCO) received *MwO* findings for Standard 9. Three MCOs are required to submit CAPs based on *PM* findings (KPMAS, UHC, and WPM) and three MCOs (CFCHP, UHC, and WPM) received *MwO* findings for Standard 11.

The following table reflects required quarterly or annual CAPs and identified *MwO* findings across all standards.

Table 46. MY 2024 MCO Opportunity Findings (SPR)

MCO	MwO	Annual CAPs	Quarterly CAPs
ABH	7.2e, 7.7a, 7.8a, 7.9c, 7.10, and 9.5c	<i>PM</i> : 4.4j, 5.1d and 7.4c	Not Applicable
CFCHP	7.4c, 7.6a, and 11.4c	<i>PM</i> : 5.1g, 7.1c, 7.3a, 7.3b, 7.5b, and 7.7a <i>UM</i> : 7.3c	<i>UM</i> : 7.7c and 7.7e
JMS	5.8d	Not Applicable	Not Applicable
KPMAS	5.7a, 7.4c, 7.6a, 7.8b, and 7.9c	<i>PM</i> : 5.1d, 7.10, 9.3a, and 11.4c	Not Applicable
MPC	5.1a, 7.4c, 7.6a, 7.11a, 8.6, and 9.3a	<i>PM</i> : 5.1g	Not Applicable
MSFC	7.4c	<i>PM</i> : 5.1g, 7.8c, 7.9b, and 9.3a <i>UM</i> : 2.1, 2.5, and 9.1a	Not Applicable
PPMCO	1.2b, 3.3a, 7.3c, 7.5b, 7.8c, 7.9a, 8.6, and 9.3a	<i>PM</i> : 5.1d, 5.1g, 5.1h, 7.4c, 7.6b, and 7.9b	Not Applicable
UHC	5.1d and 11.4c	<i>PM</i> : 5.1g, 5.1h, 7.4c, 7.7e, 7.8b, 7.8c, 9.3a, and 11.4d	Not Applicable
WPM	5.1c, 5.1g, 7.3a, 7.3b, 7.6a, 7.8c, and 11.4d	<i>PM</i> : 5.1d, 7.2e, 7.3c, 7.4c, 7.6b, 7.8a, 7.9c, 9.3a, and 11.4c	<i>UM</i> : 7.7c

Red indicates quarterly updates on the CAP are required per MDH's Performance Monitoring Policy

PM = Partially Met; *UM* = Unmet

Conclusion

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of healthcare services to managed care enrollees.

JMS received a finding of *Met* for all standards reviewed.

MCO Compliance

The following tables compare SPR results across MCOs and the HealthChoice aggregate and identify recommended CAP closures, as compliance was achieved during the MY 2024 review.

Table 47. MY 2024 MCO and HealthChoice Aggregate Results (SPR)

Standard	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
1: Systematic Process of Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2: Accountability to the Governing Body	100%	100%	100%	100%	100%	71%	100%	100%	100%	97%
3: Oversight of Delegated Entities and Subcontractors	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4: Credentialing and Recredentialing	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%
5: Enrollee Rights	99%	99%	100%	99%	99%	99%	96%	97%	99%	98%
6: Availability and Accessibility	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
7: Utilization Review	99%	84%	100%	99%	100%	97%	96%	94%	89%	95%
8: Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
9: Health Education Plan	100%	100%	100%	96%	100%	88%	100%	96%	96%	97%
10: Outreach Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
11: Fraud and Abuse	100%	100%	100%	98%	100%	100%	100%	98%	98%	99%
12: Disenrollment Requirements and Limitations	B	B	B	B	B	B	B	B	B	B
Composite Score	99%	97%	100%	99%	100%	98%	99%	98%	98%	99%
CAPs Required	3	2	0	4	1	4	2	4	4	24

Red represents a score below the required compliance score (100%) and requires a CAP.

B = Baseline Standard; score was not calculated.

All scores are rounded to the nearest whole number.

Table 48. MY 2024 Recommended CAP Closures (SPR)

MCO	Standard	Element or Component	SPR Requirements
CFCHP	7	8c	Turnaround timeframe compliance for written acknowledgement and written resolution of provider appeals, at or above the MDH-established compliance score of 95%.
KPMAS	7	8c	Demonstrate compliance with written acknowledgement of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of review period.
MPC	7	7c	Compliance with expedited appeal resolution notification at or above the MDH-established core of 95% on at least a quarterly basis throughout the MY.

Quality Strategy Highlights

MDH set goals and objectives in the [HealthChoice Quality Strategy 2022-2024](#) to ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities and increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024. Results of the MY 2024 SPR demonstrate that the HealthChoice aggregate met MDH's goal/objective in six of the eleven standards. The remaining five standards scored just below the compliance threshold, between 95% to 98%.

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, and recommendations summarizing aggregate performance across MCOs, based on the results of the MY 2024 SPR. These strengths, improvements, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024's SPR:

- MCOs demonstrate **quality** by their ability to demonstrate accountability; assess and improve performance for systems review standards; and ensure enrollee needs and rights are being met in accordance with systems review standards and MCO-specific policies, procedures, and processes.
- MCOs demonstrate **timeliness** by providing evidence of consistent assessment and performance improvement efforts related to systems review standards.
- MCOs demonstrate **access (or accessibility)** by providing evidence of compliance for Standard 6: Availability and Accessibility.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2024 SPR and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

Table 49. MY 2024 Strengths, Improvements, and Recommendations (SPR)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access	Strengths: All MCOs demonstrated the ability to design and implement effective quality assurance systems.	↑
Quality, Access	Improvements: All MCOs continue to make improvements in quality assurance monitoring policies, procedures, and processes while working to provide appropriate levels and types of healthcare services to managed care enrollees.	↑
Quality	Recommendations: All MCOs requiring a CAP received recommendations that, if implemented, should improve performance for future reviews.	↑

Green and ↑ = Domain experienced a positive impact from MCOs' performance.

Additional Information

For additional findings and comprehensive details associated with the MY 2024 SPR, please access the link to the MY 2024 SPR Statewide Executive Summary Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the SPR related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Network Adequacy Validation

Objective

In February 2023, CMS issued a new EQR protocol to assess MCO compliance with state and federal network adequacy standards: [Protocol 4, Validation of Network Adequacy](#). This new protocol states that MCOs must maintain provider networks that are sufficient to provide timely and accessible care to Medicaid enrollees across the continuum of care. Prior to implementation of CMS Protocol 4, MDH elected to conduct focused validation activities to assess network adequacy through revealed shopper telephone surveys and online provider directory validations. However, in May 2024, CMS issued the [Medicaid Program; Medicaid and Children's Health Insurance Program \(CHIP\) Managed Care Access, Finance, and Quality Final Rule \(CMS-2439-F; RIN 0938-AU99\)](#); this rule indicates that states must implement a secret shopper program and secret shopper provider directory validation by July 10, 2028. MDH is currently working towards the implementation of these new requirements by planning for the transition from a revealed shopper survey to a secret shopper survey.

Methodology

Description of Data Obtained

Description of Data Obtained for Both Standards. To determine how each MCO measures these metrics, Qlarant sent a brief survey to obtain detailed information, including MCO-source data and supporting documentation, regarding how the MCO conducts NAV and their processes.

To complete the NAV activity, Qlarant requested and validated the data files and documentation identified in the table below.

Table 50. Data and Documentation Obtained (NAV)

Source	Content Descriptions
MY 2024 NAV Questionnaire	- Processes for managing enrollee and provider data for network adequacy - Processes for calculating provider-to-enrollee ratios for network adequacy - Processes in monitoring time and distance standards for network adequacy - Additional data sources included in network adequacy assessment activities
MY 2024 MCO Provider Network Data File	- Provider name - Provider National Provider Identifier (NPI) - Provider specialty type - Primary care provider designation - Accepting new patient designation - Provider full address - Plan effective date
MY 2024 Provider Network Data Dictionary	Contents of the request files and possible values for each field
MY 2024 Enrollment Data file	- Enrollee name - Enrollee date of birth - Enrollee address - Enrollee gender - Enrollee plan type
MY 2024 Enrollment Data Dictionary	Contents of the request files and possible values for each field
Analysis Plan to Calculate Network Adequacy	Descriptions of analysis and calculation processes

Source	Content Descriptions
MY 2024 Network Adequacy Measure: Provider-to-Enrollee Ratio Report	• Software exports displaying the results of provider-to-enrollee ratio
MY 2024 Network Adequacy Measure: Provider-to-Enrollee Ratio Supporting Documentation	• Granted exemptions for MCOs to maintain a provider-to-enrollee ratio greater than regulation
MY 2024 Network Adequacy Measure: Time and Distance Report	• Software exports displaying the results of time and/or distance results
MY 2024 Information Systems Capabilities Assessment (ISCA)	• Claims and encounters data processing • Enrollment and provider data processing • Performance measure production • Requested documents

In total, there were two indicators identified for validation for provider-to-enrollee ratios and 75 indicators identified for validation for time and distance standards for all MCOs except for JMS. JMS had a total of 50 indicators identified for time and distance standards due to rural areas being outside of their coverage area.

Provider-to-Enrollee Ratios. Qlarant evaluated the NAV processes conducted by each MCO for provider-to-enrollee ratios. Due to the variances in how MCOs conduct network adequacy by provider type, Qlarant reviewed the different provider types based on COMAR 10.67.05.05 to analyze the MCOs' network adequacy processes and evaluate the following provider type indicators:

- Primary Care Provider (PCP)
- Obstetrics (OB)/Gynecology (GYN)
- Core Specialties
- Major Specialties
- Pediatric Specialties
- Other Specialties not listed in COMAR

Time and Distance Standards. Qlarant evaluated the NAV processes conducted by each MCO for time and distance standards. Due to variances in how MCOs conduct network adequacy by provider type, Qlarant reviewed the different provider types based on COMAR 10.67.05.05 and the three time and distance standards for each provider type to analyze the MCOs' NAV processes for geographic location categories (rural, urban, and suburban).

Telephone Surveys and Provider Directory Validations. Qlarant requested and received a list of contracted PCPs from each MCO. Qualifying providers for MY 2025 specialized in one of the following areas: primary care, adult medicine, internal medicine, general practice, family medicine, or pediatrics. Qlarant instructed MCOs to submit the following information for each PCP:

- NPI;
- First and Last Name;
- Credentials;
- Provider type (MCO confirmed PCP status);
- Provider specialty;
- Practice location (address, suite, city, town, state, and zip); and
- Telephone number.

Qlarant also requested the uniform resource locator (URL) link enrollees use to access each MCO's online provider directory.

Sample for Both Activities Assessing Telephone Surveys and Provider Directories. MCOs provided lists for PCPs contracted in contiguous states to Maryland (Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia). Listings included 116 PCPs from contiguous states:

- Delaware (32)
- District of Columbia (69)
- Pennsylvania (1)
- Virginia (4)
- West Virginia (10)

The HealthChoice program network has 18,519 contracted PCPs across all nine MCOs. Each PCP can only be sampled once for each MCO; therefore, if a PCP of a different name, but the same address, was included in the MCO's sample, it was replaced with a different PCP, when possible, to meet sample size. This practice increased the number of unique PCPs in the sample for each MCO. PCPs with the same NPI number who are providing services at other practice locations (different addresses), as submitted by the MCOs, were not removed as duplicates from the sample. A total of 6,175 of the contracted PCPs across MCOs displayed a unique address.

A random sample, based on the number of contracted PCPs with unique addresses, was selected for each MCO using a 90% confidence level and a 5% margin of error. The table below shows the total number of contracted PCPs per MCO and unique PCPs by address, and the respective sample size. The final sample included 2,060 PCPs.

Table 51. MY 2025 Contracted PCPs and Sample Size by MCO (NAV)

PCP Sample	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Contracted PCPs (#)	1,252	3,854	1,009	388	2,453	2,087	3,817	1,685	1,974	18,519
Unique PCPs by Address (#)	703	1,222	252	60	849	536	1,024	731	798	6,175
Sample Size (90% CL +/- 5%)	223	253	214	160*	244	240	253	234	239	2,060

*Due to KPMAS' PCP model structure, unique addresses were selected when possible.

Confidence level (CL)

Data Analysis

Provider-to-Enrollee Ratios and Time and Distance Standards. Qlarant reviews each MCO's submitted ISCA, associated HEDIS Roadmap documentation, and Final Audit Report (FAR), if any, for accreditation. Qlarant reviews a complete provider directory and enrollment file with relevant fields submitted by the MCOs. Qlarant meets with the MCOs and discusses the methodology implemented to monitor network adequacy. Qlarant synthesizes findings and completes the scoring worksheet in Protocol 4 (4.6). Worksheet 4.6 comprises the results of reviewing the ISCA, the processes employed by the MCO in monitoring network adequacy, and the results of Qlarant's review and validation of submitted data. Lastly, Qlarant completes spot checks on a subset of data to evaluate the MCOs' overall process and use of software for the process.

Worksheet 4.6 has three parts and focuses on specific elements of the validation process. The first section, "Assessment of Data Collection Procedures," describes Qlarant's findings from review of the ISCA and submitted documentation. The second section, "Assessment of MCO Network Adequacy Methods," describes Qlarant's findings of the submitted documentation related specifically to network monitoring and interviews with the MCOs. The third section, "Assessment of MCO Network Adequacy Results," describes Qlarant's validation process of the MCOs' results. The questions are scored and provided with a corresponding confidence level. If MCOs achieved a score of less than 100%, Qlarant provided information identifying any possible issues discovered in the data or an analytic process.

Following the review of submitted documentation from the MCOs, virtual site reviews were held with each MCO to resolve any outstanding questions. At the conclusion of the site reviews, Qlarant conducted a systematic review of the data sources to ensure all data variables needed for network adequacy monitoring were included. Qlarant reviewed each MCO's data collection, data processes, and data analyses to determine how well the health plan's work aligned with state regulations. To determine if each MCO's results were valid, accurate, and reproducible, a random selection of one or two provider types was obtained for partial replication. Qlarant completed the Protocol 4 Worksheet 4.6 to determine a validation score from 0% to 100% for each indicator. Each validation score corresponds with a validation rating. The validation rating determined which confidence level was assigned to each MCO's individual indicator, ranging from *No Confidence* to *High Confidence*.

MCOs were scored according to the questionnaires from Worksheet 4.6. Each score is converted to a validation rating, as identified in the table below.

Table 52. MY 2024 Validation Review Determinations (NAV)

Validation Score	Validation Rating
90.0% or greater	High Confidence
51.0% to 89.9%	Moderate Confidence
10.0% to 50.9%	Low Confidence
Less than 10%	No Confidence

States are required to set quantitative network adequacy standards to account for regional factors and the needs of Medicaid populations. MDH has outlined quantitative network adequacy standards within COMAR regulations, outlined in the [Results](#) section.

Telephone Surveys and Provider Directory Validations. Responses to the survey questions were documented in the survey tool and stored electronically on Qlarant’s secure, web-based portal. MY 2025’s analysis included:

- **Data Collection Analysis.** Qlarant assessed each MCO’s submission of requested information for completeness. Corrections were requested if issues regarding incomplete data, non-PCPs included in the listings, or incomplete telephone numbers were identified.
- **Telephone Survey Analysis.** Telephone surveys were evaluated by two review determinations: *successful* and *unsuccessful*; their criteria follow.

Table 53. MY 2025 Validation Review Determinations (NAV)

Review Determination	Criteria
Successful	• Surveyor reached the PCP within three call attempts and completed the survey. • Successful telephone surveys were validated against the details noted in each MCO’s online directory. If the PCP was not in the MCO’s online directory, the validation survey ended.
Unsuccessful	Reasons for unsuccessful surveys fall within two categories, “No Contact” and “PCP Response,” with qualifying circumstances for each. • “No Contact” unsuccessful surveys included calls in which the surveyor could not reach the PCP due to the number not reaching the intended provider (e.g., wrong number, office closed, or provider not with practice); no answer; reached voicemail; or hold time exceeded five minutes. • “PCP Response” unsuccessful surveys included calls that ended after the initial communication with a respondent for wrong location listed for the provider (provider was not with the practice or did not practice at that location); provider not being a PCP; PCP not accepting the listed MCO; or practice refusing to participate.
Compliance Score	MDH established the minimum compliance score for MY 2025 as 80%.

Key elements of the MY 2025 activity, broken down by the telephone survey and provider directory validation portions, follow. Survey questions and activities within the provider directory validation are identified in the table below.

Table 54. MY 2025 Summary of Activities (NAV)

MY 2025 Activities	Assessment
Telephone Survey	Telephone surveys solicited responses to verify PCP information, including: • Name and address of PCP • Provider acceptance of the listed MCO and new Medicaid enrollees

MY 2025 Activities	Assessment
	Routine and urgent care appointment availability
Validation of Network Adequacy Step 1	Verify information obtained during the ten-question telephone survey matched information provided by the MCO: - PCP address - PCP phone number
Validation of Network Adequacy Step 2	Verify the MCOs' provider directories matched the following information for PCPs in the sample provided during the telephone surveys: - Status of accepting new Medicaid patients - Ages served by the PCP - Languages spoken by the PCP - Availability of accommodations for disabled patients and identified specific Americans with Disabilities Act of 1990 (ADA)-specified equipment.

Qlarant's subcontractor, Global Executive Staffing, conducted MY 2025 survey activities for each PCP in the sample. MY 2025 orientation training for surveyors and validators included:

- In-depth instruction by subject matter experts on the survey tool;
- Mock scenarios of survey calls and data entry;
- Inter-rater reliability testing;
- Updates on provider directory validation tools; and
- Follow-up education, as necessary.

Surveyors conducted and documented at least three call attempts unless the surveyor reached a wrong number or if the office was found to be permanently closed. Surveyors confirmed wrong PCP telephone numbers by calling the telephone number twice; if the call resulted in a wrong number or the office was permanently closed, the survey ended. If the first call attempt resulted in no contact with a live respondent, surveyors attempted to call again on another day and time. Surveyors ended the call on the third attempt if they were prompted to leave a message, were on hold for more than five minutes, or had no answer.

To ensure quality survey and validation results, Qlarant performed quality checks and weekly oversight meetings with Global Executive Staffing's lead surveyor to review the following topics:

- Quality assurance activities;
- Progress reports;

- Surveyor/validator assignments; and
- Correction of data collection issues.

CAPs. CAPs are required for MCOs that score below the MDH-established threshold. CAPs are reviewed by MDH and Qlarant and are determined to be adequate if they address the following required elements and components:

- Action item(s) to address each requirement;
- Methodology for evaluating the effectiveness of actions taken;
- Timeframe for evaluating each action item, including plans for evaluation; and
- Responsible party for each action item.

Timeline. Qlarant’s analysis of MCOs’ NAV activities for the January 1 to December 31, 2024, measurement year, for provider ratios and time and distance standards, was conducted from August to October 2025. MCOs submitted completed ISCA and NAV questionnaires in August 2025, which were reviewed and discussed during MCO interviews in September 2025.

MY 2025 NAV telephone survey and provider directory validation activities were conducted from June to August 2025. Surveys were conducted on weekdays during normal business hours from 9:00 am to 5:00 pm Eastern Standard Time. Each MCO must submit any required CAPs within 45 calendar days of receipt of the report results.

Results

Validation results are divided into sections: Provider-to-Enrollee Ratios, Time and Distance Standards, Accuracy of PCP Information, Successful Contacts, Unsuccessful Contacts, Compliance with Appointment Standards, and Provider Directory Validations.

Provider-to-Enrollee Ratios

Purpose. COMAR requires MCOs to maintain a ratio of one PCP per 200 enrollees, with a maximum limit of one provider per 2,000 enrollees. The table below identifies COMAR provider-to-enrollee ratios required by COMAR, applicable provider types, supporting documentation, and frequency used in validation activities, and which MCO(s) monitored individual provider types out of the original 21 for MY 2024. MDH does not require MCOs to monitor ratios identified as *additional*.

Monitoring Activities. MY 2024’s validations observed the following about provider-to-enrollee ratios:

- Eight MCOs (except WPM) included the two required PCPs (adult/general and pediatric providers) in the NAV process for provider-to-enrollee ratios. WPM included Pediatric PCPs and Family/General practitioner PCPs (to account for the adult/general population).
- Six MCOs (ABH, CFCHP, JMS, MPC, PPMCO, and UHC) included OB/GYN providers in the NAV processes for provider-to-enrollee ratios. Three MCOs (ABH, MSFC, and WPM) included a dedicated GYN provider category in the NAV processes for provider-to-enrollee ratios, and one MCO (MSFC) included a dedicated OB provider category in NAV processes for provider-to-enrollee ratios. Six MCOs (JMS, MPC, MSFC, PPMCO, UHC, and WPM) included a prenatal provider category in the NAV processes for provider-to-enrollee ratios. ABH included a doula category in NAV processes for provider-to-enrollee ratios, JMS included maternal and fetal medicine providers in NAV processes for provider-to-enrollee ratios, and PPMCO included Reproductive Endocrinology providers in the NAV processes for provider-to-enrollee ratios. KPMAS did not include any providers in the NAV processes for provider-to-enrollee ratios related to women's health.
- Apart from CFCHP and KPMAS, MCOs included all Core Specialists, Major Specialists, and Pediatric Specialists in the NAV processes for provider-to-enrollee ratios.
- Five MCOs (JMS, MPC, MSFC, PPMCO, and WPM) included acute inpatient hospitals in the NAV processes for provider-to-enrollee ratios.
- Five MCOs included Diagnostic Laboratory and Radiology providers and facilities in the NAV processes for provider-to-enrollee ratios. Two MCOs (MPC and MSFC) included Diagnostic Laboratory and Diagnostic Radiology separately, and three MCOs (JMS, PPMCO, and WPM) included a combined Diagnostic Laboratory and Radiology in the NAV processes for provider-to-enrollee ratios.
- Four MCOs (JMS, MSFC, PPMCO, and WPM) included pharmacies in the NAV processes for provider-to-enrollee ratios.
- Five MCOs included Hematology and Oncology in the NAV processes for provider-to-enrollee ratios. CFCHP included Hematology providers and Oncology providers separately, MSFC included only Oncology providers, two MCOs (ABH and MPC) included Hematology/Oncology providers, and JMS included Hematology/Oncology/Radiation Oncology providers.
- CFCHP included Pain Management providers in the NAV processes for provider-to-enrollee ratios.
- JMS included Plastic Surgery providers and Podiatrists in the NAV processes for provider-to-enrollee ratios.

Table 55. MY 2024 Provider-to-Enrollee Standards (NAV)

COMAR Ratios and References	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
Minimum: 1 PCP to 200 enrollees; Maximum: 1 provider to 2,000 enrollees COMAR 10.67.05.05A(5)	• General or Family practitioner • Internist • Pediatrician • OB/GYN • Physician assistant • Certified nurse midwife • Nurse practitioner ^C • Physician ^P	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	• PCP: 8 MCOs (excluding WPM) • Pediatric PCP: all MCOs • Family Medicine: CFCHP • Family Medicine/General Medicine: ABH, JMS, and WPM • Internal Medicine and Nurse Practitioner: ABH, CFCHP, and JMS • Physician Assistant: ABH • Doula: ABH

COMAR Ratios and References	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
			• GYN only: ABH, MSFC, and WPM • Maternal and Fetal Medicine: JMS • OB only: MSFC • OB/GYN: 6 MCOs (excluding KPMAS, MSFC, and WPM) • Prenatal Provider: 6 MCOs (excluding ABH, CFCHP, and KPMAS) • Reproductive Endocrinology: MPC and PPMCO
Core Specialties <i>Additional Providers</i> COMAR 10.67.05.05-1A(2)(b)	• Cardiology • Otolaryngology (ENT) • Gastroenterology • Neurology • Oncology • Ophthalmology • Orthopedics • Surgery • Urology	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	• Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, and Urology: 8 MCOs (excluding KPMAS) • Surgery: 7 MCOs (excluding KPMAS and MPC)
Major Specialties <i>Additional Providers</i> 10.67.05.05-1A(2)(c)	• Allergy and immunology • Dermatology • Endocrinology • Infectious Diseases • Nephrology • Pulmonology	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	8 MCOs review all (excluding KPMAS)
Pediatric Specialties <i>Additional Providers</i> 10.67.05.05-1A(2)(b)	• Cardiology • Gastroenterology • Neurology • Surgery	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	7 MCOs (excluding CFCHP and KPMAS)
Ancillary Facilities <i>Additional Providers</i>	• Acute Inpatient Hospitals • Diagnostic Laboratories • Diagnostic Laboratories/X-Ray	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	• Acute Inpatient Hospitals: 5 MCOs (excluding ABH, CFCHP, KPMAS, and UHC)

COMAR Ratios and References	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
	- Diagnostic Radiology - Pharmacy		Diagnostic Laboratories and Diagnostic Radiology: MPC and MSFC Diagnostic Laboratories/X-Ray: JMS, PPMCO, and WPM Pharmacy: JMS, MSFC, PPMCO, and WPM
Other Specialists <i>Additional Providers</i>	- Hematology - Hematology/Oncology - Hematology/Oncology/Radiation Oncology - Maternal and Fetal Medicine - Oncology - Pain Management - Plastic Surgery - Podiatry	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Hematology: no MCOs Hematology/Oncology: ABH and MPC Hematology/Oncology/Radiation Oncology, Maternal and Fetal Medicine, Plastic Surgery, and Podiatry: JMS Oncology: CFCHP and MSFC Pain Management: CFCHP

C - Nurse practitioner can be certified in adult, pediatric, geriatric, OB/GYN, school nurse, or family areas of specialty.

P - Physician can practice in a specialty other than those MDH-designated as PCP.

Table 56. Number of Indicators Included for MY 2024 MCO Provider-to-Enrollee Ratios (NAV)

Indicator Analysis	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Required Indicators Identified	2	2	2	2	2	2	2	2	2 [^]
Required Indicators Complying with COMAR	2	2	2	2	2	2	2	2	1[^]
Additional Indicators Identified	26	20	31	0	24	26	24	20	24
Total Indicators Identified	28	22	33	2	26	28	26	22	26
Number of Required Indicators Missing	0	0	0	0	0	0	0	0	1 [^]

[^]WPM submitted ratios for only one subgroup for PCPs.

Time and Distance Standards

Purpose. COMAR requires MCOs to have a physical location accessible to enrollees that meets time or distance requirements. Time and distance standards are based on the geographical category of the enrollees' physical addresses (e.g., urban, suburban, and rural) and provider types.

MCOs are permitted to conduct NAV for *either* time or distance standards; validating both is not required. Time and distance standard indicators for each provider type are identified in the table below.

Monitoring Activities. MY 2024's validations observed the following about time and distance standards across MCOs:

- All MCOs monitor designated urban and suburban areas in their NAV processes for time and distance standards by provider type. JMS is exempt from monitoring designated rural areas.
- Eight MCOs (except WPM) included the two required PCPs (adult/general and pediatric providers) in NAV processes for time and distance standards. WPM included Pediatric PCPs and reported Family/General practitioners and Internal Medicine practitioners PCPs (to account for the adult/general population).
- All MCOs included the required Prenatal providers in NAV processes for time and distance standards. All MCOs included the required GYN providers in some capacity: three MCOs (ABH, KPMAS, and MSFC) reported GYN providers separately from OB providers, while the remaining MCOs (CFCHP, JMS, MPC, PPMCO, UHC, and WPM) reported an OB/GYN provider category. PPMCO included Reproductive Endocrinology providers in NAV processes for time and distance standards.
- All MCOs included all required Core Specialists, Major Specialists, Pediatric Specialists, Acute Inpatient Hospitals, and Pharmacies in NAV processes for time and distance standards.
- All MCOs included the required Diagnostic Laboratory and Radiology providers and facilities in NAV processes for time and distance standards in some capacity: MSFC included Diagnostic Laboratory and Diagnostic Radiology separately, and the remaining MCOs (ABH, CFCHP, JMS, KPMAS, MPC, PPMCO, UHC, and WPM) included a combined Diagnostic Laboratory and Radiology in NAV processes for time and distance standards.
- Five MCOs included Hematology and Oncology in NAV processes for time and distance standards. CFCHP included Hematology providers and Oncology providers separately; MSFC included only Oncology providers; two MCOs (ABH and MPC) included Hematology/Oncology providers; and JMS included Hematology/Oncology/Radiation Oncology providers.
- CFCHP included Pain Management providers in NAV processes for time and distance standards.
- JMS included Podiatrists in NAV processes for time and distance standards.

Table 57. MY 2024 Time and Distance Standards (NAV)

COMAR 10.67.05.06A Maximum Time and Distance Standards	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
Urban Time: 15 minutes Urban Distance: 10 miles Suburban Time: 30 minutes Suburban Distance: 20 miles Rural Time: 40 minutes	• PCP • OB/GYN • Pharmacy • Diagnostic Laboratory	• Beneficiary enrollment files (quarterly) • Provider directory files (quarterly)	• PCP: 8 MCOs (excluding WPM) • Pediatric PCP and Pharmacy: all MCOs • Family Medicine/General Medicine and Internal Medicine: WPM

COMAR 10.67.05.06A Maximum Time and Distance Standards	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
Rural Distance: 30 miles	X-Ray Facilities		GYN only and OB only: ABH, KPMAS, and MSFC OB/GYN: 6 MCOs (excluding ABH, KPMAS, and MSFC) Reproductive Endocrinology: PPMCO Diagnostic Laboratories: MSFC Diagnostic Laboratories/X-Ray: 8 MCOs (excluding MSFC) Diagnostic Radiology: MPC and MSFC
Urban Time: 15 minutes Urban Distance: 10 miles Suburban Time: 30 minutes Suburban Distance: 20 miles Rural Time: 90 minutes Rural Distance: 75 miles	Prenatal Care	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Prenatal Provider: all MCOs
Urban Time: 30 minutes Urban Distance: 15 miles Suburban Time: 60 minutes Suburban Distance: 45 miles Rural Time: 90 minutes Rural Distance: 75 miles	Core Specialties	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, and Urology: all MCOs
Urban Time: 30 minutes Urban Distance: 15 miles Suburban Time: 80 minutes Suburban Distance: 60 miles Rural Time: 110 minutes Rural Distance: 90 miles	Major Specialties	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, and Pulmonology: all MCOs
Urban Time: 30 minutes Urban Distance: 15 miles Suburban Time: 80 minutes Suburban Distance: 60 miles Rural Time: 250 minutes Rural Distance: 200 miles	Pediatric Subspecialties	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Pediatric Cardiology, Gastroenterology, Neurology, and Surgery: all MCOs

COMAR 10.67.05.06A Maximum Time and Distance Standards	Provider Types	Supporting Documentation and Frequency	Monitored by MCO
Urban Time: 20 minutes Urban Distance: 10 miles Suburban Time: 45 minutes Suburban Distance: 30 miles Rural Time: 75 minutes Rural Distance: 60 miles	Acute Inpatient Hospital	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Acute Inpatient Hospitals: all MCOs
Urban Time: 30 minutes Urban Distance: 15 miles Suburban Time: 60 or 80 minutes Suburban Distance: 45 or 60 miles Rural Time: 90 or 110 minutes Rural Distance: 75 or 90 miles	Other Specialties not listed in COMAR	- Beneficiary enrollment files (quarterly) - Provider directory files (quarterly)	Hematology: CFCHP Hematology/Oncology: MPC and WPM Hematology/Oncology/Radiation Oncology: JMS Oncology: CFCHP and MSFC Pain Management: CFCHP Podiatry: JMS

Table 58. Number of Indicators Included for MY 2024 Time and Distance Standards (NAV)

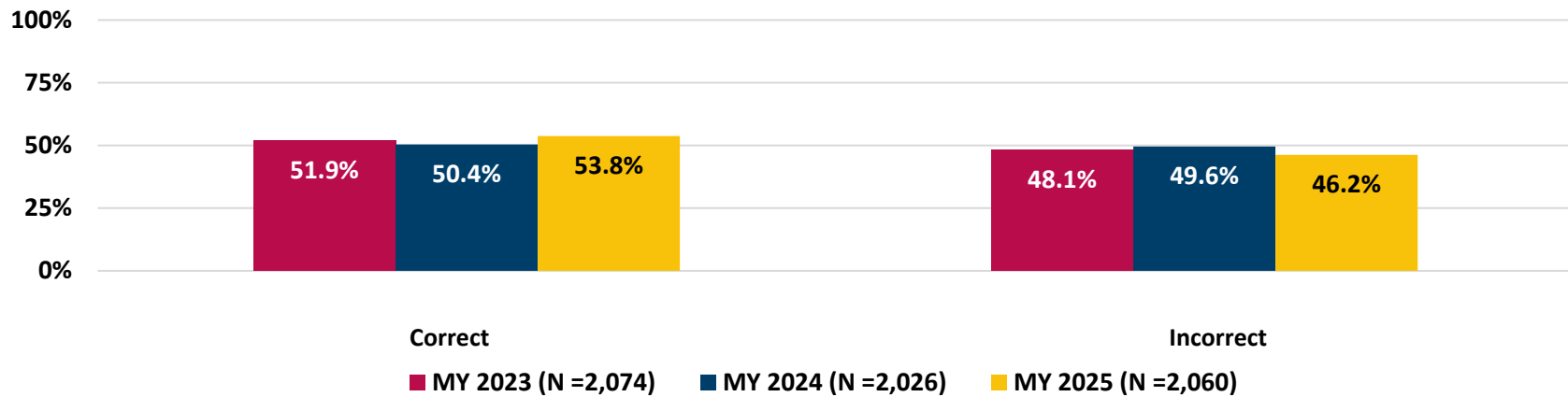
Indicator Analysis	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Required Indicators Identified	75	75	50	75	75	75	75	75	75
Required Indicators Complying with COMAR	75	75	50	75	75	75	75	75	72
Additional Indicators Identified	6	9	4	3	6	9	3	0	9
Total Indicators Identified	81	84	54	78	81	84	78	75	84
Number of Required Indicators Missing	0	0	0	0	0	0	0	0	3

Note: JMS was exempt from including time and distance NAV for rural areas due to the primary locations of its enrollees/providers in urban and suburban areas.

Accuracy of PCP Information

Phone Numbers and Addresses. Compared to MY 2024 (50.4%), MY 2025 demonstrated an increase of 3.4 percentage points in the accuracy of provider contact information (53.8%). MY 2025 had the lowest percentage of incorrect provider information compared to MY 2023 (48.1%) and MY 2024 (49.6%).

Figure 7. MYs 2023 to 2025 Accuracy of Online Directory Contact Information (Phone Number and Address) (NAV)



Successful Contacts

Survey Call Attempts. The number of attempted PCP surveys conducted increased from 2,026 in MY 2024 to 2,060 in MY 2025. The percentage of successful contacts increased by 6.2 percentage points from MY 2024 (55.4%) to MY 2025 (61.6%).

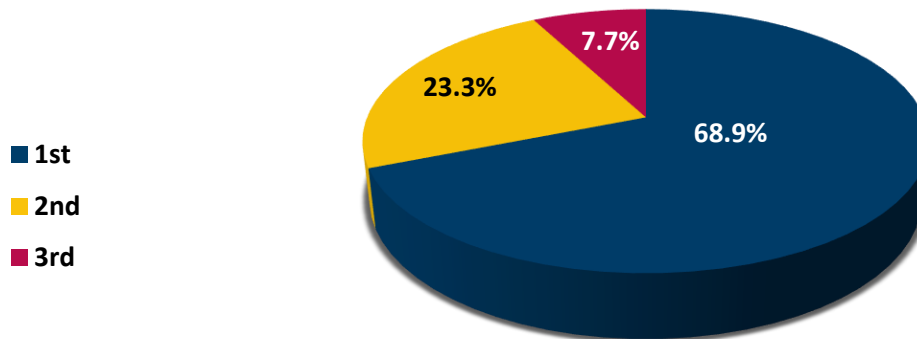
Table 59. MYs 2023 to 2025 Number of Surveys Conducted and Successful PCP Contacts (NAV)

Measurement Year	Total Surveys Conducted	Number of Successful Contacts	Percentage of Successful Contacts
2023	2,074	1,229	59.3%
2024	2,026	1,122	55.4%
2025	2,060	1,268	61.6%

Values reported are rounded to the nearest tenth of a percent for reporting only.

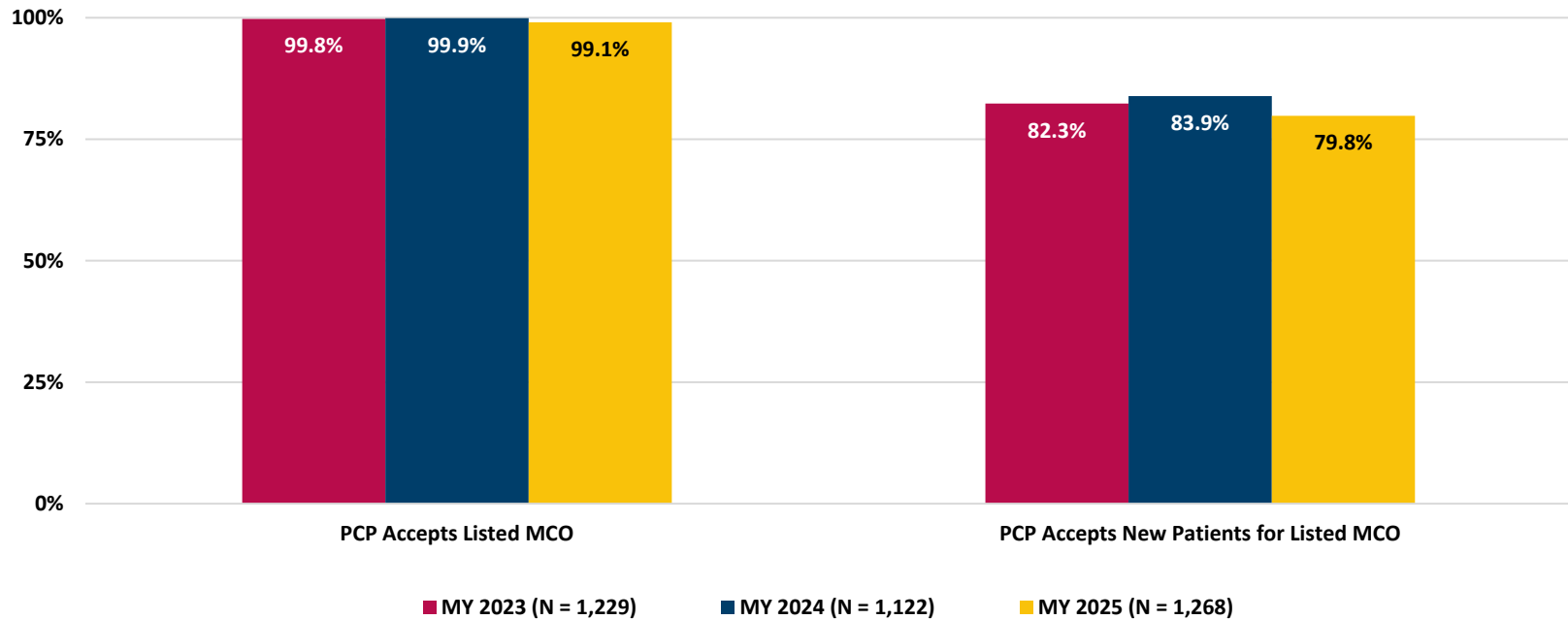
Approximately 68.9% of providers were successfully contacted on the first call attempt, 23.3% on the second, and 7.7% on the third and final attempt.

Figure 8. MY 2025 Responses by Call Attempt for Successful Contacts (NAV)



PCP Affiliation and Open Access. MY 2025 results are consistent with MY 2023 and MY 2024. In MY 2025, performance declined, indicating 79.8% of PCPs accepted new patients for the listed MCO, which is a decrease of 4.1 percentage points from MY 2024 (83.9%).

Figure 9. MYs 2023 to 2025 PCP Affiliation and Open Access (NAV)



MY 2025 Summary of Accuracy of PCP Information. Compared to all other MCOs, contact with CFCHP and PPMCO's providers was least likely to be successful at 42.3% and 45.8%, respectively. PPMCO also had the lowest percentage of providers with accurate addresses (80.2%). All MCOs exceeded 97% for *Accepts Listed MCO* with KPMAS, MSFC, and PPMCO achieving performance at 100%. KPMAS had the lowest percentage of *Accepts New Medicaid Patients Listed for MCO* at 64.0%.

Table 60. MY 2025 MCO Results from Successful Contacts for Accuracy of PCP Information (NAV)

MY 2025 Successful Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Number of Calls	223	253	214	160	244	240	253	234	239	2,060
Successful Contacts (#)	150	107	136	125	159	135	116	172	168	1,268
%	67.3%	42.3%	63.6%	78.1%	65.2%	56.3%	45.8%	73.5%	70.3%	61.6%
Accurate PCP Address Provided (#)	132	90	117	123	137	119	93	165	144	1,120
%	88.0%	84.1%	86.0%	98.4%	86.2%	88.1%	80.2%	95.9%	85.7%	88.3%
Accepts Listed MCO (#)	146	104	135	125	157	135	116	171	167	1,256
%	97.3%	97.2%	99.3%	100.0%	98.7%	100.0%	100.0%	99.4%	99.4%	99.1%
Accepts New Medicaid Patients Listed for MCO (#)	126	89	98	80	135	124	87	139	134	1,012
%	84.0%	83.2%	72.1%	64.0%	84.9%	91.9%	75.0%	80.8%	79.8%	79.8%

Values reported are rounded to the nearest tenth of a percent for reporting only.

Unsuccessful Contacts

Of the 2,060 PCP surveys attempted in MY 2025, 792 PCP surveys were unsuccessful.

Unsuccessful Contacts within the “No Contact” Category. The total of unsuccessful contact due to “No Contact” for MY 2025 (792) is the lowest compared to MY 2023 (845) and MY 2024 (904). Most of the unsuccessful contacts for MY 2025 (35.9%) were due to *Number Did Not Reach Intended Provider*, which is consistent with MY 2023 (35.7%); however, there was an increase of nine percentage points from MY 2024 (26.9%) to MY 2025. MY 2025 also resulted in an increase of 3.6 percentage points for *No Answer* (17.2%) compared to MY 2024 (13.6%). Additional findings per MCO indicate the following:

- JMS had the highest percentage of unsuccessful survey calls due to *Did Not Reach Intended Provider* at 63.9%, followed by PPMCO at 58.4%.
- CFCHP and KPMAS providers were more likely to not answer survey calls at 35.8% and 31.6%, respectively.
- ABH and MSFC providers were more likely to send survey calls to voicemail at 35.0% and 31.2%, respectively.
- KPMAS and UHC providers were more likely to place the surveyor on hold for more than five minutes at 21.1% and 22.4%, respectively.

- CFCHP had the highest total of unsuccessful survey calls due to “No Contact” with 109 calls, followed by PPMCO with 101 calls.

Figure 10. MYs 2023 to 2025 Unsuccessful Surveys due to "No Contact" (NAV)

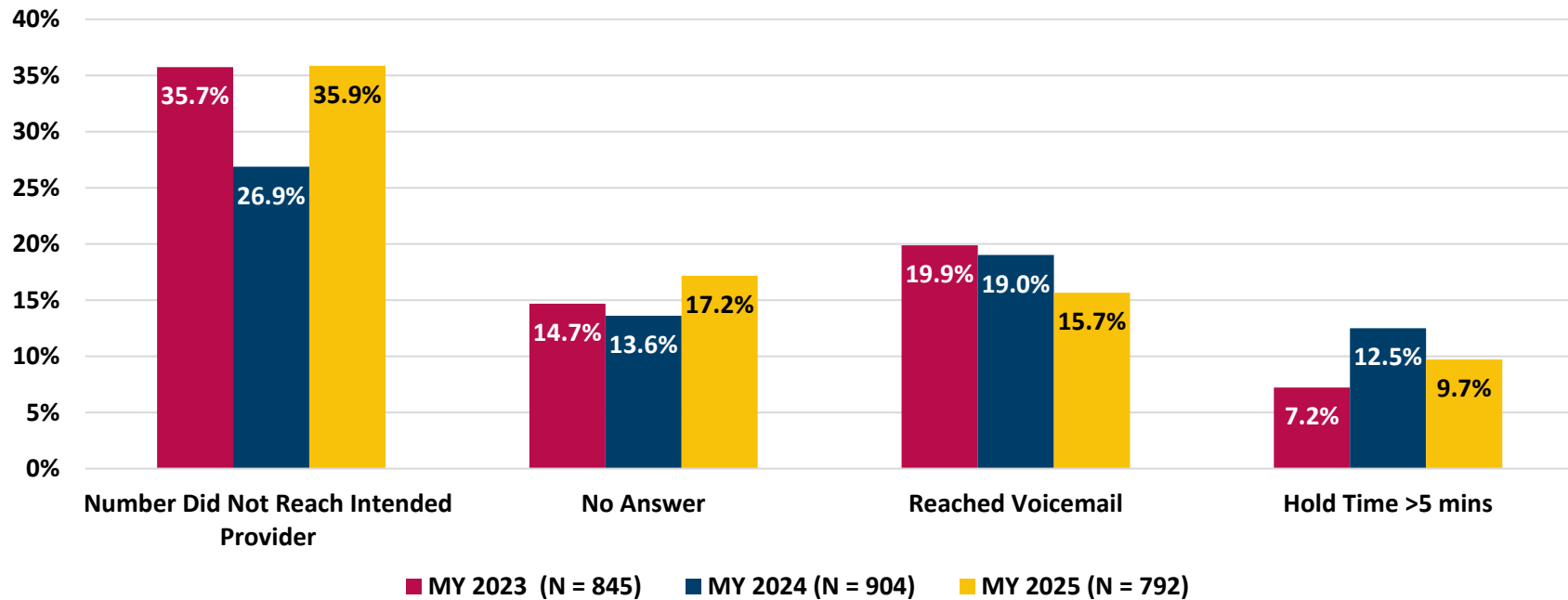


Table 61. MY 2025 "No Contact" Categories by MCO (NAV)

MY 2025 "No Contact" Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Did Not Reach Intended Provider	35.0%	53.2%	63.9%	36.8%	34.2%	32.3%	58.4%	36.7%	48.2%	45.7%
No Answer	16.7%	35.8%	16.4%	31.6%	26.0%	29.0%	10.9%	14.3%	12.5%	21.9%
Reached Voicemail	35.0%	0.0%	8.2%	10.5%	27.4%	31.2%	20.8%	26.5%	23.2%	20.0%
Hold Time >5 Minutes	13.3%	11.0%	11.5%	21.1%	12.3%	7.5%	9.9%	22.4%	16.1%	12.4%
Total Unsuccessful "No Contact" Call Counts	60	109	61	19	73	93	101	49	56	621

Denominator utilized only unsuccessful calls categorized as *No Contact*.

Values reported are rounded to the nearest tenth of a percent for reporting only.

Unsuccessful Contacts within the “PCP Response” Category. Unsuccessful survey calls due to *Wrong Location Listed for Provider* significantly decreased from MY 2024 (12.7%) to MY 2025 (1.8%). Unsuccessful survey calls due to *Not a PCP* have consistently decreased from MY 2023 (5.0%) to MY 2025 (4.0%). Unsuccessful survey calls due to *Does Not Accept Insurance* increased by 3.6 percentage points from MY 2024 (9.2%) to MY 2025 (12.8%). There was an increase of 1.3 percentage points for unsuccessful survey calls due to *Refused to Participate* from MY 2024 (1.7%) to MY 2025 (3.0%). Most of the unsuccessful survey calls due to “PCP Response” for MY 2025 is *Does Not Accept Insurance*, which is a change from MY 2024, *Wrong Location Listed for Provider*. Additional findings per MCO indicate the following:

- MSFC was more likely to have the wrong location listed for its providers at 25.0%.
- CFCHP was more likely to have a provider listed that was not a PCP at 54.1%.
- KPMAS was more likely to have PCPs not accept the MCO’s insurance at 93.8%, followed by JMS at 82.4%.
- WPM was more likely to have PCPs refuse to participate in the survey at 40.0%, followed by ABH at 23.1%.
- CFCHP and PPMCO had the highest total of unsuccessful call counts due to “PCP Response” at 37 and 36, respectively.

Figure 11. MYs 2023 to 2025 Unsuccessful Surveys due to “PCP Response” (NAV)

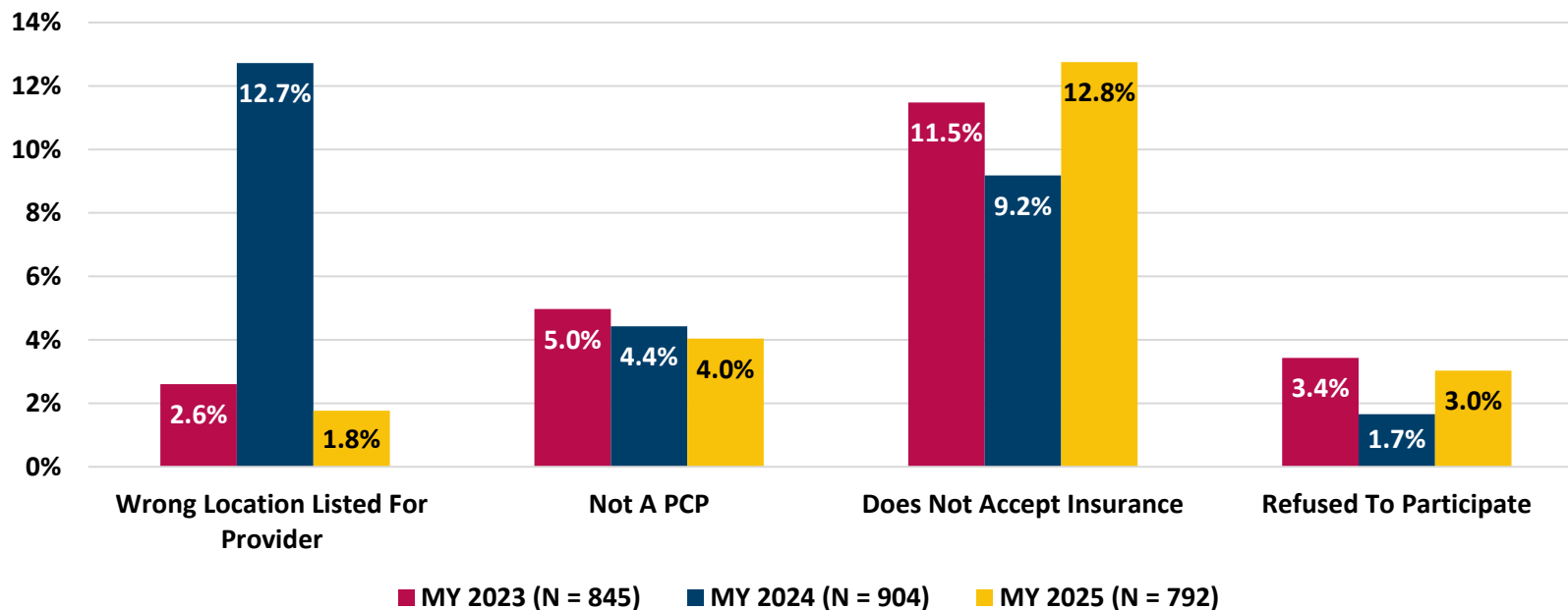


Table 62. MY 2025 "PCP Response" by MCO (NAV)

MY 2025 "PCP Response" Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Wrong Location Listed for Provider	15.4%	13.5%	5.9%	0.0%	16.7%	25.0%	2.8%	0.0%	0.0%	8.2%
Not a PCP	15.4%	54.1%	11.8%	0.0%	0.0%	0.0%	19.4%	7.7%	0.0%	18.7%
Does Not Accept Insurance	46.2%	13.5%	82.4%	93.8%	66.7%	75.0%	69.4%	76.9%	60.0%	59.1%
Refused to Participate	23.1%	18.9%	0.0%	6.3%	16.7%	0.0%	8.3%	15.4%	40.0%	14.0%
Total Unsuccessful "PCP Response" Call Counts	13	37	17	16	12	12	36	13	15	171

Denominator utilized only unsuccessful calls categorized as *PCP Response*.

Values reported are rounded to the nearest tenth of a percent for reporting only.

Compliance with Appointment Standards

MCO-specific results for compliance with routine care and urgent care appointment availability standards are displayed in the tables below.

Purpose. The COMAR requirements guiding MY 2025 activities for access and availability are as follows.

Table 63. MY 2025 Network Adequacy Appointment Requirements (NAV)

COMAR	Standard
30-Day Routine Care Appointment COMAR 10.67.05.07A(3)(b)(iv)	Requests for routine and preventative primary care appointments shall be scheduled to be performed within 30 days of the request.
48-Hour Urgent Care Appointment COMAR 10.67.05.07A(3)(b)(iii)	Individuals requesting urgent care shall be scheduled to be seen within 48 hours of the request.

Compliance with Routine Care Availability Requirements. Compliance with routine care appointment requirements increased by 4.6 percentage points from MY 2024 (89.4%) to MY 2025 (94.0%). MCO compliance with routine care appointment availability within 30 days ranged from 86.8% (MPC) to 98.3% (UHC). All MCOs met the MDH-required minimum compliance score (80%). The average wait time for a routine care appointment was between seven days (CFCHP, PPMCO and UHC) and ten days (KPMAS, MPC, and WPM).

Figure 12. MYs 2023 to 2025 Percent of PCPs in Compliance with Routine Care Appointment Standards (NAV)

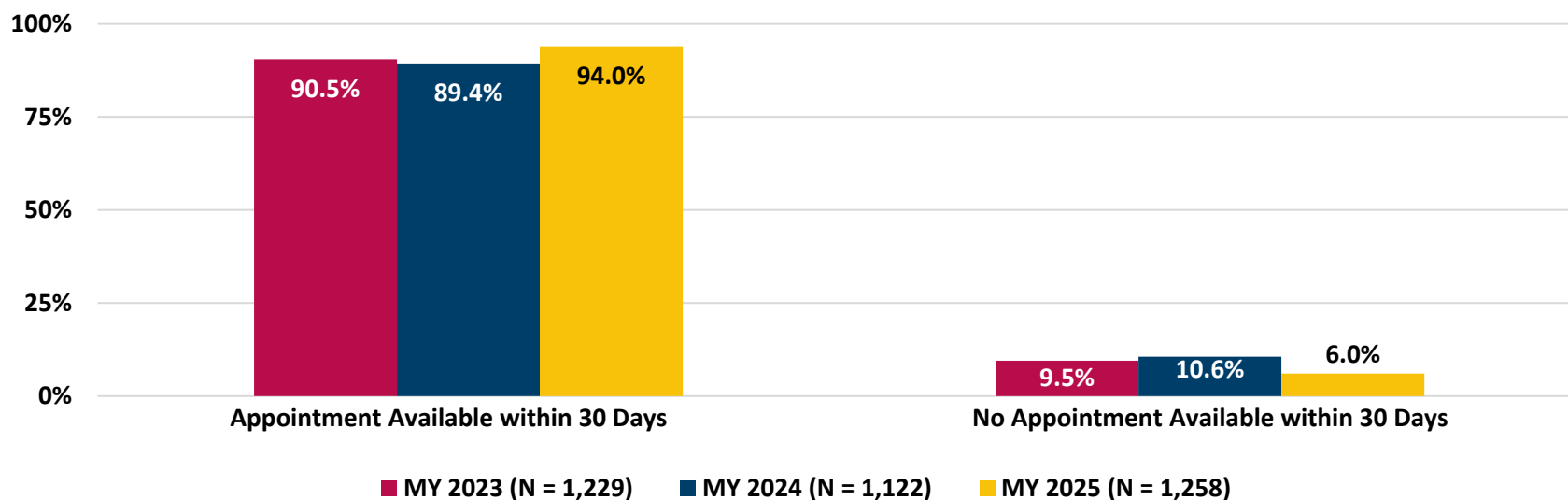


Table 64. MY 2025 MCO and HealthChoice Results for Compliance with Routine Care Appointment Standards (within 30 days) (NAV)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Compliance with Routine Care Appointment	94.0%	96.3%	94.1%	94.4%	86.8%	91.1%	95.7%	98.3%	95.8%	94.0%
# of Wait Days (Average)	9	7	8	10	10	8	7	7	10	8
# of Wait Days (Range)	0-125	0-58	0-29	0-118	0-63	0-71	0-29	0-26	0-126	0-72

Values reported are rounded to the nearest tenth of a percent for reporting only.

Compliance with Urgent Care Availability Requirements. PCP compliance with urgent care appointment requirements decreased by 2.8 percentage points from MY 2024 (91.0%) to MY 2025 (88.2%). MCO compliance with urgent care appointments within 48 hours ranged from 71.2% (KPMAS) to 96.4% (WPM). All MCOs, except for KPMAS (71.2%), exceeded the MDH-required minimum compliance score (80%). KPMAS will be required to submit a quarterly CAP to improve compliance with the urgent care appointment timeframe.

Figure 13. MYs 2023 to 2025 Percent of PCPs in Compliance with Urgent Care Appointment Standards (NAV)

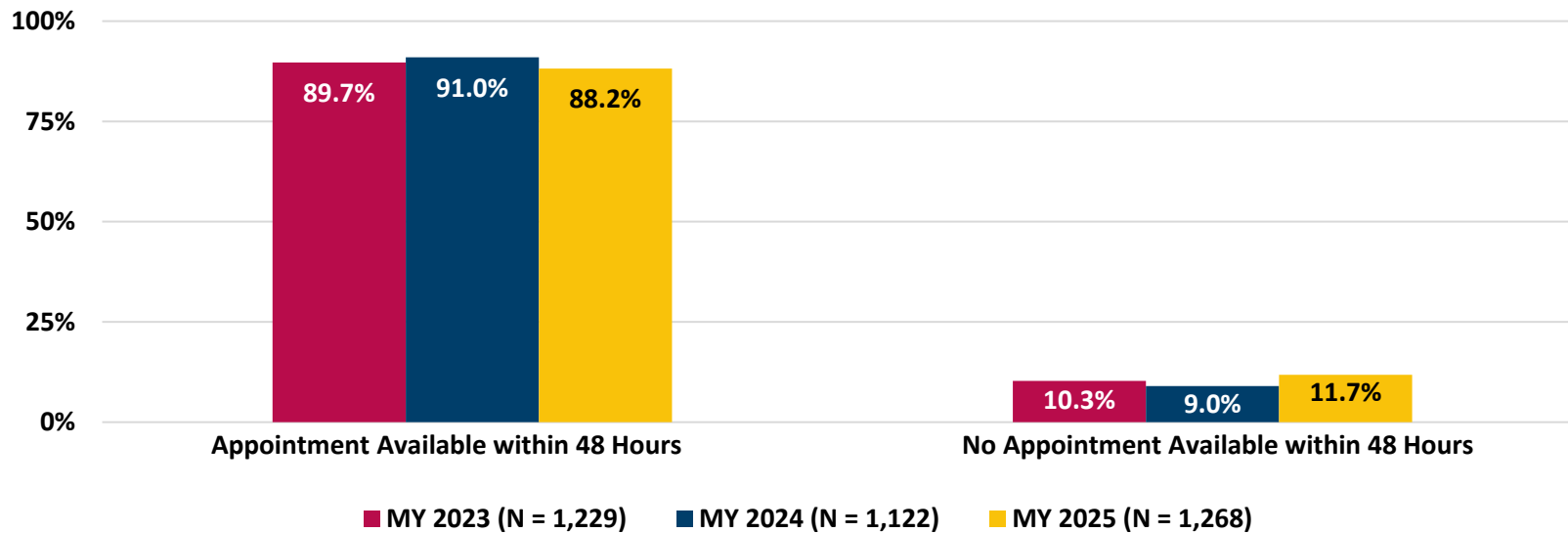


Table 65. MY 2025 MCO and HealthChoice Results for Compliance with Urgent Care Appointment Standards (within 48 hours) (NAV)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Compliance with Urgent Care Appointment	86.7%	89.7%	93.4%	71.2%^Q	89.3%	84.4%	89.6%	91.9%	96.4%	88.2%
Appointment Available with Requested PCP at Same Location within 48 hours (including telemedicine)	78.0%	76.6%	85.3%	39.2%	79.9%	70.4%	80.0%	79.7%	86.9%	75.8%
Appointment Available with Another PCP at Same Location within 48 hours (including telemedicine)	8.7%	13.1%	8.1%	32.0%	9.4%	14.1%	9.6%	12.2%	9.5%	12.6%

Bold denotes that the 80% minimum compliance score is unmet. ^Q denotes that a quarterly CAP is required. Values reported are rounded to the nearest tenth of a percent for reporting only.

Provider Directory Validations

Purpose. COMAR requirements guiding MY 2025 activities for provider directories follow.

Table 66. MY 2025 Network Adequacy Requirements for Provider Directories (NAV)

COMAR	Standard
Accuracy of Provider Directory <i>COMAR 10.67.05.02C(1)(d)</i>	MCOs shall maintain a provider directory listing individual practitioners who are the MCO's primary and specialty care providers in the enrollee's county, additionally indicating the PCP name, address, practice location(s), telephone number(s), website URL as appropriate, group affiliation, cultural and linguistic capabilities, practices accommodations for physical disabilities, whether the provider is accepting new patients, and age range of patients accepted or no age limit.

CMS finalized in the November 13, 2020, Federal Register that §438.10(h)(1)(vii) eliminated the indication of cultural competency training of the PCP requirement in the online directory. Therefore, MDH does not require a review of this component.

Validation Activities. Qlarant validated the information in the MCOs' online provider directories for each PCP that successfully completed the telephone survey. The online directories were reviewed for the following information:

- **PCP Address** assesses accuracy of the information presented in the online directory, such as the PCP's name, address, and practice location(s).
- **PCP Phone Number** assesses accuracy of the telephone number presented in the online directory.
- **ADA (Practice Accommodations for Physical Disabilities)** assesses availability of specific accommodations for individuals with disabilities in the practice location, by indication in the online directory for the PCP.
- **New Patients** assesses acceptance of new patients by the PCP, through indication in the online directory for the PCP.
- **Age Range** assesses ages served by the PCP, through indication in the online directory for the PCP.
- **PCP Languages** assesses languages spoken by the PCP, by indication in the online directory of the languages spoken by the PCP.

Providers who were not listed in the online provider directories were not included in the validation activities. The proportion of the telephone survey results matching the online directories by each of the review components listed above demonstrates the following observations:

- The classification of successful telephone surveys matching the information within the online directories for MY 2025 is comparable to MY 2024 for *PCP Address*, *Phone Number*, *ADA*, and *New Patients*.
- There was a significant decrease for specified *Age Range* (97.1% to 83.6%) from MY 2024 to MY 2025.
- Specified acceptance of *New Patients* continues to be the lowest performing category at 79.6% for MY 2025.

Validation of the MCO online provider directories demonstrates the following observations:

- All MCOs met or exceeded the minimum compliance score of 80% for five of the seven online directory requirements (*PCP Listed in Online Directory*, *PCP's Practice Location Matched Survey Response*, *PCP's Practice Telephone Number Matched Survey Response*, *Specifies Languages Spoken by PCP*, and *Practice States if Accommodations for Patients with Disabilities are Available*).
- Five out of nine MCOs' scores failed to meet the minimum compliance score for *Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response* (JMS at 75.0%, KPMAS at 78.4%, PPMCO at 73.3%, UHC at 78.5%, and WPM at 70.8%).
- PPMCO was the only MCO whose scores failed to meet the minimum compliance score for *Specifies Ages of Patients Seen* (0.0%).

Figure 14. MYs 2023 to 2025 Provider Directory Validation Results (NAV)

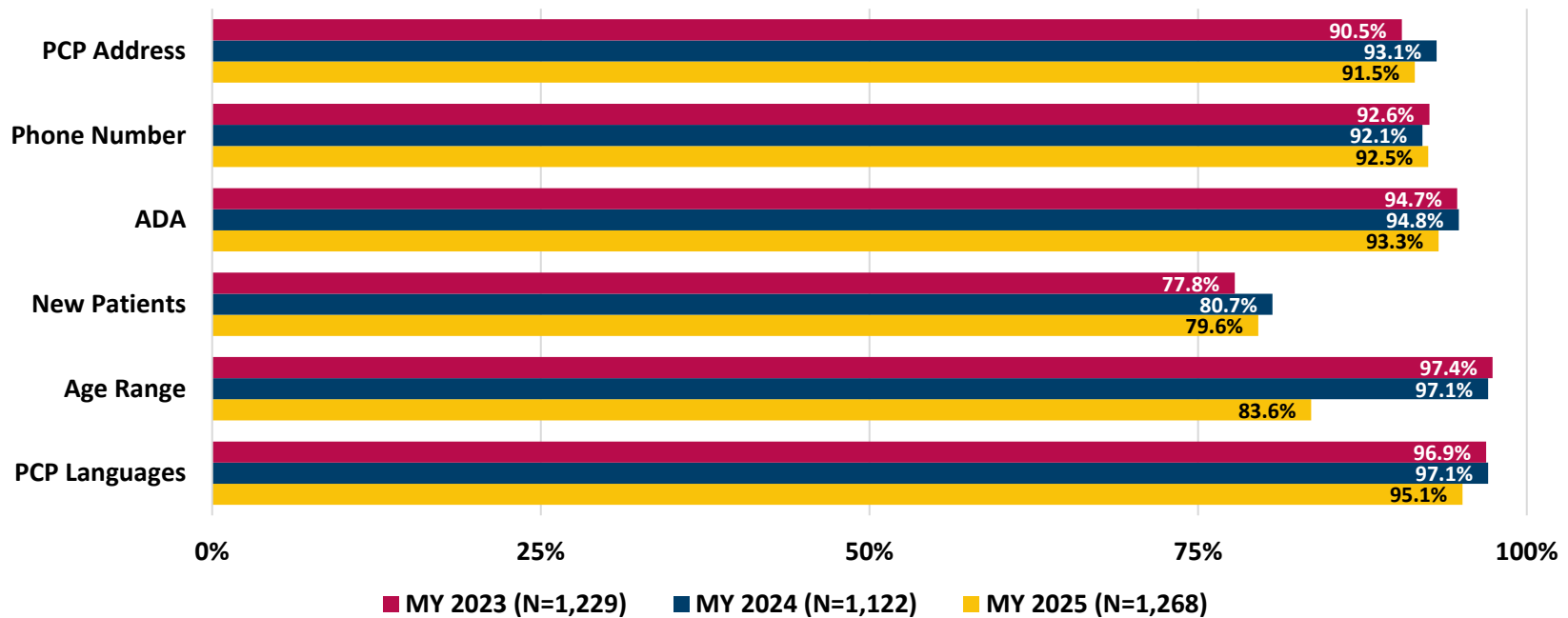


Table 67. MY 2025 MCO and HealthChoice Results for Provider Directory Validations (NAV)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
PCP Listed in Online Directory	96.0% ↑	97.2% ↓	98.5% ↓	97.6% ↓	96.9% ↓	96.3% ↓	98.3% ↓	94.8% ↑	92.9% ↑	96.3% ↓
PCP's Practice Location Matched Survey Response	94.7% ↑	93.5% ↓	95.6% ↓	96.8% ↓	93.7% ↓	91.9% ↓	85.3% ↓	89.0% ↑	84.5% ↓	91.5% ↓
PCP's Practice Telephone Number Matched Survey Response	95.3% ↑	89.7% ↑	94.1% ↓	96.8% ↑	91.2% ↓	98.5% ↑	92.2% ↓	91.3% ↑	85.1% ↓	92.5% ↑
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	80.7% ↑	84.1% ↓	75.0% ↓	78.4% ^q ↑	85.5% ↓	91.1% ↑	73.3% ↓	78.5% ↓	70.8% ^q ↓	79.6% ↓
Specifies Ages of Patients Seen	91.3% ↓	87.9% ↓	98.5% ↓	96.0% ↓	91.2% ↓	83.0% ↓	0.0% ↓	94.8% ↑	92.3% ↓	83.6% ↓
Specifies Languages Spoken by PCP	96.0% ↑	97.2% ↓	98.5% ↓	87.2% ↓	97.5% ↓	97.0% ↓	94.8% ↓	94.8% ↑	92.9% ↓	95.1% ↓
Practice has Accommodations for Patients with Disabilities	81.3% ↓	98.1% ↓	94.9% ↓	96.8% ↓	89.3% ↓	97.8% ↓	98.3% ↑	94.8% ↑	92.3% ↑	93.3% ↓

Green and **↑** = Improvement from MY 2024; **Blue** and **↓** = Decline from MY 2024; **Pink** and **↓** = Decline from MY 2024 and 80% minimum compliance score is unmet; **White** = No change from MY 2024. **Bold** denotes that the 80% minimum compliance score is unmet. ^q denotes that a quarterly CAP is required.

Values reported are rounded to the nearest tenth of a percent for reporting only.

Conclusion

Provider-to-Enrollee Ratios. Qlarant identified two provider types for MY 2024 that required MCOs to report provider-to-enrollee ratios: PCPs and Pediatric PCPs.

- Most MCOs reported ratios for additional provider types listed in COMAR as PCP subspecialties, women's specialties, core specialties, major specialties, and pediatric subspecialties.
- Some MCOs reported ratios for provider types not listed in COMAR based on each MCO's needs. These provider types include high-volume specialties, high-impact specialties, and additional specialties that must be monitored to maintain their accredited status.

Across all MCOs, 212 out of 213 identified provider-to-enrollee ratios were reported: 17 of the 18 ratios were required, and MCOs reported an additional 195 ratios.

- Eight MCOs included the two required PCPs (adult/general and pediatric providers). WPM included Pediatric PCPs, but focused on one PCP specialty type, Family/General practitioners PCPs, to account for the adult/general population.
- Four MCOs (ABH, CFCHP, JMS, and WPM) reported ratios for specific PCP specialties for their adult/general population.
- Eight MCOs (except KPMAS) reported ratios for one or more women's health providers listed in COMAR. Three MCOs (ABH, JMS, and PPMCO) reported ratios for one or more women's health providers not listed in COMAR.
- Eight MCOs (except KPMAS) reported ratios for all core specialties listed in COMAR.
- Eight MCOs (except KPMAS) reported ratios for all major specialties listed in COMAR.
- Seven MCOs (except CFCHP and KPMAS) reported ratios for all pediatric subspecialties listed in COMAR.
- Five MCOs (JMS, MPC, MSFC, PPMCO, and WPM) reported ratios for facilities listed in COMAR for geographic access (i.e., acute inpatient hospitals, diagnostic laboratories, pharmacies).
- Five MCOs (ABH, CFCHP, JMS, MPC, and MSFC) reported ratios for other provider types not listed in COMAR.

MCOs' calculations of their provider-to-enrollee ratios scored validation ratings of *Low Confidence* to *High Confidence* with validation scores ranging from 50% to 100%.

- Six MCOs (ABH, JMS, KPMAS, MPC, MSFC, and UHC) achieved a validation rating of *High Confidence* with a validation score of 100% for all required and additional indicators.
- CFCHP achieved a validation rating of *High Confidence* with a score of 100% for the required PCP providers and a validation rating of *Low Confidence* with a validation score of 50% for the required Pediatric PCPs. CFCHP achieved a validation rating of *High Confidence* with a validation score of 100% for the three PCP specialty types monitored and a validation rating of *Moderate Confidence* with a validation score of 53.3% for OB/GYN providers, Core Specialists, Major Specialists, and other specialties not listed in COMAR.
- PPMCO achieved a validation rating of *High Confidence* with a validation score of 100% for the required PCP providers and a validation rating of *Moderate Confidence* with a validation score of 62.5% for the required Pediatric PCPs. PPMCO achieved a validation rating of *High Confidence* with a validation score of 100% for the remaining additional providers.
- WPM achieved a validation rating of *High Confidence* with a validation score of 100% for the required Pediatric PCP providers. The ratio of PCP providers could not be validated because WPM only reported a ratio for one PCP specialty type. This PCP specialty type, Family/General PCPs, achieved a validation rating of *High Confidence* with a validation score of 100%. The remaining providers achieved a validation rating of *High Confidence* with a validation score of 100%.

Time and Distance Standards. Qlarant identified 25 provider types for MY 2024 that required MCOs to report geographic access metrics (time and/or distance) across three geography types: urban, suburban, and rural. Note: JMS is contractually required to provide metrics for two geography types: urban and suburban.

- Most MCOs reported geographic access metrics as required for PCPs and Pediatric PCPs.

- All MCOs reported geographic access metrics as required for OB/GYN providers and prenatal providers.
- All MCOs reported geographic access metrics as required for core specialties.
- All MCOs reported geographic access metrics as required for major specialties.
- All MCOs reported geographic access metrics as required for pediatric subspecialties.
- All MCOs reported geographic access metrics as required for facilities (i.e., acute inpatient hospitals, diagnostic laboratories, pharmacies).
- Some MCOs reported geographic access metrics not listed in COMAR based on each MCO's needs. These provider types include high-volume specialties, high-impact specialties, and additional specialties that must be monitored to maintain their accredited status.

Across all MCOs, 692 out of 699 identified geographic access metrics were reported: 647 of the 650 ratios were required, and MCOs reported an additional 45 of 49 metrics.

- Eight MCOs (except WPM) included all geographic access metrics for the two required PCPs (adult/general and pediatric providers). WPM included Pediatric PCPs, but focused on two PCP specialty types, Family/General practitioners PCPs and Internal Medicine PCPs, to account for the adult/general population.
- All MCOs included all geographic access metrics as required for OB/GYN providers (collectively or separately) and prenatal providers as listed in COMAR.
- PPMCO included geographic metrics for one women's health provider not listed in COMAR.
- All MCOs reported geographic access metrics as required for core specialties, major specialties, pediatric subspecialties, and facilities.
- Some MCOs reported geographic access metrics for provider types not listed in COMAR.

MCOs' calculations of their geographical access scored validation ratings of *Moderate Confidence* to *High Confidence*, with validation scores ranging from 64.7% to 100%.

- Six MCOs (ABH, JMS, KPMAS, MPC, MSFC, and UHC) achieved a validation rating of *High Confidence* with a validation score of 100% for all required and additional indicators.
- CFCHP achieved a validation rating of *High Confidence* with a validation score of 100% for 54 of the 75 required indicators and 9 additional indicators. The remaining 21 required indicators (Pediatric PCP, Prenatal Providers, OB/GYN, Pediatric Specialties) achieved a validation rating of *Moderate Confidence* with a validation score of 64.7%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population and women's population, respectively.
- PPMCO achieved a validation rating of *High Confidence* with a validation score of 100% for 60 of the 75 required indicators and 3 additional indicators. The remaining 15 required indicators (Pediatric PCP and Pediatric Specialties) achieved a validation rating of *Moderate Confidence* with a validation score of 64.7%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population.

- WPM achieved a validation rating of *High Confidence* with a validation score of 100% for 72 of the 75 required indicators and 9 additional indicators. The remaining three indicators could not be validated.

Telephone Surveys and Provider Directory Validations. The overall percentage of successful contacts for MY 2025 improved by 6.2 percentage points from MY 2024 (55.4%) to MY 2025 (61.6%). However, MY 2025 continued to have *Number Did Not Reach Intended Provider* (35.9%) as the main reason for unsuccessful calls due to “No Contact.” Most unsuccessful calls for MY 2025 were due to the “PCP Response” *Does Not Accept Insurance*, which is a change from MY 2024, *Wrong Location Listed For Provider*.

Compliance with standards for routine care appointments improved from MY 2024 (89.4%) to MY 2025 (94.0%). All MCOs exceeded the minimum compliance score of 80%, with an overall HealthChoice average of 94.0%.

Performance declined for compliance with standards for urgent care appointments from MY 2024 (91.0%) to MY 2025 (88.2%). Eight of the nine MCOs (except for KPMAS) exceeded the minimum compliance score of 80%, with an overall HealthChoice average of 88.2%.

The classification of successful telephone surveys matching the information within the online directories for MY 2025 is comparable to MY 2024 for *PCP Address, Phone Number, ADA, and New Patients*. MCOs specifying acceptance of *New Patients* within online directories continues to be the lowest performing category from MY 2023 (77.8%) to MY 2025 (79.6%). All MCOs met or exceeded the minimum compliance score of 80% for five of the seven online directory requirements (*PCP Listed in Online Directory, PCP’s Practice Location Matched Survey Response, PCP’s Practice Telephone Number Matched Survey Response, Specifies Languages Spoken by PCP, and Practice States if Accommodations for Patients with Disabilities are Available*).

Quality Strategy Highlights

MDH aims to deliver high-quality, accessible care to managed care enrollees. To achieve this goal, MDH developed a framework to focus quality improvement efforts for the HealthChoice program. MDH established task goals in the HealthChoice Quality Strategy for 2022-2024.

MDH’s task goal is to meet time and distance standards per COMAR regulation 10.67.05.06A for MY 2024. Eight of the nine MCOs scored validation ratings of *Moderate Confidence* and *High Confidence*, indicating the likelihood that their methodology for validating network adequacy time and distance standards will provide accurate results.

MDH’s task goal is to increase all requirements to 85% or above by MY 2024 for telephone surveys and provider directory validations. In MY 2025, HealthChoice’s aggregate performance exceeded the MDH-established minimum compliance with a score of 80% for all requirements. Seven of the nine requirements exceeded the MDH Quality Strategy goal of 85%, and two requirements, *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* and *Specifies Ages of Patients Seen*, fell below the goal by five and one percentage point, respectively. Two

of the nine requirements met or exceeded the specific MDH Quality Strategy Targets: *Urgent Care Appointment Timeframe Requirement* (94%) and *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (80%).

Table 68. MY 2025 HealthChoice Performance Against Quality Strategy Targets (NAV)

Requirement	HealthChoice	MDH Quality Strategy Targets
Compliance with Appointment Timeframe Requirements	Minimum Compliance: 80%	MY 2024: ≥85%
Routine Care Appointment Timeframe Requirement	94%	100%
Urgent Care Appointment Timeframe Requirement	89%	93%
Compliance with Provider Directory Validations	Minimum Compliance: 80%	MY 2024: ≥85%
PCP Listed in Online Directory	96%	97%
PCP's Practice Location Matched Survey Response	92%	98%
PCP's Practice Telephone Number Matched Survey Response	93%	96%
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	80%	80%
Specifies Ages of Patients Seen	84%	100%
Specifies Languages Spoken by the PCP	95%	100%
Practice has Accommodations for Patients with Disabilities	93%	100%

Source: [HealthChoice Quality Strategy 2022-2024](#)

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of MY 2024 and 2025 NAV activities. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024 and 2025:

- MCOs demonstrate **quality** by conducting monitoring activities of network adequacy to ensure provider-to-enrollee ratios and time and distance standards meet requirements for enrollees' ability to receive quality care. MCOs must also ensure that PCPs are providing accurate information during enrollee calls and when utilizing MCO online provider directories with an "easy to use" system to increase the likelihood that enrollees are able to access timely healthcare services to promote the desired health outcomes.
- MCOs demonstrate **access (or accessibility)** by ensuring that the network of PCPs is adequately supporting enrollees through "easy to use" systems to access accurate PCP information, the ability for enrollees to successfully contact PCP offices, schedule timely appointments, and providing enrollees an adequate array of available providers within their service area.
- MCOs demonstrate **timeliness** by ensuring that the network of PCPs is adequately supporting enrollees through the availability of routine and urgent care appointment times.

Areas of impact during the MY 2024 NAV activity and MY 2025 NAV telephone surveys and provider directory validations include:

- MCOs demonstrated **quality** with an increased likelihood that enrollees will have access to correct provider phone numbers and addresses in the MCO online provider directories.
- MCOs demonstrated **access** with the continued likelihood that contracted providers will accept the enrollee's MCO.
- MCOs demonstrated **timeliness** with an increase in the likelihood that enrollees can schedule routine care appointments within 30 days and demonstrated a decrease in the likelihood that enrollees can schedule urgent care appointments within 48 hours.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2025 NAV Focused Study and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance. Qlarant did not observe any aggregate improvements or recommend any actions relevant for all MCOs.

Table 69. MYs 2024 and 2025 Strengths, Improvements, and Recommendations (NAV)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Access	Strengths: • All MCOs performed at validation ratings of <i>Moderate Confidence</i> and <i>High Confidence</i> for time and distance standards.	↑
Quality, Access, and Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Timeliness	Strengths: • HealthChoice's aggregate performance exceeded the 80% minimum compliance score and the MDH Quality Strategy goal of 85% in seven of the nine requirements for appointment timeframes and provider directory validations.	↑
Timeliness	Improvements: • All MCOs exceeded the 80% minimum compliance score for compliance with routine care appointment standards.	↑
Quality, Access, Timeliness	Recommendations: • All MCOs requiring a CAP received recommendations that, if implemented, should improve performance for future reviews. • Provide complete and accurate PCP information for MCO internal listings and online provider directories to continue to improve successful contact with the intended PCP office. • Notify PCPs of the Maryland NAV survey timeframe and promote participation one month before the surveys begin to increase the likelihood of successful contacts.	↑

Domain	Strengths, Improvements, and Recommendations	Assessment
	- Refrain from completing any MCO-specific provider surveys within the same timeframe as the Maryland NAV survey to optimize PCP participation. - Review and address root causes for the decrease in <i>PCP Accepts New Patients for Listed MCO</i>. - Review and address root causes for the increase in <i>Number Did Not Reach Intended Provider</i>. - Review and address root causes for the increase in <i>No Answer</i>. - Review and address root causes for the increase of unsuccessful surveys due to “PCP Response” related to <i>Does Not Accept Insurance</i>, which was the reason for most of the unsuccessful surveys due to “PCP Response.” - Review and address root causes for the decrease in compliance of standards for urgent care appointments. - Review and address root causes for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> being the requirement with the lowest HealthChoice aggregate performance. - Provide education to provider staff members to ensure staff responses match the online provider directories. - Clearly differentiate acceptance of new patients and/or acceptance of MCO patients. - Clearly identify the age ranges served by the PCP.	

Green and ↑ = Domain experienced a positive impact from MCOs' performance.

Additional Information

For additional findings and comprehensive details associated with the MYs 2024 and 2025 NAV activities, please access the link to the MYs 2024 and 2025 NAV Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the NAV validation related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Encounter Data Validation

Objective

States rely on valid and reliable encounter/claims data submitted by MCOs to make key decisions, establish goals, assess and improve quality of care, monitor program integrity, and determine capitation rates. Collecting complete and accurate encounter data is critical to evolving payment methodologies and value-based payment elements. Validation of encounter data provides MDH with a level of confidence in the completeness, accuracy, validity, and reliability of encounter data submitted by the MCOs.

Methodology

Description of Data Obtained. Qlarant obtained the following data to complete the EDV study:

- Electronic encounter data submitted by the MCOs
- ISCA documentation from the MCOs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant conducted EDV in accordance with the *CMS External Quality Review (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 the following activities:

- **Activity 1. Reviewed state requirements for collecting and submitting encounter data.** Qlarant reviewed MDH's contractual requirements for encounter data collection and submission to ensure the MCOs followed the specifications in file format and encounter types.
- **Activity 2. Reviewed each MCO's capability to produce accurate and complete encounter data.** Qlarant evaluated each MCO's ISCA to determine whether each MCO's information system can collect and report high-quality encounter data.
- **Activity 3. Analyzed MCO electronic encounter data for accuracy and completeness.** MDH elected to contract with Hilltop to analyze and evaluate the validity of encounter data to complete Activity 3. Hilltop performed an evaluation of all electronic encounter data submitted by the MCOs for MYs 2022 through 2024 to determine the validity of the encounter data and ensure the data are complete, accurate, and of high-quality.
- **Activity 4. Reviewed medical records for confirmation of findings of encounter data analysis.** Qlarant's certified coders/nurse reviewers compared electronic encounter data to medical record documentation to confirm the accuracy of reported encounters. A random sample of encounters for inpatient, outpatient, and office visit claims were reviewed to evaluate if the electronic encounter was documented in the medical record and the level of documentation supported the billed service codes. Reviewers validate patient identifiers, diagnosis codes, procedure codes, and if applicable, revenue codes.
- **Activity 5. Submitted findings to MDH.** Qlarant prepared a report for submission to MDH, which includes results, strengths, recommendations, and any required CAPs.
- **Corrective Actions.** MCOs identified as requiring corrective action submitted a CAP with proposed detailed actions to correct any identified deficiencies from the EDV review. Qlarant evaluated and determined the adequacy of compliance for all CAPs. A CAP was determined to be adequate only if it addressed all required elements and components (such as timelines, action steps with identified responsible parties, and documented evidence).

Timeline. Qlarant conducted EDV for MY 2024, encompassing January 1, through December 31, 2024, for all nine HealthChoice MCOs. CAPs must be submitted within 45 calendar days of receipt of the EDV results.

Results

Activity 1: State Requirements for Collecting and Submitting Encounter Data

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

MDH’s Encounter Data Requirements and Specifications:

- Requirements for collecting and submitting encounter data by the MCOs, including specifications in the contracts between MDH and the MCO.
- Format requirements for data submissions from the MCOs.
- Requirements specifying the encounter types needing validation.
- MDH’s standards for encounter data completeness and accuracy.
- Requirements regarding timeframes for data submission.

Edit Check and Process Descriptions:

- A description of the information flow from the MCO to MDH, including the role of any contractors or data intermediaries.
- A list and description of edit checks built into MDH’s Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks.

Resources:

- MDH’s abridged data dictionary.
- Qlarant’s prior year EQR report on validating encounter data.
- Hilltop’s current MY report, *EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2022 to CY 2024*.
- Any other information relevant to encounter data validation.

Performance Standards. MDH establishes performance standards used to define requirements for encounters in MY 2024 HealthChoice MCO Agreements and Appendix O of MCO contracts. Subsections 4 and 5 of Section II.1 of the MY 2024 HealthChoice MCO Agreement (page 13) specify MDH’s requirements for collecting and submitting encounter data by the MCOs. Appendix O of the contract includes all the COMAR

provisions applicable to MCOs, including regulations concerning encounter data. Regulations applying to MY 2024 encounters are noted in the table below.

Table 70. MY 2024 Encounter Data Requirements (EDV)

Requirement	COMAR
A description of the applicant's management information system, including, but not limited to: - Capacities, including: - The ability to generate and transmit electronic claims data consistent with the Medicaid Statistical Information System (MSIS) requirements or successor systems. - The ability to collect and report data on enrollee and provider characteristics and on all services furnished to enrollees through an encounter data system. - The ability to screen the data collected for completeness, logic, and consistency; and - The ability to collect and report data from providers in standardized formats using secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts; - Software; - Characteristics; and - Ability to interface with other systems.	10.67.03.11A
A description of the applicant's operational procedures for generating service-specific encounter data.	10.67.03.11B
Evidence of the applicant's ability to report monthly, service-specific encounter data in UB04 or CMS1500 format.	10.67.03.11C
MCOs shall submit to MDH the following: Encounter data in the form and manner described in COMAR 10.67.04.15B, 42 CFR §438.242(c), and 42 CFR §438.818.	10.67.07.03A(1)
MCOs shall report to MDH any identified inaccuracies in the encounter data reported by the MCOs or its subcontractors within 30 days of the date discovered, regardless of the effect which the inaccuracy has upon MCOs reimbursement.	10.67.07.03B
Encounter Data: - MCOs shall submit encounter data reflecting 100% of provider-enrollee encounters, in CMS1500 or UB04 format or an alternative format previously approved by MDH. - MCOs may use alternative formats, including: - Accredited Standards Committee X12N 837 and National Council for Prescription Drug Program formats; and - Accredited Standards Committee X12N 835 format, as appropriate. - MCOs shall submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of data to be specified by CMS and MDH, including, at a minimum: - Enrollee and provider identifying information. - Service, procedure, and diagnosis codes. - Allowed, paid, enrollee responsibility, and the third-party liability amounts; and - Service, claims submissions, adjudication, and payment dates.	10.67.04.15B

Requirement	COMAR
- MCOs shall report encounter data within 60 calendar days after receipt of the claim from the provider. - MCOs shall submit encounter data utilizing a secure online data transfer system.	

MDH sets forth requirements regarding timeframes for data submission in COMAR 10.67.04.15B, which specifies that MCOs must report encounter data within 60 calendar days after receipt of the claim from the provider. For daily data exchanges, the cutoff time is 3 p.m. for transmission of a single encounter data file for an MCO to receive an 835 the next day. Any encounters processed after the cutoff time will be picked up in the next adjudication cycle on the following business day.

Encounter Data Processes. MDH provided an abridged data dictionary and described the process of encounter data submission from the MCOs to MDH. MCOs can submit encounter data through a web portal or through a file transfer protocol. Each MCO may contract with a vendor or use data intermediaries to prepare encounter data submissions.

The electronic data interchange (EDI) is an automated system that includes rules dictating the transfer of data from each MCO to MDH. MDH uses the Health Insurance Portability and Accountability Act (HIPAA) EDI transaction sets and standards for data submission of 820, 834, 835, and 837 files. The 837 file contains patient claim information, while the 835 file contains the payment and/or explanation of benefits for a claim. MDH processes encounters via the Electronic Data Interchange Translator Processing System for completeness and accuracy. All encounters are validated on two levels: first by performing Level 1 and Level 2 edit checks on 837 data, using HIPAA EDI implementation guidelines; and second, within MMIS' adjudication process. The system treats encounters that fail the MMIS edit checks in the following manner:

- All denied and rejected encounters appear with the MMIS Explanation of Benefit code and description in the 8ER file, with one exception: Explanation of Benefit code 101 is excluded from this report.
- All paid and denied encounters appear in the 835 file. Denied encounters use the HIPAA EDI Claim Adjustment Reason Codes and Remittance Advice Remark Codes to report back the denied reason. Encounters marked as suspended are not included in the 835.
- In addition, MMIS generates a summary report for each MCO.

Activity 2: MCO's Capability to Produce Accurate and Complete Encounter Data

Purpose. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. The following steps assessed each MCO's information systems process and capabilities in capturing complete and accurate encounter data:

- Review of the MCO's ISCA.** The purpose of the ISCA review is to assess the MCO's information systems capabilities to capture and assimilate information from multiple data sources. The documentation review also determines if the system may be vulnerable to

incomplete or inaccurate data capture, integration, storage, or reporting. Documentation review findings are used to identify issues that may contribute to inaccurate or incomplete encounter data.

2. **Interview of MCO personnel, as needed.** After reviewing the findings from the ISCA, Qlarant conducted follow-up interviews with MCO personnel, as needed, to supplement the information and ensure an understanding of the MCO's information systems and processes.

Results. Results of the document review and interview process follow.

Table 71. MY 2024 ISCA Summary (EDV)

Information System Component Assessment	HealthChoice Aggregate
Captures Data Appropriately	Yes/No
Captures accurate encounter data	Yes
Captures all appropriate data elements for claims processing	Yes
Clean Claims Assessment	%
Clean Claims in 30 Days Timeliness Standard	96%
Clean Claims in 30 Days Timeliness Rate	98%
Electronic Claims Assessment	%
Percentage of electronic professional claims	95%
Percentage of electronic institutional/facility claims	87%

Activity 3: Analysis of MCO's Electronic Encounter Data for Accuracy and Completeness

Purpose. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Therefore, Hilltop completed Activity 3 of the EDV, which requires the following four steps for analysis:

1. Develop a plan to test data quality, based on validity requirements per data element.
2. Verify data integrity through conducting a macro analysis of encounter data.
3. Generate and review analytic reports through conducting a micro analysis of encounter data.
4. Compare findings to state-identified benchmarks.

Hilltop's report conclusions for MY 2024's Activity 3 are provided below.

The analysis of the CY 2024 electronic encounter data shows a decrease in provider enrollment-related denied encounters. Although the changes in provider encounter edits still present challenges, the Department and the MCOs have continued to build on recent improvements.

The CY 2024 encounter data validation demonstrates progress in reducing denied encounters. The most concerning issue in CY 2024 encounter data is the ongoing volume of encounter denials from provider enrollment errors. The Department should continue to work with the MCOs to resolve their NPI Crosswalk and provider exceptions and enrollment issues, which will allow for more accurate rate setting in the future. Workgroup meetings with MCOs are ongoing for the CY 2025 contract, aiming to further refine which encounters should be excluded from the HFMR. In addition, “inappropriate denials” due to MMIS limitations are included in the HFMR. The Department will work with the MCOs to ensure that appropriately denied encounters will not be reported on the HFMR. In addition, some MCOs had unusually high volumes of \$0 encounters, which should also be excluded from the HFMR. In August 2025, the Department distributed files to each MCO detailing their CY 2024 \$0 reimbursement encounters submitted with and without a 09 indicator to help MCOs improve the quality of their encounter data. The Department will continue to work with the MCOs to provide an explanation and ensure the accuracy of the provider reimbursement field with future submissions.

Generally, the MCOs have similar distributions of denials, types of encounters, types of visits, and outliers, except where specifically noted in the results. This analysis identified minor outliers that merit further monitoring and investigation, though the MCOs have improved. Hilltop prepared recipient-level reports for Department staff to discuss with the MCOs. The Department should review the content standards and criteria for accuracy and completeness with the MCOs. Continued work with each MCO to address identified discrepancies will improve the quality and integrity of encounter submissions and enhance the Department’s ability to assess the efficiency and effectiveness of the Medicaid program.

Hilltop found that the volume of accepted encounters was generally consistent with MCO enrollment. Although the time dimension analysis showed variation among MCOs regarding the timeliness of encounter submissions, most encounters were submitted within the eight-month maximum time frame allotted by the Department. While the MCOs demonstrated mixed performance on the number of encounters submitted within six months, there was a decrease in encounters submitted after six months during the evaluation period.

Activity 4: Analysis of Medical Records to Confirm Encounter Data Accuracy

Purpose. A review of enrollees’ medical records offers a method to examine the completeness and accuracy of encounter data. Using the encounter/claims data file prepared by Hilltop, Qlarant identified all enrollees with an inpatient, outpatient, and office visit service claim.

Medical Record Sample. The sample size was selected to ensure a 90% confidence interval with a $\pm 5\%$ margin of error for sampling. Oversampling was used to ensure an adequate number of medical records were received to meet the required sample size. Hospital inpatient and outpatient encounter types were oversampled by 300%, while office visit encounter types were oversampled by 400% for each MCO.

Records were requested directly from the billing providers. Qlarant mailed each sampled provider a letter with the specific record request, which included the patient's name, medical assistance identification number, date of birth, date(s) of service, claim number, and treating physician's national provider identifier number. Targeted follow-up was conducted, as needed, with providers who did not respond to the initial request, including phone calls and fax requests. Providers were asked to securely submit medical record information to Qlarant with the following instructions:

- Identify documentation submitted for each patient using the patient's first and last name, medical assistance identification number, date of birth, age, gender, and provider name.
- Include all relevant medical record documentation to ensure receipt of adequate information for validating service codes (a list of recommended documentation was provided for reference).

The total number of EDV minimum samples required, classified by encounter type, is displayed in the table below. The sample size for MY 2024 remained consistent with previous years. Additional provider outreach was required to meet the minimum sample.

Table 72. MYs 2022 to 2024 Minimum Sample Required for Review by Encounter Type (EDV)

Sample Size by Encounter Type	MY 2022	MY 2023	MY 2024
Inpatient	52 (2%)	52 (2%)	55 (2%)
Outpatient	497 (20%)	458 (19%)	455 (19%)
Office Visit	1,907 (78%)	1,944 (79%)	1,947 (79%)
Total	2,456	2,454	2,457

Note: Values reported are rounded to the nearest percentage for reporting only.

The following table specifies review sizes and identifies if sample size was achieved, per MCO.

Table 73. MY 2024 MCO EDV Medical Record Review Response Rates by Encounter Type (EDV)

Response Rate by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Inpatient Records Reviewed (#)	7	7	8	5	5	6	7	6	5
Minimum Reviews Required (#)	7	7	8	5	5	6	6	6	5
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient Records Reviewed (#)	52	50	76	18	56	56	58	51	48
Minimum Reviews Required (#)	50	49	73	18	54	56	58	50	47

Response Rate by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Office Visit Records Reviewed (#)	218	221	193	252	216	212	210	219	224
Minimum Reviews Required (#)	216	218	192	249	214	211	209	217	221
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Total	277	278	277	275	277	274	275	276	277

Match Rates. Medical records received were verified against the sample listing and enrollee demographic information from the data file to ensure consistency between submitted encounter data and corresponding medical records. All diagnosis, procedure, and revenue codes included in the data were validated per record for the EDV. Reviews determined whether the diagnosis, procedure, and revenue codes, if applicable, were substantiated by the medical record. Qlarant defines findings of consistency in terms of *Match*, *No Match*, and *Invalid*, as described in the table below.

Table 74. MY 2024 Review Determinations (EDV)

Review Determinations	Criteria
Match	Determinations were a <i>Match</i> when reviewers found documentation in the record.
No Match	Determinations were a <i>No Match</i> when there was a lack of documentation in the record, coding error(s), or upcoding.
Invalid	Determinations were <i>Invalid</i> when a medical record was not legible or could not be verified against the encounter data by key identifiers: patient name, gender, date of birth, or date(s) of service. When this situation occurred, the reviewer ended the review process.

Trended Match Rate Observations. MY 2024's EDV review observed the following about match rates of HealthChoice performance across all three encounter types:

- **Match Rate Compliance.** All three encounter types, inpatient, outpatient, and office visit, exceeded the established threshold (90%) by five to nine percentage points. The total percentage of matched elements exceeds the threshold by eight percentage points.
- **Match Rate Trends.** The total percentage of matched elements experienced a slight decrease, by two percentage points, from MY 2022 to MY 2023; however, the total percentage of matched elements has remained consistent and above the compliance threshold.

Table 75. MYs 2022 through 2024 Results by Encounter Type (EDV)

Encounter Type	MY 2022	MY 2023	MY 2024
Inpatient	56	54	56
Outpatient	517	467	465
Office Visit	1,953	1,967	1,965
Total Records Reviewed	2,526	2,488	2,486
Inpatient	1,206	1,208	1,231
Outpatient	7,106	6,286	6,212
Office Visit	9,753	10,650	10,276
Total Possible Elements[^]	18,065	18,144	17,719
Inpatient	1,203	1,195	1,211
Outpatient	7,033	6,144	6,125
Office Visit	9,409	10,157	9,720
Total Matched Elements	17,645	17,496	17,056
Inpatient	100%	99%	98%
Outpatient	99%	98%	99%
Office Visit	96%	95%	95%
Total Percentage of Matched Elements	98%	96%	96%

[^] Possible elements include diagnosis, procedure, and revenue codes.

Inpatient Encounters

Aggregate Results by Code Type. MY 2024's EDV study observed the following about match rates of HealthChoice performance for inpatient encounters when trending data from MY 2022 to MY 2024:

- **Match Rate Compliance.** The total match percentage for inpatient encounter type has demonstrated a consistent decline of one percentage point from MY 2022 to present; however, it has continued to surpass the established threshold (90%) by nine or ten percentage points and remained above the established threshold for MY 2024 by eight percentage points.
- **Match Rate Trends.** The aggregate results have trended consistently over the last three years, decreasing or increasing by one to three percentage points only.

Table 76. MYs 2022 through 2024 Inpatient Encounter Type Results by Code (EDV)

Match Results by Code Type	MY 2022	MY 2023	MY 2024
Match	469	488	456
No Match	1	9	6
Total Elements	470	497	462
Diagnosis Match Percentage	100%	98%	99%
Match	117	73	90
No Match	0	2	2
Total Elements	117	75	92
Procedure Match Percentage	100%	97%	98%
Match	617	634	665
No Match	2	2	12
Total Elements	619	636	677
Revenue Match Percentage	100%	100%	98%
Match	1,203	1,195	1,211
No Match	3	13	20
Total Elements	1,206	1,208	1,231
Total Match Percentage	100%	99%	98%

Note: Values reported are rounded to the nearest percentage for reporting only.

MCO Results by Code Type. MY 2024's EDV review observed the following about match rates of MCO performance by diagnosis, procedure, revenue, and total codes from inpatient encounters:

- **Match Rate Compliance.** All MCOs, except for UHC, scored above the established compliance threshold by eight or more percentage points. UHC scored (88%) two percentage points below the established compliance threshold for inpatient encounter type. This decline in score is associated with procedure and revenue codes.
- **Match Rate Trends.** Five of the nine MCOs (ABH, CFCHP, JMS, KPMAS, and WPM) demonstrated full compliance (100%) for inpatient encounter type.

Table 77. MY 2024 MCO Inpatient Results by Code Type (EDV)

Code Types by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	68	72	62	42	38	51	39	38	46
Diagnosis Codes Total (#)	68	72	62	42	40	53	40	39	46
Diagnosis Codes Score (%)	100%	100%	100%	100%	95%	96%	98%	97%	100%
Procedure Codes Match (#)	8	8	11	9	12	15	15	9	3

Code Types by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Procedure Codes Total (#)	8	8	11	9	12	15	15	11	3
Procedure Codes Score (%)	100%	100%	100%	100%	100%	100%	100%	82%	100%
Revenue Codes Match (#)	90	95	80	63	79	106	38	58	56
Revenue Codes Total (#)	90	95	80	63	79	106	38	70	56
Revenue Codes Score (%)	100%	100%	100%	100%	100%	100%	100%	83%	100%
Total Codes Match (#)	166	175	153	114	129	172	92	105	105
Total Codes Total (#)	166	175	153	114	131	174	93	120	105
Total Codes Score (%)	100%	100%	100%	100%	98%	99%	99%	88%	100%
Number of Reviews	7	7	8	5	5	6	7	6	5

Note: Values reported are rounded to the nearest percentage for reporting only.

Outpatient Encounters

Aggregate Results by Code Type. MY 2024's EDV study observed the following about match rates of HealthChoice performance for outpatient encounters, when trending data from MY 2022 to MY 2024:

- **Match Rate Compliance.** Outpatient total match element percentages remained consistent year-over-year, dropping by only one percentage point in MY 2023 and regained that percentage point in MY 2024, ending at nine percentage points above the compliance threshold.
- **Match Rate Trends.** While diagnostic match percentage has remained steady (98%) year-over-year, MCOs demonstrated fluctuation in the procedure match percentage, declining in MY 2023 by two percentage points (97%). This fluctuation was quickly resolved as the procedure match percentage regained those two points in MY 2024, returning to the baseline from MY 2022 (99%).

Table 78. MYs 2022 through 2024 Outpatient Encounter Type Results by Code (EDV)

Match Results by Code Type	MY 2022	MY 2023	MY 2024
Match	2,046	1,714	1,707
No Match	41	42	32
Total Elements	2,087	1,756	1,739
Diagnosis Match Percentage	98%	98%	98%
Match	2,887	2,620	2,616
No Match	19	75	38
Total Elements	2,906	2,695	2,654
Procedure Match Percentage	99%	97%	99%

Match Results by Code Type	MY 2022	MY 2023	MY 2024
Match	2,024	2,100	1,802
No Match	6	13	17
Total Elements	2,030	2,113	1,819
Revenue Match Percentage	100%	99%	99%
Match	6,957	6,434	6,125
No Match	66	130	87
Total Elements	7,023	6,564	6,212
Total Match Percentage	99%	98%	99%

Note: Values reported are rounded to the nearest percentage for reporting only.

MCO Results by Code Type. MY 2024's EDV study observed the following about match rates of MCO performance by diagnosis, procedure, revenue, and total codes from outpatient encounters:

- **Match Rate Compliance.** All MCOs exceeded the established compliance threshold, ranging from five to ten percentage points above.
- **Match Rate Trends.** Four of the nine MCOs (JMS, KPMAS, MPC, and WPM) demonstrated full compliance (100%) for outpatient total code match percentage. ABH consistently demonstrated the lowest score per code type; however, all results still exceeded the established threshold (90%).

Table 79. MY 2024 MCO Outpatient Results by Code Type (EDV)

Code Types by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	172	229	239	71	211	175	206	223	181
Diagnosis Codes Total (#)	184	240	241	71	212	177	206	226	182
Diagnosis Codes Score (%)	93%	95%	99%	100%	100%	99%	100%	99%	99%
Procedure Codes Match (#)	315	334	335	141	314	293	285	339	260
Procedure Codes Total (#)	334	335	337	141	314	295	297	341	260
Procedure Codes Score (%)	94%	100%	99%	100%	100%	99%	96%	99%	100%
Revenue Codes Match (#)	221	218	246	99	216	205	198	217	182
Revenue Codes Total (#)	230	219	246	99	216	206	201	219	183
Revenue Codes Score (%)	96%	100%	100%	100%	100%	100%	99%	99%	99%
Total Codes Match (#)	708	781	820	311	741	673	689	779	623
Total Codes Total (#)	748	794	824	311	742	678	704	786	625
Total Codes Score (%)	95%	98%	100%	100%	100%	99%	98%	99%	100%
Number of Reviews	52	50	76	18	56	56	58	51	48

Note: Values reported are rounded to the nearest percentage for reporting only.

Office Visit Encounters

Aggregate Results by Code Type. MY 2024's EDV study observed the following about match rates of HealthChoice performance for office visit encounters when trending data from MY 2022 to MY 2024:

- **Match Rate Compliance.** Total match percentage for office visits, while declining from MY 2022, remains consistently above the established compliance threshold.
- **Match Rate Trends.** The aggregate diagnosis match percentage has declined by two percentage points each MY, demonstrating an overall decline of four percentage points from MY 2022 to MY 2024. Procedure match percentage has only fluctuated by one percentage point year to year, demonstrating true consistency.

Table 80. MYs 2022 through 2024 Office Visit Results by Code (EDV)

Match Results by Code Type [^]	MY 2022	MY 2023	MY 2024
Match	5,669	5,982	5,731
No Match	165	294	400
Total Elements	5,848	6,276	6,131
Diagnosis Match Percentage	97%	95%	93%
Match	3,740	4,175	3,989
No Match	158	199	156
Total Elements	3,905	4,374	4,145
Procedure Match Percentage	96%	95%	96%
Match	9,409	10,157	9,720
No Match	323	493	556
Total Elements	9,732	10,650	10,276
Total Match Percentage	96%	95%	95%

[^]Revenue codes are not applicable for office visit encounters.

Note: Values reported are rounded to the nearest percentage for reporting only.

MCO Results by Code Type. MY 2024's EDV study observed the following about match rates of MCO performance by diagnosis, procedure, and total codes from office visit encounters:

- **Match Rate Compliance.** All MCOs met or exceeded the established compliance threshold for total code match. JMS was the only MCO to fall below the threshold in diagnosis code match percentage but did meet the requirement within procedure code matches.
- **Match Rate Trends.** Seven of the nine MCOs demonstrated a lower compliance percentage within diagnosis match code than procedure match codes from MY 2023 to MY 2024, the exception being UHC, which presented a consistent percentage across both code type

matches (95%), and WPM, which presented a one-percentage-point increase from procedure to diagnosis match scores. JMS showed the largest difference between code types, with a decrease of nine percentage points between procedure and diagnosis.

Table 81. MY 2024 MCO Office Visit Results by Code Type (EDV)

Code Types by MCO^	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	703	664	535	483	718	629	656	681	662
Diagnosis Codes Total (#)	745	727	615	502	764	677	684	720	697
Diagnosis Codes Score (%)	94%	91%	87%	96%	94%	93%	96%	95%	95%
Procedure Codes Match (#)	500	499	288	392	430	396	508	462	514
Procedure Codes Total (#)	522	528	300	398	437	408	519	484	549
Procedure Codes Score (%)	96%	95%	96%	98%	98%	97%	98%	95%	94%
Total Codes Match (#)	1,203	1,163	823	875	1,148	1,025	1,164	1,143	1,176
Total Codes Total (#)	1,267	1,255	915	900	1,201	1,085	1,203	1,204	1,246
Total Codes Score (%)	95%	93%	90%	97%	96%	94%	97%	95%	94%
Number of Reviews	218	221	193	252	216	212	210	219	224

^Revenue codes are not applicable for office visit encounters.

Note: Values reported are rounded to the nearest percentage for reporting only.

Aggregate Results for MY 2024 EDV

Two MCOs, JMS and WPM, have consistently demonstrated full compliance (100%) for the inpatient encounter type during all three compared years, MY 2022 through MY 2024. KPMAS has maintained full compliance (100%) in the outpatient encounter type, while both MSFC and UHC have also demonstrated consistency, maintaining a 99% compliance score for all three years. While eight of the nine MCOs show eight to ten percentage points above the compliance threshold, UHC's inpatient compliance score (88%) has fallen two percentage points below the threshold. This will result in UHC being required to submit a CAP for MY 2024. JMS also demonstrated a significant decline in the office visit encounter type, dropping by eight percentage points (90%), but has met the established threshold.

Table 82. MYs 2022 through 2024 MCO and HealthChoice Results by Encounter Type (EDV)

MY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Inpatient	%	%	%	%	%	%	%	%	%	%
MY 2022	100%	100%	100%	100%	99%	99%	100%	99%	100%	100%
MY 2023	96%	99%	100%	99%	97%	98%	100%	99%	100%	99%
MY 2024	100%	100%	100%	100%	98%	99%	99%	88%	100%	98%
Outpatient	%	%	%	%	%	%	%	%	%	%
MY 2022	99%	100%	99%	100%	99%	99%	97%	99%	99%	99%

MY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
MY 2023	99%	98%	98%	100%	98%	99%	94%	99%	97%	98%
MY 2024	95%	98%	100%	100%	100%	99%	98%	99%	100%	99%
Office Visit	%	%	%	%	%	%	%	%	%	%
MY 2022	95%	93%	96%	99%	96%	99%	97%	98%	94%	96%
MY 2023	95%	95%	98%	97%	94%	95%	96%	95%	95%	95%
MY 2024	95%	93%	90%	97%	96%	94%	97%	95%	94%	95%

Note: Values reported are rounded to the nearest percentage for reporting only.

Red font denotes a CAP requirement for components scoring below the 90% minimum compliance score.

All Encounters *No Match* Summary

No Match Reason Coding Error Summary. Of the errors found in MY 2024, inpatient encounter type had no coding errors. The percentage of coding errors found in office visit encounters has increased significantly year-over-year, increasing a total of 31 percentage points in diagnosis codes and 39 percentage points in procedure codes from MY 2022. Of the errors found for revenue codes, the coding error reason consistently shows few to no instances.

Table 83. MYs 2022 through 2024 Coding Error Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2022 No Match (#)	MY 2022 Rate (%)	MY 2022 Total Errors* (#)	MY 2023 No Match (#)	MY 2023 Rate (%)	MY 2023 Total Errors* (#)	MY 2024 No Match (#)	MY 2024 Rate (%)	MY 2024 Total Errors* (#)
Inpatient Diagnosis	0	0%	1	4	44%	9	0	0%	6
Outpatient Diagnosis	2	5%	41	5	12%	42	2	6%	32
Office Visit Diagnosis	9	6%	165	70	24%	294	148	37%	400
Inpatient Procedure	0	0%	0	0	0%	2	0	0%	2
Outpatient Procedure	0	0%	19	4	5%	75	3	8%	38
Office Visit Procedure	6	4%	158	38	19%	199	67	43%	156
Inpatient Revenue	0	0%	2	0	0%	2	0	0%	12
Outpatient Revenue	0	0%	13	2	8%	25	0	0%	17

*Total Errors account for all three no match reasons: Coding Error, Lack of Documentation, and Upcoding.

No Match Reason Lack of Documentation Summary. Of the revenue errors found year-over-year, 90% to 100% were due to lack of documentation. All errors found for inpatient encounters for MY 2024 were due to lack of documentation. While this reason does consistently account for most errors found, office visit encounters demonstrate a significant decline from MY 2022: 32 percentage points for diagnosis codes and 39 percentage points for procedure codes.

Table 84. MYs 2022 through 2024 Lack of Documentation Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2022 No Match (#)	MY 2022 Rate (%)	MY 2022 Total Errors* (#)	MY 2023 No Match (#)	MY 2023 Rate (%)	MY 2023 Total Errors* (#)	MY 2024 No Match (#)	MY 2024 Rate (%)	MY 2024 Total Errors* (#)
Inpatient Diagnosis	1	100%	1	5	56%	9	6	100%	6
Outpatient Diagnosis	39	95%	41	37	88%	42	30	94%	32
Office Visit Diagnosis	156	95%	165	224	76%	294	252	63%	400
Inpatient Procedure	0	0%	0	2	100%	2	2	100%	2
Outpatient Procedure	19	100%	19	71	95%	75	35	92%	38
Office Visit Procedure	152	96%	158	154	77%	199	89	57%	156
Inpatient Revenue	2	100%	2	2	100%	2	12	100%	12
Outpatient Revenue	13	100%	13	23	92%	25	17	100%	17

*Total Errors account for all three no match reasons: Coding Error, Lack of Documentation, and Upcoding.

***No Match* Reason Upcoding Summary.** There are no reported instances of upcoding for MY 2024. This shows consistency with MY 2022, determining the MY 2023 instance within office visit procedure codes to be an outlier.

Table 85. MYs 2022 through 2024 Upcoding Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2022 No Match (#)	MY 2022 Rate (%)	MY 2022 Total Errors* (#)	MY 2023 No Match (#)	MY 2023 Rate (%)	MY 2023 Total Errors* (#)	MY 2024 No Match (#)	MY 2024 Rate (%)	MY 2024 Total Errors* (#)
Inpatient Diagnosis	0	0%	1	0	0%	9	0	0%	6
Outpatient Diagnosis	0	0%	41	0	0%	42	0	0%	32
Office Visit Diagnosis	0	0%	165	0	0%	294	0	0%	400
Inpatient Procedure	0	0%	0	0	0%	2	0	0%	2
Outpatient Procedure	0	0%	19	0	0%	75	0	0%	38
Office Visit Procedure	0	0%	158	7	4%	199	0	0%	156
Inpatient Revenue	0	0%	2	0	0%	2	0	0%	12
Outpatient Revenue	0	0%	13	0	0%	25	0	0%	17

*Total Errors account for all three no match reasons: Coding Error, Lack of Documentation, and Upcoding.

Conclusion

Qlarant and Hilltop completed an EDV study for MDH based on an assessment of encounters paid during MY 2024. MCO results remain consistent year-over-year with MCOs experiencing a one-to-five-percentage-point fluctuation but remaining above the compliance threshold (90%). In MY 2024, this remains true with the exception of JMS, which demonstrated an eight-percentage-point decrease for office visit encounter type (90%) and UHC's inpatient encounter type, which declined by 11 points (88%). This decline in UHC's inpatient encounter type performance places it beneath the compliance threshold by two percentage points. This is the first instance of an MCO requiring a CAP in the past three reporting years.

Quality Strategy Highlights

MDH established goals for match rates in the HealthChoice Quality Strategy for 2022-2024. The target compliance score for each encounter type was 99% for MY 2024. As displayed in the table below, the HealthChoice aggregate inpatient match rate fell just shy of the target score by one percentage point.

Table 86. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets (EDV)

Requirement: Minimum Compliance Score: $\geq 90\%$	MY 2024 HealthChoice Aggregate	MDH Quality Strategy Targets for MY 2024
Inpatient Match Rates	98%	99%
Outpatient Match Rates	99%	99%
Office Visit Match Rates	95%	99%

Source: [HealthChoice Quality Strategy 2022-2024](#)

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of the EDV study. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definition for MY 2024's EDV study:

- MCOs demonstrate **quality** by ensuring accuracy and completeness of encounter data submitted to MDH, and when compared to medical record reviews.
- MCOs demonstrate **access (or accessibility)** by ensuring access to accurate, capable, and complete information systems, which analyze and maintain encounter data in MDH's Electronic Data Interchange Translation Processing System and Medicaid Management Information System.
- MCOs demonstrate **timeliness** by ensuring encounter data submissions meet timeframe requirements.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2024 EDV study and identify positive (↑), negative (↓), or NA assessments of MCO performance. Qlarant did not observe any aggregate improvements as MCOs demonstrated consistency over the trended period.

Table 87. MY 2024 Strengths, Improvements, and Recommendations (EDV)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	Strengths: - Aggregate results have remained consistent year-over-year for total match percentage. - HealthChoice aggregate results for outpatient encounter types met the MDH HealthChoice target rate as documented within the Quality Strategy.	↑
Quality	Opportunities: - While remaining well above the compliance threshold, the HealthChoice aggregate total for inpatient encounter types has shown a consistent decline of one percentage point per year. MCOs have an opportunity to investigate claims data for reporting inconsistencies, as documented in the MCO-specific sections below. - Aggregate inpatient and office visit match rates did not meet the MDH HealthChoice Quality Strategy target for MY 2024, missing the goal of 99% compliance by one and four percentage points, respectively.	↓
Quality	Recommendations: Opportunity for Improvement Exists in Office Visit Encounter Match Rates. All MCOs should investigate possible cause(s) for office visit encounter match rates, as an opportunity for improvement exists. While aggregate scores remained consistent from MY 2023 (95%), after the initial decline from MY 2022 (97%), no improvements have been noted in attempts to reach the MY 2024 Quality Strategy target rate (99%). Continued Lack of Documentation. Lack of documentation continues to be the primary reason for <i>No Match</i> findings across all encounters and code types. More than 55% of the aggregate office visit errors found were due to lack of documentation. Qlarant has observed this to be a pattern within the trended data. Complete and Accurate Medical Records. MCOs are encouraged to regularly audit encounter data submitted from providers to ensure that medical records justify the services billed, such as orders and reports of major services, operating records, procedures, test results, and patient care. MCOs are encouraged to monitor and ensure telehealth visits are coded properly with the correct modifiers. Provider Submissions. MCOs are encouraged to educate providers on audit needs and provide uniform billing (UB) billing forms with patient records for clarity. Providing the orders for admission to observation and admission to the hospital unit to clarify the admission date will benefit inpatient	↓

Domain	Strengths, Improvements, and Recommendations	Assessment
	records. Monitoring the discharge date to confirm matches within the claim data for outpatient and emergency visits ensures the validity of the record. • MCOs Should Strive for Continued Improvement. While MCO compliance rates may exceed minimum compliance scores and consistent scoring demonstrates stability within the process, there should be continued efforts towards improvement to ensure a high level of quality. • MCO-specific recommendations are documented within the tables below.	

Green and ↑ = Domain experienced a positive impact from MCOs' performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Blue** and ↓ Domain experienced a negative impact with provided guidance for enhancing MCOs' performance and reporting.

Additional Information

For additional findings and comprehensive details associated with the MY 2024 EDV activity, please access the link to the MY 2024 EDV Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the EDV activity related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Early and Periodic Screening, Diagnosis, and Treatment

Objective

Maryland's EPSDT/Healthy Kids Program mission is to improve accessibility and ensure the availability of quality healthcare for HealthChoice children and adolescents through 20 years of age. The EPSDT MRR supports this mission and assesses the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. HealthChoice MCOs are responsible for providing or arranging the full range of healthcare services for Maryland Medicaid enrollees. MCOs contract with providers to deliver covered health services to their enrollees. At its core, the Healthy Kids program is a partnership between healthcare providers, MCOs, public health officials, local health departments, and families.

Methodology

Description of Data Obtained. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Upon receiving Hilltop's full MY 2024 preventive care encounters sample frame, Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs. Sample size per MCO included a 10% oversample and provided a 90% confidence level with a 5% margin of error. A total sample of 2,651 medical records was included in the review for MY 2024 across all HealthChoice MCOs. Abstracted data from the MRRs was entered into Qlarant's EPSDT evaluation tool. Data was organized and analyzed in the following age groups:

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

Qlarant's methodology included selecting samples, defining exclusions and inclusions within samples, scheduling onsite reviews, gathering updated fax numbers, faxing medical record requests, securely storing and receiving medical records, and conducting outreach attempts for missing information.

- **Selecting Samples.** Qlarant used random sampling for MY 2024's MRR, which does not ensure all providers and practices within the MCO network are included in the sample and may include both EPSDT-certified and non-EPSDT-certified providers. MCOs are still required by regulation to ensure preventive services are rendered to Medicaid enrollees through 20 years of age, even if providers without certification by the EPSDT program are unfamiliar with the preventive care requirements. MCOs with low memberships are likely to have the same providers reviewed every year to meet the minimum record sampling requirements. Conclusions about individual provider performance in meeting program requirements cannot be made if the sample size per provider is too small (less than ten charts) or the case-mix does not include all ages.
- **Defining Exclusions and Inclusions within Samples.** Enrollees were eligible through 20 years of age, as of the last day of the measurement year, and with qualifying preventive care encounters (CPT 99381-85 or 99391-95). Only one date of service was selected from the sample for children less than two years of age who may have had four to six preventive visits within a 12-month period. EPSDT services were included for enrollees enrolled on the last day of the measurement year, and for at least 320 days in the same MCO. If the enrollee's age on the last day of the selected period was less than 365 days, the criteria was modified to read the same MCO for 180 days, with no break in eligibility. The following specialty codes were included in the sample: 16 (pediatrics), 28 (general practice), 29 (family practice), 30 (internal medicine), and 171 (nurse practitioner). The specialty code 007 (OBGYN) is excluded from the MRR. Telehealth visits were flagged and excluded from the MRR.
- **Scheduling Onsite Reviews.** For MY 2024, nurse reviewers conducted MRRs onsite at the provider offices or MCO headquarters, except for providers with five or fewer patients in the sample (singles). Qlarant's contracted administrative scheduler worked with the respective offices to determine the date and time of the review. If unsuccessful in initiating contact for scheduling after three attempts, Qlarant contacted the MCOs for assistance with solidifying provider contact and scheduling onsite MRR(s). In the event a provider office had more than one MCO identified, the MCO with the most patients on the listing was contacted first for assistance, with other MCOs contacted as needed. The administrative scheduler sent a copy of the patient listing to the provider office at the time of scheduling via fax. The nurse reviewers then confirmed the patient list with the provider office via telephone 48 hours prior to the onsite review.

Qlarant required access to the entire medical record to ensure adequate information was available to evaluate compliance with the EPSDT program guidelines. All documentation needed to be present at the time of the record review, as no documentation was accepted after the nurse left the practice site office.

- **Gathering Updated Fax Numbers.** Providers with five or fewer patients in the sample (singles) were initially contacted to obtain updated office fax numbers to submit the MY 2024 medical record request. Providers were notified that the fax request for medical records would be submitted to the fax number provided.
- **Faxing Medical Record Requests.** Qlarant directly faxed each sampled billing provider a letter with their specific medical record request.
- **Singles Medical Record Reviews:**
 - ***Securely Storing and Receiving Medical Records.*** Providers were asked to securely submit complete medical record information for specific dates of service to Qlarant via secure fax or Kiteworks.
 - ***Outreach Attempts for Missing Information.*** Upon receipt of medical records via secure fax or Kiteworks, Qlarant reviewed each record for completeness and outreached providers for any missing documentation. Qlarant conducted two outreach attempts for missing documentation. MCOs were notified when outreach attempts were exhausted for specific medical records and provided an opportunity to obtain this information. Any medical records with missing information not received by the conclusion of the EPSDT MRR activity were reviewed “as is” and scored accordingly.
- **MCO-Provided Records.** Some MCOs provide medical records, and nurse reviewers conduct onsite reviews at the MCOs’ headquarters, instead of onsite at provider offices. For MY 2024, three MCOs used this approach (JMS, KPMAS, and MSFC).
- Each record was reviewed for validity and completeness at the time of the onsite or desktop review. In the event a record was classified as invalid (incorrect date of birth, incorrect gender, incorrect date of service, patient not seen by provider, not an EPSDT record, or no record), the review for that medical record stopped, and it did not count against the total score.
- MRR samples contained total samples, completed reviews, and invalid records. Five invalid records were identified within the MY 2024 sample. During onsite or desktop reviews, nurse reviewers verified that all medical records matched the patient listing. Medical records were only considered valid if the reviewer successfully verified:
 - Patient name
 - Date of birth
 - Gender

- Date of service
- EPSDT record

Table 88. MY 2024 MCO and HealthChoice Sample Size Summary (EPSDT)

MY 2024 Sample Size	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Minimum (90% CL with 5% Error)	265	267	261	269	270	267	270	269	270	2,408
Maximum (10% Oversample)	292	294	288	296	297	294	297	296	297	2,651
Total Valid Sample Reviewed	277	273	281	293	283	273	288	272	257	2,497
Invalid Record Total	0	0	3	1	0	0	0	1	0	5

Confidence level (CL); Margin of error (error)

Technical Methods of Data Collection and Analysis. Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Prior to reviewing medical records, these nurses were required to complete Qlarant's EPSDT annual training and achieve an inter-rater reliability rate of 90% or above. The MY 2024 EPSDT MRR was conducted by six nurses who completed the EPSDT training and achieved a 90% or higher inter-rater reliability rate. One of the six nurses was a HEDIS nurse, three of the six nurses had experience completing a prior EPSDT MRR, and the two remaining nurses completed their first EPSDT MRR with Qlarant this year.

Abstracted data from the MRRs were organized and analyzed within the five age groups identified previously. Within each age group, specific elements were scored based on medical record documentation. Elements within each component are weighted equally, scored, and added together to calculate the final component score. Similarly, elements' composite (overall) scores follow the same methodology. CAPs for MCOs are required if the minimum compliance score for each component (80%) is not met. New elements or elements with revised criteria are scored as baseline for the MY.

Table 89. MY 2024 Validation Review Determinations and Scoring (EPSDT)

Review Determination	Score
Complete	2
Incomplete	1
Missing	0
Not Applicable*	NA
Compliance Score	MDH established the minimum compliance for MY 2024 at 80%.

***Exception** – a vision assessment for a blind child or a documented refusal of a flu vaccine by a parent received a score of two.

Corrective Action Plan Process. MCOs are required to submit CAPs for elements or components not meeting the minimum compliance score. Qlarant evaluates CAPs to determine whether they are acceptable and provides recommendations to the MCOs until an acceptable CAP is submitted. CAPs are determined to be adequate only if they address all required elements and components.

Qlarant evaluates the effectiveness of any CAPs initiated because of the prior year's review. A review of all required EPSDT components is completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT MRR determines whether the CAPs were implemented and effective. To make this determination, Qlarant evaluates all data collected or trended by the MCO through the monitoring mechanism established in the CAP. If an MCO has not implemented or followed through with the tasks identified in the CAP, MDH may take further action according to their Performance Monitoring Policy.

Timeline. Qlarant conducted EPSDT activities from July 2025 to October 2025 to assess MCOs' MY 2024 compliance with EPSDT and Healthy Kids requirements. MCOs upload required CAPs to their respective portals, with an email notification to Qlarant, within 45 calendar days of receiving their final report.

Results

EPSDT MRR indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas: *Health and Developmental History (HX)*, *Comprehensive Physical Examination (PE)*, *Laboratory Tests/At-Risk Screenings (LAB)*, *Immunizations (IMM)*, and *Health Education/Anticipatory Guidance (HED)*. The following sections describe each component, summarize and trend results of MCO performance, and describe aggregate performance scores with HealthChoice aggregate and total composite scores.

EPSDT Component Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across all components:

- All MCOs' total composite scores exceeded the 80% minimum compliance score.
- All MCOs exceeded the 80% minimum compliance score for four of the five component scores.
- Two of the nine MCOs (MPC and UHC) fell below the 80% minimum compliance score for the *Laboratory Tests/At-Risk Screenings* component, requiring CAP submissions along with a focused provider education project for two years per MDH's Performance Monitoring Policy, due to multiple years of not meeting the requirement.
- The HealthChoice aggregate component scores ranged from 83% (*Laboratory Tests/At-Risk Screenings*) to 95% (*Comprehensive Physical Examination*).
- The HealthChoice aggregate *Health and Developmental History*, *Comprehensive Physical Examination*, and *Health Education/Anticipatory Guidance* component scores decreased from MY 2023 to MY 2024, with the most significant decrease of four percentage points for the *Health Education/Anticipatory Guidance* component score.
- The total HealthChoice aggregate composite score has consistently declined from MY 2022 (95%) to MY 2024 (92%).

Table 90. MY 2024 Component Results by MCO and Measurement Year Aggregates (EPSDT)

Component	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
HX	92%	90%	94%	95%	93%	93%	93%	85%	90%	96%	93%	92%
PE	95%	94%	98%	97%	94%	96%	96%	86%	94%	98%	97%	95%
LAB	80%	82%	94%	93%	79%*	82%	81%	74%*	80%	85%	80%	83%
IMM	90%	88%	96%	97%	90%	91%	92%	89%	91%	95%	92%	92%
HED	92%	90%	98%	98%	92%	94%	91%	85%	89%	97%	96%	92%
Total Composite Score	91%	90%	97%	96%	91%	92%	92%	85%	91%	95%	93%	92%

Red font denotes a CAP requirement for components scoring below the 80% minimum compliance score.

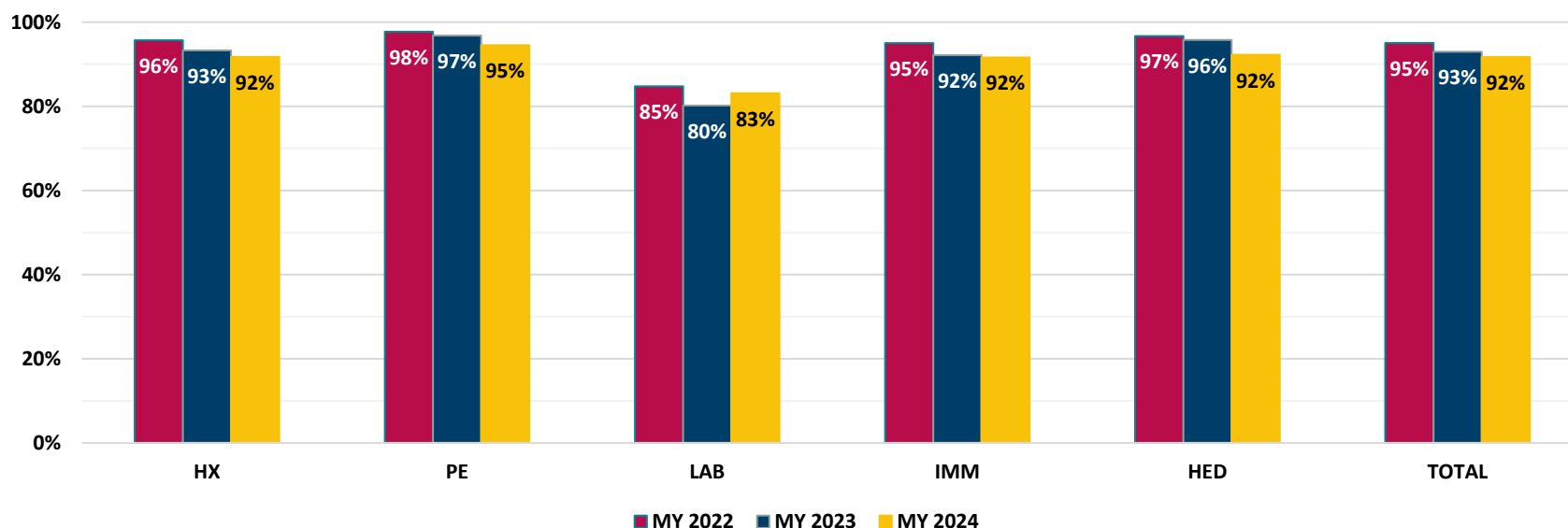
* Score fell below the minimum compliance score for multiple years and requires a CAP along with a focused provider education project per MDH's Performance Monitoring Policy.

Trending Analysis of Aggregate Compliance Scores. The purpose of a trend analysis is to demonstrate changes in patterns of care at multiple points in time. Score variation is to be expected; not all increases or decreases from MY 2022 through MY 2024 can be interpreted as reflecting differences in quality of care.

MY 2024's EPSDT MRR observed the following about MCO performance trends across all component scores:

- All component scores remained consistent from MY 2022 to MY 2024.
- Though minimal, the *Health and Developmental History, Comprehensive Physical Examination, Health Education/Anticipatory Guidance* components scores, and total composite scores have consistently declined from MY 2022 to MY 2024.
- There was an increase of three percentage points for *Laboratory Tests/At-Risk Screenings* from MY 2023 (80%) to MY 2024 (83%).
- All five aggregate component scores have met or exceeded the 80% minimum compliance score from MY 2022 to MY 2024.

Figure 15. MYs 2022 to 2024 HealthChoice Aggregate Results by Component (EPSDT)



Health and Developmental History Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Health and Developmental History* component:

- All MCOs exceeded the 80% minimum compliance score, ranging from 85% (UHC) to 95% (KPMAS).
- ABH, JMS, KPMAS, MPC, MSFC, and PPMCO met or exceeded the HealthChoice aggregate component score, ranging from 92% (ABH) to 95% (KPMAS).
- Ten of the eleven HealthChoice aggregate element scores exceeded the 80% minimum compliance score, except for the *Recorded Maternal Depression Screening* element, which fell below compliance by three percentage points (77%).
- Two of the nine MCOs (ABH and JMS) exceeded the 80% minimum compliance score for all elements.
- All MCOs exceeded the 80% minimum compliance score for the *Recorded Medical History*, *Recorded Psychological History*, *Recorded Developmental Surveillance/History*, *Recorded Mental/Behavioral Health Assessment*, and *Recorded Substance Use Assessment* elements.
- UHC was the only MCO to score below the 80% minimum compliance score for the *Recorded Family History* element (79%).

- MPC, UHC, and WPM scored below the 80% minimum compliance score for the *Recorded Perinatal History* element at 76%, 75%, and 78%, respectively.
- CFCHP, KPMAS, MPC, PPMCO, and UHC scored below the 80% minimum compliance score for the *Recorded Maternal Depression Screening* element, ranging from 9% (KPMAS) to 79% (CFCHP).
- WPM was the only MCO to score below the 80% minimum compliance score by six percentage points for the *Recorded Developmental Screening Tool* element (74%).
- MSFC and WPM scored below the 80% minimum compliance score for the *Recorded Autism Screening Tool* element at 76%.
- KPMAS was the only MCO to score below the 80% minimum compliance score for the *Depression Screening* element at 57%.
- Despite an increase of nine percentage points from MY 2023 to MY 2024, the HealthChoice aggregate score for the *Recorded Maternal Depression Screening* element remains below the 80% minimum compliance score (68% to 77%).
- All HealthChoice aggregate scores for each element have declined in comparison from MY 2022 to MY 2024, with the most significant decrease of eight percentage points for the *Recorded Family History* element (93% to 85%).

Table 91. MY 2024 Health and Developmental History Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Recorded Medical History	94%	93%	89%	97%	95%	94%	94%	86%	94%	97%	95%	93%
Recorded Family History	86%	82%	85%	92%	87%	89%	87%	79%	82%	93%	89%	85%
Recorded Perinatal History	91%	85%	88%	100%	76%	85%	85%	75%	78%	90%	86%	86%
Recorded Maternal Depression Screening	84%	79%	92%	9%	73%	88%	77%	78%	92%	82%	68%	77%
Recorded Psychological History	95%	93%	99%	96%	95%	97%	96%	87%	96%	99%	96%	95%
Recorded Developmental Surveillance/History	95%	93%	95%	100%	96%	97%	97%	88%	95%	98%	96%	95%
Recorded Developmental Screening Tool	93%	82%	100%	100%	89%	88%	94%	84%	74%	93%	84%	90%
Recorded Autism Screening Tool	81%	87%	100%	100%	84%	76%	100%	80%	76%	88%	82%	87%
Recorded Mental/Behavioral Health Assessment	95%	95%	100%	100%	97%	96%	99%	90%	97%	98%	97%	96%
Recorded Substance Use Assessment	89%	89%	99%	96%	95%	93%	89%	85%	88%	93%	94%	91%
Depression Screening	85%	80%	100%	57%	88%	84%	85%	82%	83%	89%	87%	83%

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Total Composite Score	92%	90%	94%	95%	93%	93%	93%	85%	90%	96%	93%	92%

Bold font denotes scores below the 80% minimum compliance score.

Comprehensive Physical Examination. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Comprehensive Physical Examination* component:

- All MCOs exceeded the 80% minimum compliance score.
- ABH, JMS, KPMAS, MSFC, and PPMCO met or exceeded the HealthChoice aggregate component score, ranging from 95% (ABH) to 98% (JMS).
- All HealthChoice aggregate element scores exceeded the 80% minimum compliance score.
- All MCOs except for MPC and UHC, met or exceeded the 80% minimum compliance score for all elements.
- MPC scored below the minimum compliance score for the *Graphed Head Circumference* element at 68%.
- UHC scored below the minimum compliance score for the *Hearing Assessment*, *BMI Graphing*, and *Graphed Head Circumference* elements at 77%, 77%, and 79%, respectively.
- All HealthChoice aggregate scores for each element have declined from MY 2022 to MY 2024, with the most significant decrease of ten percentage points for the *BMI Graphing* element (99% to 89%).

Table 92. MY 2024 Comprehensive Physical Examination Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Documentation of Minimum 5 Systems Examined	98%	97%	99%	100%	97%	99%	99%	90%	97%	99%	99%	97%
Vision Assessment	89%	89%	97%	87%	88%	86%	93%	81%	90%	94%	91%	89%
Hearing Assessment	86%	87%	97%	88%	84%	84%	93%	77%	88%	93%	90%	87%
Nutritional Assessment	96%	94%	100%	98%	96%	97%	97%	87%	95%	98%	98%	96%
Conducted Oral Assessment	95%	94%	95%	100%	94%	94%	97%	85%	94%	96%	98%	94%
Measured Height	99%	97%	100%	99%	99%	100%	99%	92%	98%	100%	99%	98%
Graphed Height	97%	96%	99%	99%	96%	100%	98%	89%	97%	99%	99%	97%
Measured Weight	99%	99%	100%	100%	100%	100%	100%	92%	99%	100%	100%	99%
Graphed Weight	98%	96%	99%	100%	96%	99%	98%	89%	97%	99%	99%	97%
BMI Percentile	97%	98%	100%	99%	98%	99%	98%	90%	96%	100%	98%	97%
BMI Graphing	87%	89%	97%	99%	88%	94%	86%	77%	83%	99%	95%	89%

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Measured Head Circumference	98%	84%	98%	93%	85%	95%	97%	82%	95%	94%	95%	92%
Graphed Head Circumference	95%	80%	92%	93%	68%	95%	89%	79%	80%	92%	93%	86%
Measured Blood Pressure	97%	95%	99%	96%	98%	98%	95%	89%	97%	97%	95%	96%
Total Composite Score	95%	94%	98%	97%	94%	96%	96%	86%	94%	98%	97%	95%

Bold font denotes scores below the 80% minimum compliance score.

Laboratory Tests/At-Risk Screenings Results. MY 2024's EPSDT review observed the following about aggregate MCO performance across the *Laboratory Test/At-Risk Screenings* component:

- Two of the nine MCOs (MPC and UHC) fell below the minimum compliance score at 79% and 74%, respectively.
- JMS and KPMAS exceeded the HealthChoice aggregate component score (83%) at 94% and 93%, respectively.
- The *Conducted Lead Risk Assessment* element was the only element that all MCOs exceeded the 80% minimum compliance score.
- The *9-11 Year Dyslipidemia Lab Test* element had the most MCOs (all MCOs except for JMS) score below the 80% minimum compliance score, ranging from 53% (ABH and UHC) to 75% (KPMAS).
- UHC had the most element scores that fell below the 80% minimum compliance score for twelve of the sixteen elements, ranging from 53% for the *9-11 Year Dyslipidemia Lab Test* element to 79% for the *Recorded Cholesterol Risk Assessment* and *Referral to Lab for Blood Test* elements.
- The *9-11 Year Dyslipidemia Lab Test*, *18-21 Year Dyslipidemia Lab Test*, *12 Month Blood Lead Test*, *12 Month Anemia Test*, and *24 Month Anemia Test* element HealthChoice aggregate scores fell below the 80% minimum compliance score.
- The *12 Month Blood Lead Test* and *12 Month Anemia Test* element scores have consistently declined from MY 2022 to MY 2024.

Table 93. MY 2024 Laboratory Tests/At-Risk Screenings Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Newborn Metabolic Screen	84%	83%	71%	100%	69%	73%	91%	75%	77%	81%	81%	80%
Recorded TB Risk Assessment	84%	86%	96%	75%	80%	86%	86%	77%	84%	89%	83%	84%
Recorded Cholesterol Risk Assessment	80%	83%	97%	88%	79%	88%	90%	79%	80%	85%	83%	85%
9-11 Year Dyslipidemia Lab Test	53%	55%	87%	75%	54%	65%	68%	53%	66%	72%	59%	65%
18-21 Year Dyslipidemia Lab Test	50%	80%	100%	100%	71%	44%	86%	71%	73%	80%	75%	76%

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Conducted Lead Risk Assessment	95%	95%	98%	92%	88%	93%	87%	86%	89%	91%	90%	92%
12 Month Blood Lead Test	76%	74%	91%	95%	73%	74%	74%	66%	78%	86%	80%	79%
24 Month Blood Lead Test	72%	84%	88%	95%	83%	70%	71%	72%	84%	84%	75%	81%
3-5 Year (Baseline) Blood Lead Test	100%	93%	100%	99%	91%	97%	78%	87%	93%	95%	78%	95%
Referral to Lab for Blood Test	85%	90%	96%	100%	87%	87%	84%	79%	86%	90%	87%	89%
Conducted Anemia Risk Assessment	87%	85%	98%	99%	86%	84%	76%	73%	77%	81%	81%	84%
12 Month Anemia Test	73%	73%	88%	94%	71%	72%	74%	66%	77%	85%	78%	77%
24 Month Anemia Test	70%	78%	89%	94%	86%	67%	69%	70%	88%	82%	73%	79%
3-5 Year Anemia Test	95%	94%	100%	99%	88%	100%	78%	88%	100%	90%	76%	95%
Recorded STI/HIV Risk Assessment	89%	86%	98%	95%	93%	92%	92%	79%	83%	89%	91%	90%
HIV Test Per Schedule	100%	75%	100%	100%	64%	70%	90%	89%	90%	89%	91%	91%
Total Composite Score	80%	82%	94%	93%	79%	82%	81%	74%	80%	85%	80%	83%

Bold font denotes scores below the 80% minimum compliance score.

Immunizations Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Immunizations* component:

- All MCOs exceeded the 80% minimum compliance score, ranging from 88% (CFCHP) to 97% (KPMAS).
- JMS, KPMAS, and PPMCO met or exceeded the HealthChoice aggregate component score at 96%, 97%, and 92%, respectively.
- Thirteen of the 14 HealthChoice aggregate element scores exceeded the 80% minimum compliance score, except for the *Influenza* element, which remained below compliance by nine percentage points (71%).
- All MCOs exceeded the 80% minimum compliance score for 11 of the 14 elements.
- CFCHP was the only MCO to score below the 80% minimum compliance score for the *Human Papillomavirus (HPV)* (79%) element.
- CFCHP and UHC were the only MCOs to score below the 80% minimum compliance score for the *Assessed Immunizations Up to Date* element at 77% and 78%, respectively.
- Seven of the nine MCOs (ABH, CFCHP, MPC, MSFC, PPMCO, UHC, and WPM) scored below the 80% minimum compliance score for the *Influenza* element, ranging from 56% (UHC) to 71% (MPC and MSFC).
- Thirteen of the 14 HealthChoice aggregate element scores have declined from MY 2022 to MY 2024, with the most significant decline of ten percentage points for the *Influenza* element (81% to 71%) and seven percentage points for the *Assessed Immunizations Up to Date* element (90% to 83%).

Table 94. MY 2024 Immunizations Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Hepatitis B	94%	93%	98%	99%	92%	95%	95%	92%	94%	97%	96%	95%
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	96%	96%	98%	100%	94%	99%	94%	92%	98%	99%	98%	96%
Haemophilus Influenzae Type B (Hib)	96%	95%	98%	99%	93%	99%	93%	91%	97%	98%	96%	96%
Pneumococcal (PCV-7 or PCV-13) [Prevnar]	95%	94%	98%	99%	94%	99%	94%	91%	97%	99%	97%	96%
Polio (IPV)	93%	92%	97%	98%	94%	95%	95%	93%	96%	97%	96%	95%
Measles/Mumps/Rubella (MMR)	92%	92%	98%	98%	95%	95%	96%	93%	96%	97%	96%	95%
Varicella (VAR)	92%	92%	99%	98%	94%	94%	96%	94%	96%	97%	96%	95%
Tetanus/Diphtheria/Acellular Pertussis (TDaP)	93%	85%	98%	98%	94%	95%	97%	96%	97%	95%	96%	95%
Influenza (Flu)	64%	61%	85%	95%	71%	71%	64%	56%	62%	81%	69%	71%
Meningococcal (MCV4)	91%	86%	97%	98%	94%	93%	96%	95%	94%	95%	96%	94%
Hepatitis A	90%	90%	98%	98%	93%	92%	96%	91%	93%	96%	94%	94%
Rotavirus (RV)	100%	88%	92%	100%	83%	93%	100%	100%	96%	100%	94%	94%
Human Papillomavirus (HPV)*	88%	79%	97%	95%	83%	92%	93%	91%	90%	93%	92%	90%
Assessed Immunizations Up to Date	82%	77%	92%	92%	82%	82%	82%	78%	80%	90%	81%	83%
Total Composite Score	90%	88%	96%	97%	90%	91%	92%	89%	91%	95%	92%	92%

Bold font denotes scores below the 80% minimum compliance score.

*Data collected for informational purposes only; not used in the calculation of the overall component score.

Health Education/Anticipatory Guidance Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Health Education/Anticipatory Guidance* component:

- All MCOs exceeded the 80% minimum compliance score, ranging from 85% (UHC) to 98% (JMS and KPMAS).
- ABH, JMS, KPMAS, MPC, and MSFC met or exceeded the HealthChoice aggregate component score, ranging from 92% (ABH and MPC) to 98% (JMS and KPMAS).
- All MCOs exceeded the 80% minimum compliance score for the *Documents Age – Appropriate Anticipatory Guidance, Documented Health Education/Referral for Identified Problems/Tests, and Specified Requirements for Return Visit* elements.

- JMS, KPMAS, MPC, and MSFC exceeded the 80% minimum compliance score for all elements.
- ABH, CFCHP, PPMCO, UHC, and WPM scored below the 80% minimum compliance score for the *Documented Referral to Dentist* element, ranging from 71% (PPMCO) to 78% (ABH).
- All HealthChoice aggregate scores for each element have declined from MY 2022 to MY 2024, with the most significant decrease of 12 percentage points for the *Documented Referral to Dentist* element (93% to 81%).

Table 95. MY 2024 Health Education/Anticipatory Guidance Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Documented Age – Appropriate Anticipatory Guidance	96%	95%	99%	100%	96%	97%	98%	88%	95%	99%	98%	96%
Documented Health Education/Referral for Identified Problems/Tests	98%	96%	99%	94%	97%	98%	99%	91%	95%	99%	99%	96%
Documented Referral to Dentist	78%	75%	95%	99%	80%	85%	71%	72%	76%	93%	91%	81%
Specified Requirements for Return Visit	94%	91%	98%	100%	93%	97%	97%	88%	91%	96%	95%	94%
Total Composite Score	92%	90%	98%	98%	92%	94%	91%	85%	89%	97%	96%	92%

Bold font denotes scores below the 80% minimum compliance score.

Conclusion

The analysis of the EPSDT MRR results ensures the MCOs' providers are delivering timely access to healthcare services according to EPSDT standards for its population of children and adolescents through 20 years of age. For MY 2024, all component scores fell below MDH's Quality Strategy Targets for MY 2024. However, the MY 2024 EPSDT MRR demonstrates steady compliance in the HealthChoice aggregate scores and MCO total composite scores from MY 2022 to MY 2024. All MCOs' total composite scores performed well above the 80% minimum compliance score, ranging from 85% (UHC) to 97% (JMS). Despite an increase of three percentage points from MY 2023 (80%) to MY 2024 (83%), the HealthChoice aggregate score for the *Laboratory Tests/At-Risk Screenings* component remains an opportunity for improvement, as it is the only component that results in CAPs for two MCOs (MPC and UHC) for MY 2024.

Process Analysis

The following are areas Qlarant noted as most challenging during the MY 2024 MRR completion:

- Providers not reviewing or accurately confirming patient listings sent at the time of scheduling.
- Receiving requested medical records in a timely manner in compliance with initial requests to providers.
- Providers not complying with the MCOs' requests to obtain medical record documentation.

Quality Strategy Highlights

MDH set a task goal of increasing all EPSDT requirements to 80% or above by MY 2024 in the HealthChoice Quality Strategy for 2022-2024, based on pre-Covid public health emergency aggregate performance. Specific HealthChoice performance metrics and targets are displayed in the table below.

All components met or exceeded the MDH minimum threshold (80%) in MY 2024. All components fell below MDH's Quality Strategy Targets for MY 2024 by one percentage point (*Immunizations*) to four percentage points (*Laboratory Tests/At-Risk Screenings*). The HealthChoice aggregate total missed the MY 2024 target by two percentage points.

Table 96. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets (EPSDT)

Requirement: Minimum Compliance Score: ≥80%	HealthChoice Aggregate MY 2024	MDH Quality Strategy Targets for MY 2024
Health and Developmental History	92%	94%
Comprehensive Physical Examination	95%	97%
Laboratory Tests/At-Risk Screenings	83%	87%
Immunizations	92%	93%
Health Education/Anticipatory Guidance	92%	94%
HealthChoice Aggregate Totals	92%	≥94%

Source: [HealthChoice Quality Strategy 2022-2024](#)

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on results of the MY 2024 EPSDT medical record review. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024's EPSDT medical record review:

- Providers, and by extension the MCOs, demonstrate **quality** by increasing the likelihood of desired health outcomes of timely screening and preventive care by maintaining compliance with the Maryland Schedule of Preventive Health Care standards.
- Providers demonstrate **access (or accessibility)** by incorporating the timely use of services to achieve optimal outcomes.
- Providers demonstrate **timeliness** by ensuring children and adolescents up to age 20 are receiving timely screenings and preventive care, according to guidelines specified in the Maryland Schedule of Preventive Health Care Standards.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2024 EPSDT MRR and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

Table 97. MY 2024 Strengths, Improvements, and Recommendations (EPSDT)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, Timeliness	Strengths: • All MCOs exceeded the 80% minimum compliance score for the <i>Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> components. • All HealthChoice aggregate component scores exceeded the 80% minimum compliance score.	↑
Quality, Access, Timeliness	Improvements: • ABH, CFCHP, MSFC, PPMCO, and WPM improved performance for the <i>Laboratory Tests/At-Risk Screenings</i> component and were found to be in compliance for MY 2024, no longer requiring corrective action.	↑
Quality, Access, Timeliness	Recommendations: • Review and address root causes for all HealthChoice aggregate component scores falling below MDH's Quality Strategy Targets for MY 2024. Consider extending the quality strategy targets for additional MYs. • Monitor MCO performance for elements comprising the <i>Health and Developmental History, Comprehensive Physical Examination, and Health Education/Anticipatory Guidance</i> components, as all HealthChoice aggregate element scores have declined from MY 2022 to MY 2024. • Monitor MCOs to ensure <i>Recorded Maternal Depression Screenings</i> are being tracked, appropriately documented within the medical record, and that MCOs are working towards improved performance to bring the HealthChoice aggregate element score (77%) within compliance for the <i>Health and Developmental History</i> component. • Monitor the <i>Laboratory Tests/At-Risk Screenings</i> component elements to ensure MCOs are working towards improved performance for the following areas: <i>9-11 Year Dyslipidemia Lab Test</i> (65%), <i>18-21</i>	↓

Domain	Strengths, Improvements, and Recommendations	Assessment
	<i>Year Dyslipidemia Lab Test (76%), 12 Month Blood Lead Test (79%), 12 Month Anemia Test (77%), and 24 Month Anemia Test (79%).</i> - Monitor MCO performance for elements comprising the <i>Immunizations</i> component, as 13 of the 14 HealthChoice aggregate element scores have declined from MY 2022 to MY 2024, with the most significant decline in the <i>Influenza</i> and <i>Assessed Immunizations Up to Date</i> elements. Ensure MCOs are following influenza immunization protocols and processes, influenza immunizations and refusals are appropriately documented within the medical record, and that MCOs are working towards improved performance. - Monitor MCOs to ensure <i>Documented Referral to Dentist</i> is appropriately documented within the medical record, as five of the nine MCOs (ABH, CFCHP, PPMCO, UHC, and WPM) fell below the 80% minimum compliance score for this element in the <i>Health Education/Anticipatory Guidance</i> component.	

Green and ↑ = Domain experienced a positive impact from MCOs' performance. **Pink** and ↓ = Domain experienced a negative impact from MCOs' performance.

Additional Information

For additional findings and comprehensive details associated with the MY 2024 EPSDT review, please access the link to the MY 2024 EPSDT Statewide Executive Summary Report in [Appendix E. Appendix A](#) includes informed conclusions from the EPSDT review related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Consumer Report Card

Objective

Visual comparisons of performance demonstrated in a CRC help Medicaid enrollees compare and select a HealthChoice MCO. Qlarant designs and develops the report card to compare the quality of healthcare among plans and to allow consumers to detect differences easily in MCO performance.

Six reporting categories include measures meaningful to enrollees. Consumers may focus on MCO performance in the areas most important to them and their families. Two categories are relevant to all enrollees (Access to Care and Doctor Communication and Service); the remaining categories are relevant to specific Maryland HealthChoice enrollees, including adults (Keeping Adults Healthy), children (Keeping Kids Healthy), children with chronic illness (Care for Kids with Chronic Illness), and pregnant enrollees and their infants (Pregnancy and Infant Care). The "Pregnancy and Infant Care" category was added to the 2025 CRC and replaced the category "Taking Care of Women" used in previous CRCs.

Methodology

Qlarant compares each MCO's actual score on select performance measures 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.

Data Collection and Review. Ratings for each MCO are derived from performance measure scores selected from HEDIS, survey results from both the adult and child CAHPS questionnaires, and MDH's encounter data measures. Recommended categories are based on measures reported by MCOs in 2025 and are designed to focus on clearly identifiable areas of interest.

Timeline. Qlarant conducted activities for the 2025 CRC from January 1, 2024, to December 31, 2024, based on HEDIS MY 2023 data made available in 2024.

Results

Performance results of the 2025 Consumer Report Card are as follows.

Table 98. 2025 Results (CRC)

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Care	★	★	★★★★	★	★★★★	★★★★	★★★★	★★★★	★★★★
Doctor Communication and Service	★★	★★	★★	★★	★★	★★	★★	★★	★★
Keeping Kids Healthy	★	★	★★★★	★★★★	★	★	★★	★★★★	★★★★
Care for Kids with Chronic Illness	★	★★	NA	★★	★★★★	★★	★★★★	★	★★
Pregnancy and Infant Care	★	★★	★★	★★★★	★★	★	★★	★	★★
Keeping Adults Healthy	★	★★	★★★★	★★★★	★★	★	★	★★	★

★★★★ Above HealthChoice Average; ★★ HealthChoice Average; ★ Below HealthChoice Average; NA = Not Applicable

Comparison of the Star Ratings from the previous MY follows.

Table 99. Star Rating Changes from 2024 to 2025 (CRC)

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Care	∅	↓	∅	∅	∅	↑	∅	↑	↑
Doctor Communication and Service	↑	∅	↓	↑	↓	↑	↓	∅	∅
Keeping Kids Healthy	∅	∅	∅	∅	∅	∅	∅	↑	∅

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Care for Kids with Chronic Illness	↑ ^N	∅	NA	↑	∅	∅	↓	∅	∅
Pregnancy and Infant Care	∅	∅	↓	∅	∅	↓	∅	∅	∅
Keeping Adults Healthy	∅	∅	∅	∅	∅	∅	∅	∅	∅

Green and ↑ = improvement from MY 2022; Pink and ↓ = decline from MY 2022; White and ∅ = no change from MY 2022; Gray and NA = reported as Not Applicable for both 2024 and 2025

^N MCO evaluated in 2025 CRC, but not in the 2024 CRC.

NA- Reported as not applicable for both MYs 2024 and 2025.

Conclusion

Conclusions for CRC activities are drawn from the 2025 CRC and comparisons to the 2024 CRC. This section identifies findings from applicable MY 2023 CAHPS, HEDIS, and encounter data measures.

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, and recommendations summarizing aggregate performance across MCOs, based on the results of the 2025 CRC activities. These strengths, improvements, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for CRC activities:

- MCOs demonstrate **quality** by ensuring quality care is provided to enrollees, including preventive care and care for specialty populations, as evidenced by the performance measures included in the CRC.
- MCOs demonstrate **access (or accessibility)** by managing adequate delivery, quality, and cost of healthcare services for its enrollees; ensuring quality customer service, yearly provider visits for all enrollees, providers schedule appointments without a long wait; and answering enrollee calls quickly.
- MCOs demonstrate **timeliness** by ensuring timely services are available for its enrollees to promote desired health outcomes, preventing long wait times for appointment scheduling, and providing timely preventive screenings and immunizations.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the 2025 CRC activities and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance. There are no formal recommendations for the MCOs from the 2025 CRC activities.

Table 100. 2025 Strengths, Improvements, and Recommendations (CRC)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	Strengths: Four MCOs (ABH, KPMAS, UHC, and WPM) either maintained or increased 2025's star rating.	↑
Quality, Access, Timeliness	Improvements: - Three MCOs (MSFC, UHC, and WPM) improved from 2024's star rating for <i>Access to Care</i>. - Three MCOs (ABH, KPMAS, and MSFC) improved from 2024's star rating for <i>Doctor Communication and Service</i>.	↑

Green and ↑ = Domain experienced a positive impact from MCOs' performance.

Additional Information

For additional findings and comprehensive details associated with the information reporting strategy and analytic methods associated with the 2025 CRC, please access the link to the Information Reporting Strategy and Analytic Methodology in [Appendix E](#). English and Spanish versions of the 2025 CRC are available in [Appendix E](#). [Appendix A](#) includes informed conclusions from the 2025 CRC activity related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

Grievances, Appeals, and Denials Focused Study

Objective

Qlarant conducts quality studies to ensure MCOs comply with federal and state regulations governing requirements and timeliness of notices for enrollee and provider grievances, enrollee appeals, pre-service authorization requests, and adverse determinations; facilitates increased compliance by illustrating trends and opportunities for improvement and providing recommendations; and ensures HealthChoice enrollees are not denied access to medically necessary services and supports. These studies consist of quarterly and annual validations of data provided by the MCOs, annual record reviews, and a comparison of each MCO's performance with their peers, including year-over-year performance assessments when data is available.

Methodology

Description of Data Obtained. Qlarant assessed MCO compliance based on MCO-reported data and conducted an annual record review of MY 2024's sample of grievance, appeal, and pre-service denial records. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for MY 2024. Qlarant selected 35 cases from each listing using a random sampling approach and requested each MCO upload the

selected case records. Reviews utilized the 10/30 rule, where initial samples of ten grievance, ten appeal, and ten denial records were reviewed; an additional 20 records were reviewed when noncompliant components were identified in the first ten records.

Technical Methods of Data Collection and Analysis. Qlarant develops MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly and annual MCO report submissions. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of noncompliance. Aggregated MCO results allow peer comparison and identification of MCO-specific trends after three years of data were available. Quarterly and annual reports submitted to MDH included analysis of MCO data and recommendations, as appropriate. MCOs received separate reports with summarized quarterly review findings to identify areas for follow-up when data issues, ongoing noncompliance, or negative trends are identified. MDH received results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, as a component of each SPR report. Appropriate staff for each MCO received results of the record reviews and received technical assistance, as needed, to facilitate improved compliance.

Annual record review and reports inform review determinations of MCO performance scores for various components and provide peer comparisons and trended performance.

Qlarant used four review determinations to identify the MY 2024 compliance designations used to document MCO performance outcomes for both MCO-reported and record review findings: *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, and *Not Applicable (NA)*.

Table 101. MY 2024 Validation Review Determinations (GAD)

Review Determinations	Explanation of Determination
Met (M)	MCO achieves ≥95% for all quarters and demonstrates consistent compliance.
Partially Met (PM)	MCO achieves ≥95% for at least one quarter, but not all quarters; and demonstrates inconsistent compliance.
Unmet (UM)	MCO achieves <95% for all quarters and demonstrates no evidence of compliance.
Not Applicable (NA)	Qlarant uses when information is not available for a category under review.
Compliance Score	MDH established minimum compliance for MY 2024 at 95%.

Performance Thresholds. Recent studies conducted by the Government Accountability Office (GAO)^{3,4} emphasize the importance of monitoring grievance, appeals, and denials to ensure enrollees in managed care have access to needed services. The Office of the Inspector General (OIG) identified and selected seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all states. These 7 parent companies operated 115 MCOs in 37 states, which enrolled a total of 29.8 million people in 2019. OIG collected data on

³ July 2023. Government Accountability Office (GAO). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

⁴ March 2024, Government Accountability Office (GAO) report, Medicaid Managed Care Additional Federal Action Needed to Fully Leverage New Appeals and Grievance Data.

denials and related appeals for each MCO they operated. OIG also surveyed state Medicaid agency officials from 37 states to examine selected aspects of state oversight of MCO prior authorization denials and appeals, along with state processes for external medical reviews and state fair hearings.

MDH recognizes the importance of this monitoring, as Maryland MCOs receive a fixed payment for each enrollee served, with the expectation that each MCO will ensure enrollees receive appropriate and timely access to the array of benefits HealthChoice offers. The CFR §438.210 section defines federal standards and allows MCOs to set limits on the amount of care given to HealthChoice enrollees, (e.g., a specific number of visits for therapies). MCOs may also request providers to submit a prior authorization request to determine the medical necessity of, for example, certain diagnostic or surgical procedures. As a result, MDH must monitor MCO practices and provide the safeguards needed to prevent MCOs from limiting or denying needed care to benefit financially.

In MY 2024, MDH worked with Qlarant to identify performance thresholds for several GAD metrics. Without a performance threshold and benchmark, MCO oversight is far more subjective and does not allow for valid peer-to-peer comparisons. These metrics would enhance the ability to determine performance variances within the Managed Care Program Annual Report (MCPAR) requirements. For example, MDH had already established a compliance score of 95% for all GAD timeliness requirements. Using guidance from the GAO studies and as a place to obtain baseline data, MDH established performance thresholds for the following metrics.

- Identifying grievances, appeals, and denials per 1,000 enrollees and utilizing the median score of the nine MCOs as a gauge for peer-to-peer comparisons.
- Establishing the standard for all timeliness metrics to meet or exceed a 95% compliance score.
- Identifying percent of appeals with more than 50% overturned, indicating favor to the enrollee.
- Identifying pre-service authorization denial percentage at <30%.
- Establishing no limits placed on grievances, since they provide potential information for process improvements.

CAPs. The GAD-related standards fall predominantly within 42 CFR Part 435 Subpart D on coverage and authorization of services and quality, Subpart E on enrollee rights, and Subpart F on the MCOs' grievances and appeals systems. As part of the quarterly GAD review process, MCOs that demonstrated noncompliance with one or more timeliness requirements were not placed on a CAP, in MY 2024. Instead of requesting a CAP, Qlarant's teams accountable for SPR and GAD reviews worked directly with individual MCOs to provide technical assistance when data gaps and report errors were identified, and when Qlarant required an explanation of unusual data variances. Any corrective action needed to address non-compliant GAD findings were requested at the time of the annual SPR.

The SPR CAP process requires each MCO to submit a CAP, which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs are reviewed by Qlarant and determined adequate only if they address all required elements and components (such as timelines,

action steps, and documented evidence). In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted.

Recognizing the need to provide more real-time and meaningful feedback to the MCOs, Qlarant and MDH continued to collaborate to identify key GAD performance metrics that align with recommendations from CMS and MDH and have the most immediate impact on enrollee care and outcomes. Until determined otherwise, Qlarant plans to use the key performance indicators outlined in the “Performance Thresholds” subsection above as a means for providing MCOs guidance and education to reduce the need for more formal corrective action.

Timelines. MY 2024 GAD reviews are quarterly and annual, with record requests from July 1 through October 31, 2024. This timeline allows MCOs an opportunity to address and fully implement any recent regulatory changes noted as incomplete during the SPR conducted earlier in 2024. All MCOs submit quarterly GAD reports to Qlarant within 30 days after the close of the fourth quarter. Any required CAPs must be submitted within 45 calendar days of receipt of the SPR final results.

Results

This section provides MCO-specific findings from a review of performance against select GAD measures. The data used to inform these results came from two sources: MCO-reported annual GAD data for MY 2024 and an annual record review specific to documentation practices for GAD metrics. Findings compare MY 2023 to MY 2024 and, where feasible, compare across three consecutive years (MYs 2022 through 2024). This latter data reveals positive and negative trends in MCO performance and allows for comparisons in relation to peers.

Compliance with Resolution Timeframes. Annual comparisons of MCO-reported compliance with resolution timeframes for enrollee and provider grievances (Tables 102 and 103, respectively), and enrollee appeals (Table 104) follow.

Table 102. Annual Trending of Compliance with Enrollee Grievance Resolution Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Emergency Medically Related (24 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	NA	NA	100%	57%	100%	100%	NA	100%	100%
Annual 2023	NA	NA	100%	92%	100%	100%	NA	80%	NA
Annual 2024	100%	100%	100%	NA	100%	100%	NA	17%	NA
Non-emergency Medically Related (5 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	NA	NA	100%	98%	100%	93%	100%	100%	100%
Annual 2023	NA	NA	100%	99%	100%	100%	100%	74%	100%
Annual 2024	100%	NA	96%	97%	97%	100%	85%	62%	NA

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Administrative (30 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	91%	100%	99%	100%	100%	100%	100%	100%
Annual 2023	100%	99%	100%	100%	100%	100%	99%	99%	98%
Annual 2024	100%	99%	99%	100%	100%	100%	100%	95%	100%

Bold font ≥95% for at least one quarter within the reporting period.

Red font <95% for all reporting periods = Unmet (UM)

NA = Not Applicable

Table 103. Annual Trending of Compliance with Provider Grievance Resolution Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Emergency Medically Related (24 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	NA	NA	NA	NA	100%	NA	NA	NA	NA
Annual 2023	NA	NA	NA	NA	NA	NA	NA	NA	NA
Annual 2024	NA	NA	NA	NA	NA	NA	NA	NA	NA
Non-emergency Medically Related (5 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	NA	NA	NA	NA	NA	NA	NA	100%	NA
Annual 2023	NA	NA	NA	NA	100%	NA	NA	NA	NA
Annual 2024	NA	NA	NA	NA	NA	NA	NA	NA	NA
Administrative (30 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	85%	100%	NA	100%	100%	100%	100%	100%
Annual 2023	100%	100%	100%	NA	100%	100%	100%	94%	92%
Annual 2024	100%	100%	NA	NA	100%	100%	100%	91%	71%

Bold font ≥95% for at least one quarter within the reporting period.

NA = Not Applicable

Table 104. Annual Trending of Compliance with Enrollee Appeal Resolution Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited (72 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	97%	100%	75%	86%	96%	99%	97%	87%
Annual 2023	100%	100%	100%	100%	92%	100%	99%	95%	97%
Annual 2024	100%	97%	100%	80%	100%	97%	99%	92%	97%
Non-emergency (30 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	96%	100%	100%	100%	100%	100%	100%	98%
Annual 2023	100%	100%	100%	100%	99%	100%	100%	100%	95%

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2024	100%	100%	100%	93%	100%	100%	100%	97%	99%

Bold font ≥95% for at least one quarter within the reporting period.

Red font <95% for all reporting periods = Unmet (UM)

Quarterly Compliance with Determination Timeliness. Qlarant assessed compliance with COMAR requirements for the timeliness of pre-service and adverse determinations through MCO-reported compliance, MCO annual GAD reports, or a record review of GAD documentation. Pre-service denials are first assessed through the timeliness of determinations and resolutions, and then through the timeliness of notification to the enrollee and provider on the decision's outcome. Results of MCO-reported compliance with determination notifications of expedited, standard, and outpatient pharmacy timeframes for pre-service and adverse determinations follow. Prescriber notifications of outcomes (within 24 hours) relate only to adverse determinations.

Table 105. Annual Trending of Compliance with Pre-Service Determination Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited - Medical Denials (72 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	99%	100%	100%	100%	99%	100%	98%	100%	98%
Annual 2023	99%	100%	100%	100%	99%	100%	98%	100%	99%
Annual 2024	99%	100%	100%	100%	100%	100%	98%	100%	99%
Standard - Medical Denials (2 calendar days)	%	%	%	%	%	%	%	%	%
Annual 2022	98%	100%	100%	92%	100%	99%	99%	100%	84%
Annual 2023	99%	99%	100%	99%	100%	99%	99%	100%	99%
Annual 2024	100%	99%	100%	99%	100%	99%	99%	100%	100%
Outpatient Pharmacy - Denials (24 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	99%	99%	100%	99%	98%	99%	100%	100%
Annual 2023	100%	100%	98%	100%	99%	100%	99%	100%	100%
Annual 2024	100%	100%	98%	100%	98%	100%	99%	100%	100%

Bold font ≥95% for at least one quarter of the reporting period.

Table 106. Annual Trending of Compliance with Adverse Determination Notification Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited - Medical (72 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	100%	100%	100%	98%	100%	95%	100%	97%
Annual 2023	99%	100%	100%	100%	99%	100%	95%	100%	96%
Annual 2024	98%	100%	91%	100%	99%	100%	97%	100%	99%
Standard - Medical (2 calendar days)	%	%	%	%	%	%	%	%	%

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	98%	100%	100%	96%	99%	99%	96%	100%	98%
Annual 2023	99%	100%	98%	100%	100%	99%	100%	100%	99%
Annual 2024	99%	100%	100%	99%	100%	100%	95%	100%	99%
Outpatient Pharmacy (24 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	99%	100%	100%	100%	97%	100%	100%	100%
Annual 2023	100%	99%	100%	100%	100%	100%	100%	100%	100%
Annual 2024	100%	100%	100%	100%	100%	99%	100%	100%	100%
Prescriber Notification of Outcome (within 24 hours)	%	%	%	%	%	%	%	%	%
Annual 2022	100%	99%	99%	100%	100%	98%	99%	100%	100%
Annual 2023	100%	98%	99%	99%	100%	100%	99%	100%	100%
Annual 2024	100%	100%	98%	100%	100%	100%	98%	100%	100%

Bold font ≥95% for at least one quarter of the reporting period.

Record Review Results. Results comparing record review compliance with required elements follows. A random selection of grievance, appeal, and adverse determination records from MY 2024 determines results. Qlarant utilized the 10/30 rule for review.

Table 107. MY 2024 MCO Annual Grievance Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	100%	100%	100%	100%	100%	100%	100%	100%	87%
Acknowledgment Letter Timeliness (5 Days*)	100%	90%	100%	100%	87%	100%	97%	100%	100%
Issue is Fully Described	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Timeliness	100%	100%	100%	100%	100%	97%	73%	100%	100%
Resolution Appropriateness	100%	100%	100%	100%	100%	97%	73%	100%	100%
Resolution Letter Timeliness (2 Days*)	100%	100%	100%	100%	100%	97%	73%	100%	100%
Resolution Letter in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	100%	100%	100%

Red font <95% for reporting period = Unmet (UM)

*Measured in calendar days

Table 108. MY 2024 MCO Annual Appeal Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Processed Based Upon Level of Urgency	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Timeframe for Written Appeal Acknowledgment Letter (5 Days*)	100%	100%	100%	100%	100%	100%	100%	94%	100%

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Compliance with Verbal Notification of Denial of an Expedited Request	100%	100%	NA	100%	100%	NA	NA	100%	100%
Compliance with Written Notification of Denial of an Expedited Request (2 Days*)	100%	100%	NA	100%	100%	NA	NA	67%	100%
Compliance with Timeframe for Expedited Appeal Resolution Notification (72 hours)	100%	100%	100%	100%	NA	50%	100%	100%	NA
Compliance with Verbal Notification of Expedited Appeal Decision	100%	100%	100%	100%	NA	100%	100%	79%	NA
Compliance with Written Notification Timeframe for Non-Emergency Appeal (30 Days*)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appeal Decision Documented	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Made by Health Care Professional with Appropriate Expertise	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Available to Enrollee in Easy-to-Understand Language	100%	100%	100%	80%	100%	100%	100%	100%	100%

Red font <95% for reporting period = Unmet (UM)

NA = Not Applicable

* Measured in calendar days

Table 109. MY 2024 MCO Annual Adverse Determination Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriateness of Adverse Determinations	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Pre-Service Determination Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Adverse Determination Notification Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Required Letter Components	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Prescriber Notification	100%	NA	100%	100%	100%	100%	100%	0%	100%

Red font <95% for reporting period = Unmet (UM)

NA = Not Applicable

Record Review Issues for Determination Timeliness. Record reviews assessed compliance with the COMAR requirement for timeliness of pre-service determinations. Results are based upon a random selection of pre-service adverse determination records from MY 2024. The following table documents specific issues identified in the record review process that are not identified as metrics in assessing MCO compliance.

Table 110. MY 2024 MCO Adverse Determination Issues (GAD Record Review)

MCO	Issues Identified
MSFC	Pharmacy requests inappropriately categorized pre-service pharmacy requests as “urgent,” as noted in the MY 2023 review.
PPMCO	Two adverse determination letters noted a five-day mailing assumption was included in the appeal filing timeframe.
PPMCO	Provider claims appeal letter was incorrectly sent, when sending a copy of an adverse determination letter for a preauthorization request was the correct approach.

Conclusion

Annual report trends for MYs 2022 to 2024 added context to MCO-reported results for MY 2024 GAD studies. This section includes conclusions from the data.

MCO Compliance

This section captures overall MCO compliance scores from quarterly report submissions and annual record review components against MDH’s compliance score for MY 2024 (95%).

Table 111. MY 2024 MCO Overall Compliance with Regulatory Timeframes (GAD)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	M	M	M	M	M	PM	PM	M
Provider Grievances	M	M	NA	NA	M	M	M	PM	PM
Enrollee Appeals	M	M	M	PM	M	M	M	PM	M
Adverse Determinations	M	M	M	M	M	M	M	M	M
Adverse Notifications	M	M	PM	M	M	M	M	M	M
Prescriber Notifications	M	M	M	M	M	M	M	M	M

Bold font ≥95% for at least one reporting period, but not all reporting periods = Partially Met (PM)

MCO achieves ≥95% for all quarters and demonstrates consistent compliance = Met (M)

Table 112. MY 2024 MCO Overall Compliance with Record Review Components (GAD)

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	UM	M	M	UM	M	UM	M	UM
Enrollee Appeals	M	M	M	UM	M	UM	M	UM	M
Adverse Determinations	M	M	M	M	M	M	M	M	M
Adverse Notifications	M	M	M	M	M	M	M	M	M
Prescriber Notifications	M	NA	M	M	M	M	M	UM	M

Red font <95% for reporting period = Unmet (UM)

MCO achieves ≥95% for all quarters and demonstrates consistent compliance = Met (M)

NA = Not Applicable

Data Validity Analysis

Threats to the validity of the MCO-submitted quarterly GAD reports continued to be assessed. Limitations in the accuracy of the self-reported MCO data are noted below.

MCO-reported data has room for error if there is not some form of inter-rater reliability measured across the MCOs in how they are interpreting instructions.

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of the MY 2024 GAD study. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024's GAD study:

- MCOs demonstrate **quality** by increasing the likelihood of desired health outcomes.
- Providers demonstrate **timeliness** by ensuring utilization management decisions are made in a timely manner to accommodate clinical urgency and minimize any disruption or delays in providing health care.

Applicable domains in quality, access, or timeliness correspond to areas of impact during the MY 2024 GAD study and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

Table 113. MY 2024 Strengths, Improvements, and Recommendations (GAD)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Timeliness	Strengths: - Based upon annual records reviewed, MCOs showed improvements in regulatory and contractual compliance during MY 2024. - Four MCOs (ABH, JMS, KPMAS, and MSFC) met enrollee grievance timeliness metrics in all applicable categories. - Seven of the nine MCOs (eight in MY 2023) met the required appeal resolution timeframe for both expedited and non-emergency appeals. The two outliers are KPMAS and UHC. - Four MCOs (ABH, CFCHP, JMS, and PPMCO) met timeliness requirements for both appeals categories for three consecutive years. - All nine MCOs exceeded the compliance score (95%) for timeliness of a denial determination/resolution in all three denial categories. - Eight of the nine MCOs were compliant with adverse determination notification timeframes, excluding provider notification for pharmacy denials. The outlier is JMS for expedited pre-service denial notification. - Three MCOs (CFCHP, JMS, and MPC) had only one opportunity for improvement in MY 2024.	↑
Quality	Improvements: - Five MCOs' performance improved from MY 2023 to MY 2024 (ABH, CFCHP, JMS, MPC, and WPM). - The number of incidences of non-compliance (opportunities for improvement) decreased across all nine MCOs from MY 2023 (24) to MY 2024 (23).	↑
Quality, Timeliness	Recommendations: - Five MCOs (CFCHP, MPC, PPMCO, UHC, and WPM) have opportunities for improvement in the grievances domain. In order of prevalence, PPMCO has the highest with four, followed by UHC with three. WPM has two opportunities and CFCHP and MPC each have one. - Sixty-one percent of the opportunities for improvement are in the record review portion of the MY 2024 GAD Review. Two MCOs (PPMCO and UHC) account for 57% of the opportunities for improvement, with PPMCO having four opportunities and UHC having eight. In MY 2023, the same two MCOs accounted for 50% of all improvement opportunities. PPMCO has all but one of these opportunities in the record review component of the annual GAD review. UHC has five of the eight opportunities in the timeliness metrics. - Require an explanation for data variances in quarterly GAD reports. In MY 2024, some, but not all, MCOs offered an explanation for data variances when submitting GAD quarterly reports. These reports have a place for this in the analysis of data. While there have been improvements, MCOs	↓

Domain	Strengths, Improvements, and Recommendations	Assessment
	should describe any unique changes from the prior quarter or year to help MDH identify aggregate trends or potential issues across MCOs. Conduct more meetings. MCOs might benefit from having semi-annual or quarterly meetings virtual or in-person, to share issues around GAD. Qlarant could facilitate the dialogue to gain insight into other improvement strategies.	

Green and ↑ = Domain experienced a positive impact from MCOs' performance. Pink and ↓ Domain experienced a negative impact from MCOs' performance.

Continued Improvement Summary

Table 114. MY 2024 Summary of Opportunities for Improvement (GAD)

Improvement Opportunities	MY 2024
Grievances – GAD Reports	MCO
Enrollee Emergency Medically Related Resolution turnaround time (TAT)	UHC
Enrollee Non-Emergency Medically Related Resolution TAT	PPMCO and UHC
Provider Administrative Grievance Resolution TAT	UHC and WPM
Grievances – Record Review Results	MCO
Appropriately Classified	WPM
Acknowledgement Letter Timeliness	CFCHP and MPC
Resolution Timeliness	PPMCO
Resolution Appropriateness	PPMCO
Resolution Letter Timeliness	PPMCO
Appeals – GAD Reports	MCO
Compliance with Enrollee Expedited Appeal Resolution Timeframes	KPMAS and UHC
Compliance with Enrollee Standard Appeal Resolution/Notification Timeframes	KPMAS
Appeals – Record Review Results	MCO
Compliance for Timeframe for Written Appeal Acknowledgment Letter	UHC
Compliance with Timeframe for Written Notification of Denial of Expedited Appeal Request	UHC
Compliance with 72-hour Timeframe for Expedited Appeal Resolution Notification	MSFC
Compliance with Verbal Notification of Expedited Appeal Decision	UHC
Appeal Decision Available to Enrollee in Easy-to-Understand Language	KPMAS
Pre-Service Denials – GAD Reports	MCO
Expedited Pre-Service Notification TAT for Medical Denials	JMS
Compliance with 24-Hour Prescriber Notification	UHC
Adverse Determinations – Record Review Results	MCO

Improvement Opportunities	MY 2024
Appropriateness of Adverse Determinations – Inappropriate classification of pharmacy requests as “urgent”	MSFC

Additional Information

For additional findings and comprehensive details associated with the MY 2024 GAD focused study, please access the link to the MY 2024 GAD Annual Report in [Appendix E](#). [Appendix A](#) includes informed conclusions from the GAD focused study related to quality, access, and timeliness for the HealthChoice program and progress assessments with previous recommendations.

State Recommendations

As identified in the introduction of this report, MDH aims to deliver high-quality, accessible care to managed care enrollees. To achieve this goal, MDH developed a framework to focus quality improvement efforts for the managed care programs. This section identifies goals and objectives described in the HealthChoice Quality Strategy for 2022-2024.

Table 115. HealthChoice Program Goals and Objectives

Goal	Objective
Improve HealthChoice aggregate performance on Medicaid HEDIS measures by reaching or exceeding the pre-pandemic HealthChoice aggregate by MY 2024.	1. Increase the number of HEDIS measures that meet or exceed the HealthChoice aggregate achieved in MY 2018 or MY 2019, whichever is highest, by MY 2024. 2. Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Means by MY 2024.
Improve overall health outcomes for HealthChoice enrollees through expanding the network of available provider types, creating targeted quality and operational initiatives to enhance enrollee access to care, and promoting health service delivery innovation.	1. Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures by three percentage points no later than MY 2024. 2. Improve the HealthChoice aggregate for measures tracking chronic health outcomes by MY 2024.
Ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities.	1. Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024. 2. Increase the HealthChoice aggregate scores to at least 80% for all EPSDT/Healthy Kids MRR components by MY 2024. 3. Increase the HealthChoice aggregate scores to at least 85% for all NAV activities by MY 2024.

Goal	Objective
	4. Increase the HealthChoice aggregate scores to at least 90% for EDV by MY 2024. 5. Increase the HealthChoice aggregate to minimum compliance for each element of review for GAD by MY 2024.

Source: [HealthChoice Quality Strategy 2022-2024](#)

Recommendations on How the State Can Target Quality Strategy Goals and Objectives

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

Performance Measure Validation

MetaStar did not make any formal recommendations in their *Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2024 Results*; observations provided in their “Implications and Discussion” section are captured in the [“HealthChoice Aggregate Quality, Access, and Timeliness” section for HEDIS](#).

CSS did not make any formal recommendations in their *State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations Adult and Child Populations 2025 CAHPS® 5.1H Member Experience Survey*; observations provided in their “Key Driver Analysis” section are captured in the [“HealthChoice Aggregate Quality, Access, and Timeliness” section for CAHPS](#).

Network Adequacy Validation

Qlarant provides the following recommendations for observations from MY 2024 activities for provider-to-enrollee ratios and time and distance standards:

- Consider requiring MCOs provide additional ratios for high-volume and high-impact specialties to demonstrate adequate coverage based on MCO billing processes.

Qlarant provides the following recommendations for observations from the MY 2025 telephone surveys and provider directory validations:

- Continue to monitor the use of urgent care and emergency department services, and review utilization trends to ensure enrollees are not accessing these services due to an inability to identify or access PCPs.

- Continue allowing telemedicine appointments for routine or urgent care appointments to accommodate enrollee preferences and needs when appropriate.
- Ensure MCOs are implementing policies and procedures to promote health equity and monitor the availability of diverse providers with language fluencies other than English.

Grievance, Appeal, and Denial Focused Study

Qlarant provided the following recommendations from MY 2024 activities:

- CMS added appeal outcomes as a required data element to the MCPAR, which will apply to all MCPARs beginning in June 2025. CMS has also added fields to capture the number of prior authorization denials, and these fields will be required for submitted MCPARs starting in June 2026⁵. Unlike some states, Maryland is already assessing these metrics through MCO quarterly GAD reporting. At such times, these new MCPAR requirements are implemented by CMS. MDH and Qlarant should determine if CMS establishes performance thresholds/benchmarks, and if so, these metrics must be added to the current analysis tables at the end of each MCO worksheet for monitoring purposes.
- Consider removing the timeliness metrics, such as resolution and notification, from the record review; and use the quarterly reporting to look at TAT, as is currently done. The record review would focus on appropriate classification of GAD, language used in letters, the letter components, and any measures specific to the letter, such as timeliness of acknowledgement letter.
- Increase consistency of pharmacy adverse determination notifications. There is inconsistency among the MCOs in the timeframe standard for enrollee notification of an adverse determination in response to a preauthorization request for a covered outpatient drug. Some MCOs use 24 hours from receipt of the request, while others use 72 hours from the determination, which has been the standard. Qlarant recommends that MDH update the requirement to 24 hours from the determination to support more timely notification, especially with the provision of 14 calendar days now available for receiving requested information from the prescriber.
- Given ABH's excellent performance over the past three years as an example, MDH may want to consider some method of reward for MCOs whose performance consistently exceeds requirements.
- Establish CAPs for MCOs who have been non-compliant on the same metrics for the past two years.

Qlarant provides the following updates from MY 2023 recommendations:

- **Clarify the preauthorization requirements for covered outpatient drugs and expectation that additional information, if needed, be requested at the time of submission of the request.** MDH issued an MCO transmittal on October 3, 2024, which clarifies preauthorization requirements and includes a provision for allowing a provider up to 14 calendar days to submit additional information,

⁵ Medicaid Managed Care: Additional Federal Action Needed to Fully Leverage New Appeals and Grievances Data. OIG March 14, 2024.

if requested. This should positively impact the number of adverse determinations, appeals, and grievances related to pharmacy and increase enrollee and provider satisfaction with the preauthorization process.

- **Clarify requirement for verbal enrollee notification of receipt of an expedited appeal if written acknowledgement is not provided by the MCO.** Follow-up is needed with MDH. Plan was to request update to COMAR.
- **Among the many OIG findings from their July 2023 report, a total of 115 MCOs in 37 states were studied and determined that one out of every eight requests for prior authorization of services, an average rate of 12.5%, were denied. The study showed that denial rates varied from a low of 2% to a high of 41%. The Maryland MCOs are at the 28% median. Would a value between 12.5% and 25% be a good metric to use for monitoring denial rates?** MDH will wait until CMS posts any performance metrics for appeals and pre-service authorizations in June 2025.

Appendices Introduction

Section Summaries

MCO-Specific Summaries

Quality assurance activities that took place in MYs 2023, 2024, and 2025 are the basis for findings in [Appendix A's](#) summary of MCO performance. Each MCO's section identifies positive or negative impacts on quality, access, and timeliness of care as strengths, improvements, opportunities for improvement, or recommendations; and assesses progress on addressing previous annual recommendations.

SPR Standards and Guidelines

[Appendix B](#) provides an in-depth listing and crosswalk of the SPR standards and guidelines to Quality Assessment Performance Improvement (QAPI) standards and 42 CFR Part 438, Subpart D.

Hilltop's MY 2024 Encounter Data Validation Report

MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters and contracted with Hilltop to analyze and evaluate the validity of encounter data in order to complete Activity 3 (analyzing MCO electronic encounter data for accuracy and completeness). [Appendix C](#) provides the full report of Hilltop's evaluation of all electronic encounter data submitted by the MCOs for MYs 2022 through 2024, to determine the validity of the encounter data and ensure complete, accurate, and high-quality data.

2025 Final IRS and Methodology

[Appendix D](#) explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH released in 2025, based on data reported by MCOs during calendar year 2024 for MY 2023. The information reporting strategy explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience. The analytic method provides a statistical basis and the analysis method used for reporting comparative MCO performance.

Report Reference Page

[Appendix E](#) provides webpage links to access additional findings and comprehensive details associated with task-specific reports.

Report Requirements

[Appendix F](#) identifies the placement in this ATR of required and recommended elements associated with the CMS EQR protocols.

Appendix A: MCO-Specific Summaries

While conducting EQR activities, Qlarant evaluated MCO performance to identify strengths, improvements, and recommendations; and evaluated compliance in addressing previous recommendations that resulted in the need for corrective action. Identified strengths, improvements, and recommendations correspond to quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or recommendation are identified with an arrow (↑) or (↓) and color-coded cells, indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where applicable, recommendations include opportunities. Assessment outcomes (shown as color-coded cells and ↑, ↓, or ●) identify if the MCO adequately addressed previous MY recommendations. This section includes results per MCO.

ABH

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for ABH:

- PMV: MetaStar did not observe any formal improvements for HEDIS. CSS did not observe any formal improvements for either the adult or child surveys. Qlarant did not observe any formal strengths or improvements or provide any formal recommendations for PHIP.
- SPR: ABH was not monitored for an MY 2023 CAP or *MwO* finding, so no quality, access, and/or timeliness improvements were observed.
- NAV: No formal improvements were identified for ABH's Provider-to-Enrollee Ratios and Time and Distance Standards activities.
- CRC: Qlarant did not observe any formal strengths or recommend any formal actions as a result of the 2025 CRC activities.

Table 116. ABH Strengths, Improvements, and Recommendations

Domain	ABH Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • ABH's performance resulted in confidence levels of <i>High Confidence</i> for both PIP topics for the Overall and Methodology Validation Ratings. • ABH continues to demonstrate and enhance efforts toward incorporating a healthy equity focus within its interventions. • ABH followed the PDSA cycle to assess interventions and identified barriers on the enrollee, provider, and MCO levels. • ABH conducted a disparity analysis stratified by race/ethnicity for each strategy.	↑

Domain	ABH Summary	Assessment
	ABH reviewed data on a quarterly basis through the rapid cycle PIP process.	
Quality	Improvements: ABH sustained or improved performance in comparison with the baseline MY 2022 and MY 2023 for all postpartum care-related measures.	↑
Access and Timeliness	Opportunities: ABH may consider analyzing its goal of increasing enrollment for the disparate populations in HVS by 5% above the prior year's rate each subsequent MY to determine if the goal is attainable within the postpartum care-related PIP.	NA
Quality and Timeliness	Recommendations: - ABH should consider system change solutions and individual behavior in utilizing enrollee feedback as to why enrollees do not start prenatal care in the first trimester. - ABH should conduct a root cause analysis to identify why the improved performance for the PPC-CH rate for MY 2023 was not sustained. - ABH should conduct a root cause analysis to identify why the PPC-AD rate for MY 2024 was sustained rather than increased from MY 2023.	↓
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Timeliness	Strengths: MetaStar observed the following strengths: - No issues were identified with the completion of the Roadmap General Information or Appendix Sections. ABH provided a standardized and well-documented HEDIS measurement year (MY) 2024 Roadmap on time, which greatly facilitated both the offsite and virtual onsite phases of the HEDIS Compliance Audit. - ABH utilized a software vendor with NCQA-certified measures. The auditor confirmed via the IDSS that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the globally unique identifiers (GUIDs). In addition, there were no Tier 4 warnings identified by NCQA for ABH. - ABH maintained excellent communication with the auditor throughout the audit process and alerted the auditor when there were concerns that could potentially impact the audit. - ABH provided all required documents, databases, and rate files on or prior to the required deadlines. ABH also provided all requested audit follow-up items in a timely manner.	↑
Quality, Access	Recommendations: MetaStar recommended the following actions:	↓

Domain	ABH Summary	Assessment
	The auditor solicited further explanation as needed for rates that were above the ninetieth percentile or below the tenth percentile, or rates that changed by more than five percentage points from the prior year. ABH should continue to explore the reasons for any low reported rates to improve for future HEDIS reporting.	
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality	Strengths: CSS observed the following strengths: Adult: CSS did not observe any formal strengths for ABH's adult surveys. Child: Showed positive three-year trends for five non-CCC measures, but none were statistically significant.	↑
Quality, Access	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: - Designated the worst performing plan with three measures scoring the lowest among all plans. Six measures scored in the bottom decline, one in the bottom third, and two in the middle third. Two measures (<i>Rating of Personal Doctor</i> and <i>Rating of Health Plan</i>) performed statistically significantly worse than the HealthChoice Aggregate. Child: - Designated the worst performing plan among CCC measures, with three measures scoring in the bottom decile, all having the lowest score of participating plans, and two measures (<i>Access to Prescription Medicines</i> and <i>Access to Specialized Services</i>) significantly below the HealthChoice average. - Designated an average scoring plan on the non-CCC measures, with two in the bottom decile, three in the bottom third, and four in the middle third.	↓
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access, Timeliness	Strengths: ABH's 2024 Population Assessment. Data on numerous population characteristics is analyzed to facilitate targeted quality and care management initiatives. The enhancement of ABH's predictive modeling software from Consolidated Outreach and Risk Evaluation (CORE) to CORE-2 increased opportunities to identify those most vulnerable (e.g., enrollees having the most complex clinical	↑

Domain	ABH Summary	Assessment
	conditions, those with concomitant behavioral health needs, and those determined to experience more social determinants of health indicators). • Comprehensive policies that support timely oversight and staff feedback in response to accuracy, completeness, and timeliness of individual grievance cases. • Ongoing granular review of utilization to determine the root causes of opioid usage and implementation of targeted interventions to address opportunities for improvement. • The Member Disenrollment/Disruptive Member Transfer Policy detailed the potential reasons that ABH would request enrollee disenrollment and voluntary disenrollment.	
Quality, Timeliness	Opportunities: • Ensure that all initial credentialing records include a notice of intent to continue or reject the application process. This letter must be sent to the provider within 30 days of receipt of the initial application. (Component 4.4j) • Demonstrate that ABH is tracking and trending grievances by category, identifying opportunities for improvement, and taking appropriate action to address identified opportunities consistent with its Enrollee Complaint/Grievance Process Policy. (Component 5.1d) • Revise the Pharmacy Prior Authorization and Formulary Exceptions Policy to include the requirement for notifying the prescriber of the outcome (approve, deny, or request additional information) of the preauthorization request for a covered outpatient drug by telephone or other telecommunication device within 24 hours of receipt of the request. (Component 7.4c) • Remove reference to urgent and non-urgent as all outpatient drug requests are subject to the same requirements. There is no separate classification based upon level of urgency. (Component 7.4c) • Provide reports of compliance with the timeframe for notifying the prescriber of the outcome of a preauthorization request within 24 hours of receipt on at least a quarterly basis. (Component 7.4c) • MwOs: ABH must address the following opportunities to achieve compliance in MY 2025: ○ Improve documentation of the requirement for annual training of Utilization Management staff on the interpretation and application of medical necessity criteria/guidelines. (Component 7.2e). ○ Improve the Enrollees Appeals Policy to specify the timeframe for filing an appeal is within 60 calendar days from “the date on the MCO’s adverse determination letter.” (Component 7.7a) ○ Improve the Provider Appeals Policy to require written notice of appeal resolution to be sent to the provider regardless of whether the appeal is filed verbally or in writing. (Component 7.8a) ○ Improve documentation in meeting minutes to explain ABH’s criteria for selection of opportunities for improvement in relation to utilization management identified from the CAHPS and Provider Satisfaction survey results. (Component 7.9c)	↓

Domain	ABH Summary	Assessment
	○ Improve the final step in the job aid for timely payment of IRO invoices to identify the process for follow-up with Accounts Payable to ensure payment is issued within the designated timeframe and cross-reference this job aid in the Provider Appeals Policy. (Element 7.10) ○ Improve documentation of provider feedback related to evaluations of ABH's Health Education Plan. (Component 9.5c) ● CAP: ABH must submit a CAP to achieve compliance in MY 2025: ○ Improve adherence to the timeframes set forth in ABH's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d). (Component 4.4j) ○ Improve use of grievance data to identify and address quality improvement opportunities. (Component 5.1d) ○ Improve the Pharmacy Prior Authorization and Formulary Exceptions Policy by including the requirement for 24-hour prescriber notification and demonstrating compliance on at least a quarterly basis. (Component 7.4c)	
Quality, Access	Recommendations: ● Update the Quality Improvement Process Desktop Procedure, as the most recent version is from October 2020. ● Discuss barriers to providers referring enrollees for health education in ABH's Quality Management/Utilization Management Committee meetings attended by participating providers to address opportunities in response to any identified barriers.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: ● Results for all 28 indicators focused on network capacity achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%. ● Results for all 81 indicators focused on time and/or distance standards achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations: ● Maintain monitoring levels.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Access, Timeliness	Strengths:	↑

Domain	ABH Summary	Assessment
	Scores for compliance with routine care and urgent care appointment timeframes remained above the 80% minimum compliance score by 14.0 and 6.7 percentage points, respectively.	
Quality	Improvements: Performance has improved for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (80.7%) from MY 2024 to MY 2025.	↑
Quality, Access, Timeliness	Recommendations: - Monitor timeframes for urgent care appointments due to the decrease in performance from MY 2024 to MY 2025 to ensure continued compliance in MY 2026. - Review and address root causes for the continued increase in “No Contact” due to <i>Reached Voicemail</i> (35.0%).	↓
Encounter Data Validation		
Quality	Strengths: - Demonstrated 100% compliance for inpatient encounter type. - Held consistent results year-over-year for office visit encounter type.	↑
Quality	Improvements: ABH improved their inpatient encounter match results by four percentage points, regaining their standing at 100% compliance from MY 2022.	↑
Quality	Recommendations: - Outpatient encounter type total match rate percentage remained consistent during MY 2022 and MY 2023; however, the match rate fell four percentage points in MY 2024. Of the outpatient codes validated, diagnosis codes have the lowest compliance score at 93%. - Investigate possible causes for the decline in outpatient encounter type match rate and determine if a mitigation plan is needed for quality improvement of submitted claims. - Coordinate with provider offices to ensure an understanding in claim requirements to improve the quality of office visit documentation compliance.	↓
Early and Periodic Screening, Diagnosis, and Treatment		
Quality, Access, Timeliness	Strengths: - ABH met or exceeded the 80% minimum compliance score for all components in MY 2024. - All elements comprising the <i>Health and Developmental History</i> component exceeded the 80% minimum compliance score.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component increased from 79% in MY 2023 to 80% in MY 2024.	↑

Domain	ABH Summary	Assessment
Quality, Access, Timeliness	Recommendations: - Review and address root causes for the consistent decline in element scores from MY 2022 to MY 2024 for <i>Recorded Psychosocial History</i>, <i>Recorded Developmental Surveillance/History</i>, and <i>Recorded Mental/Behavioral Health Assessment</i> for the <i>Health and Developmental History</i> component. - Review and address root causes for the consistent decline in element scores from MY 2022 to MY 2024 for <i>Vision Assessment</i>, <i>Hearing Assessment</i>, <i>Nutritional Assessment</i>, <i>BMI Percentile</i>, and <i>BMI Graphing</i> for the <i>Comprehensive Physical Examination</i> component. - Review and address root causes for element scores falling below the 80% minimum compliance score for <i>9-11 Year Dyslipidemia Lab Test</i>, <i>18-21 Year Dyslipidemia Lab Test</i>, <i>12 Month Blood Lead Test</i>, <i>24 Month Blood Lead Test</i>, <i>12 Month Anemia Test</i>, and <i>24 Month Anemia Test</i> for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the significant decrease in element score from MY 2023 to MY 2024 for <i>TB Risk Assessment</i> for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the consistent decline in scores from MY 2022 to MY 2024 for <i>Measles/Mumps/Rubella</i>, <i>Varicella</i>, <i>Influenza</i>, and <i>Hepatitis A</i> for the <i>Immunizations</i> component. ABH should note that the <i>Influenza</i> element fell below the 80% minimum compliance score.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality, Access	Improvements: Improved 2024's star rating in two performance areas (Doctor Communication and Service and Care for Kids with Chronic Illness).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - For three consecutive years, ABH has been the only MCO to meet all performance metrics on the GAD reports. - Quarterly and annual self-report GAD reports are consistently error free. - Consistently exceeds the compliance score for timeliness of grievance resolution and grievance resolution notifications; timeliness of appeal acknowledgement and resolution notifications; and timeliness of prescriber notifications, pre-service determinations, and adverse determination notifications. - Case notes fully describe grievance, investigation, and resolution. - Appropriately categorizes and resolves all grievances. - Resolution letters describe grievance and resolution.	↑

Domain	ABH Summary	Assessment
	Writes all appeal and adverse determination letters in easy-to-understand language.	
Quality	Improvements: Compliance with written grievance acknowledgement exceeded the compliance score (95%).	↑
Quality	Recommendations: Train staff on regulation prohibiting written confirmation of an oral appeal.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for ABH:

- PIP, PMV, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- SPR: ABH was not monitored for a MY 2023 CAP or MwO findings, so no formal recommendations were provided that required corrective action.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 117. ABH Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	ABH Addressed Recommendations
MY 2024 NAV Focused Study Activities	MY 2025 NAV Telephone Surveys and Provider Directory Validations Action(s) Taken	↑, ↓, or ●
Ensure staff responses regarding accepting new Medicaid patients for ABH align with responses provided in the online directory through provider staff education. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. ABH should consider reviewing the root causes for the decline in performance and address the identified issues to improve performance.	ABH initiated a corrective action plan that was reviewed by both Qlarant and MDH. ABH was then found to be compliant with <i>Specifies PCP Accepts New Medicaid Patients and Matches Survey Response</i> . Qlarant recommends the MY 2024 CAP to be closed.	↑
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	

Recommendation	Assessment and Actions Taken	ABH Addressed Recommendations
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by one percentage point (79%), and therefore, ABH will be required to submit a CAP.	ABH initiated a CAP that was reviewed by both Qlarant and MDH. ABH was then found to be compliant with <i>Laboratory Tests/At-Risk Screenings</i> .	↑

Green and ↑ = MCO addressed the recommendation

CFCHP

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for CFCHP:

- PMV: CSS did not observe any formal improvements for either the adult or child surveys.
- NAV: No formal strengths or improvements were identified for CFCHP's Provider-to-Enrollee Ratios and Time and Distance Standards activities.
- CRC: Qlarant did not observe any formal improvements or recommend any formal actions as a result of the 2025 CRC activities.

Table 118. CFCHP Strengths, Improvements, and Recommendations

Domain	CFCHP Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • CFCHP's performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics, with performance validation rates of 98.0% for the Prenatal Care PIP and 90.9% for the Postpartum Care-Related PIP. • With a rate of 89.1% for MY 2024, CFCHP's PPC-AD rate is well beyond the NHM, the Maryland Average Reportable Rate (MARR) and is well positioned beyond the ninetieth percentile. • CFCHP's PPC-CH HEDIS rate of 95.1% for MY 2024, surpassed the performance goal rate by 1.8 percentage points. When comparing the MY 2024 final rate to other benchmarks, CFCHP surpassed the ninetieth percentile and the NHM. CFCHP's MY 2024 PPC-CH rate also exceeded the MARR.	↑
Quality, Access, and Timeliness	Improvements: • CFCHP has steadily improved each HEDIS rate from baseline MY 2022 to MY 2024.	↑

Domain	CFCHP Summary	Assessment
Quality and Timeliness	Opportunities: - Demonstrate statistically significant improvement for the PPC-AD HEDIS rate. - Cite evidence-based sources and describe how the proven successful methodology in the source is being incorporated within the interventions.	NA
Quality	Recommendations: - Report accurate HEDIS numerator, denominator, and rate for each MY. - Maintain performance within the ninetieth percentile for the PPC-CH and PPC-AD rates.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Timeliness	Strengths: MetaStar observed the following strengths: CFCHP's HEDIS team was responsive to auditor requests and provided information and documentation in a timely manner. The team served as subject matter experts for all organizational functions. The team also worked diligently to identify root causes of any identified reporting issues and implement corrections when necessary to ensure successful reporting.	↑
Quality, Access	Improvements: MetaStar observed the following improvements: - CFCHP expanded the list of supplemental data sources to include additional sources for measurement year (MY) 2024. This included sources from the two separate methods used to ingest the supplemental data, one for Medicaid and Medicare Dual Eligible Special Needs Plan (DSNP) submissions and the other for the Medicare Employer Group Waiver Plan (EGWP) submission. - Roadmap documentation was updated for MY 2024 to incorporate processes for all product lines.	↑
Quality	Recommendations: MetaStar recommended the following actions: For current claims processing, rendering provider is not a required field, resulting in the lack of servicing provider information for outpatient claims submitted by facilities. It is recommended that CFCHP investigate claims data for services requiring provider specialty to determine if this is resulting in any data gaps.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	
Quality	Strengths: CSS observed the following strengths: Child: Showed a positive directional trend over the previous two years for one non-CCC measure and three CCC measures.	↑

Domain	CFCHP Summary	Assessment
Quality	Recommendations: <i>CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement:</i> Adult: ○ Showed a negative directional trend over the previous two years for six measures, though none were statistically significant compared to the 2024 scores. ○ Scored in the bottom third for seven measures and in the bottom decile for two measures. Child: ○ Scored the lowest among all plans for one non-CCC measure (<i>Rating of Personal Doctor</i>) and scored in the bottom third for six measures and in the bottom decile for three measures.	↓
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Access	Strengths: • CFCHP’s wide range of health education activities held throughout Maryland addressing topics related to the healthcare needs and race/ethnicity of its enrollees. • The success of CFCHP’s marketing efforts, and those of one of its vendors, resulted in increasing the number of unique enrollees who completed a health education program from 1,689 enrollees in MY 2022 to 16,180 in MY 2023.	↑
Timeliness	Improvements: • Achieved compliance with the timeframe for written acknowledgement and written resolution of provider appeals at or above the MDH compliance score of 95% on a quarterly basis for all four quarters of the review period.	↑
Quality, Access, Timeliness	Opportunities: • Demonstrate consistent compliance with timeframes for written enrollee appeal acknowledgement and resolution/notification for expedited appeals at or above the MDH compliance score of 95% for all four quarters of the MY. • Demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for expedited appeal resolution and written notification within two calendar days of the denial decision, at or above the MDH compliance score of 95%, on at least a quarterly basis throughout the MY. • Add the following potential reasons for disenrollment to “Section F. HealthChoice Eligibility/Disenrollment” of the enrollee handbook: changes to assistance category, not validly enrolled in MCO, and enrollee death.	↓

Domain	CFCHP Summary	Assessment
	• Add language to the CFCHP Medicaid Disenrollments Standard Operating Procedure that “CFCHP will submit to MDH, within thirty days of discovering a discrepancy, a list of enrollees who are known to CFCHP to have reasons listed in the referenced COMAR regulations from the HealthChoice Program.” CFCHP must report any discrepancies to mdh.hcenrollment@maryland.gov for resolution. • Add the following statement to the CFCHP Medicaid Disenrollments Standard Operating Procedure: “Federal regulation prohibits CFCHP from requesting enrollee disenrollment based on any of the following: An adverse change in the enrollee’s health status, the enrollee’s utilization of medical services, an enrollee’s diminished mental capacity, and an enrollee’s uncooperative or disruptive behavior resulting from his or her special needs.” • MwO: CFCHP must address the following opportunities to achieve compliance in MY 2025: ○ Update the Pharmacy Prior Authorizations Standard Operating Procedure to include information from the MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) ○ Revise the Pharmacy Prior Authorizations Standard Operating Procedure to require notification of an enrollee of an adverse determination within 24 hours of the preauthorization determination request. This change from receipt to determination is required to support the additional time allowed for a provider to submit requested clinical information, as outlined in the MCO transmittal dated October 3, 2024. (Component 7.6a) ○ Improve monitoring by the CFCHP Compliance Officer to ensure the Compliance Committee annually reviews and approves delegated entities’ Compliance Plans. This review and approval must be clearly documented in the Compliance Committee meeting minutes. (Component 11.4c) • CAP: CFCHP must submit a CAP to achieve compliance in MY 2025: ○ Demonstrate consistent compliance with grievance acknowledgement letter timeliness, on at least a quarterly basis, at or above the MDH compliance score of 95% (Component 5.1g). ○ Provide evidence that all Utilization Management staff members sign an Affirmative Statement on an annual basis, that includes the required content identified in the Affirmative Statement Policy. (Component 7.1c) ○ Improve consistency in reporting identified utilization metrics to the Quality Improvement Committee, in accordance with the Health Services Program Description. (Component 7.3a) ○ Improve documentation of the appropriate action taken, based on identified opportunities to improve overutilization and underutilization of healthcare services. CFCHP will demonstrate evidence by reporting to the appropriate committee(s) identified in CFCHP’s Health Services Program Description and/or applicable policies. (Component 7.3b)	

Domain	CFCHP Summary	Assessment
	○ Demonstrate routine monitoring of action plans implemented to address areas of overutilization and underutilization by the appropriate committee(s), as identified in CFCHP's Health Services Program Description and/or applicable policies. (Component 7.3c) ○ Improve the Timeliness of Utilization Management Decisions Policy or a policy/standard operating procedure of CFCHP's choice by including all required adverse determination letter components. (Component 7.5b) ○ Revise the Medicaid Member Appeals Policy to clarify the appeal filing timeframe is 60 calendar days from the date on the notice of adverse benefit determination. This also should be clarified in the standard operating procedure. (Component 7.7a)	
Quality, Timeliness	Recommendations: • Eliminate some of the narrative of the Quality Improvement Evaluation, and present more of the annual evaluation data in chart and graph format to offer a more efficient way to provide information to leadership and relevant committees for their impact. • Convene a cross-functional workgroup to discuss how processing delays may be eliminated as a result of grievances being incorrectly routed or received by an area other than the Grievance and Appeals Department. • Revisit CFCHP's current reporting structure to bring together all initiatives to address overutilization and underutilization to ensure appropriate monitoring and oversight. For example, workgroups could be established to address each of the key focus areas identified in CFCHP's Health Services Program Description. An overutilization and underutilization workplan would support consolidated reporting from the workgroups with coordination at the Health Services Department level. This department then would be responsible for providing updates to the Quality Improvement Committee on a regular basis. Alternatively, the current role of the corporate Utilization Management Committee, which oversees all lines of business, could be revisited. The Quality Improvement Committee should serve as an oversight body rather than a working committee. • Develop a marketing strategy to increase provider awareness of CFCHP's health education programs, incorporating the results of CFCHP's offerings on key outcome metrics. • Add language to the CFCHP Medicaid Disenrollments Standard Operating Procedure (SOP) that MDH must allow disenrollments, subject to MDH's approval, for other reasons, including: ○ Poor quality of care ○ Lack of access to services covered under the contract ○ Access to providers experienced in dealing with the enrollee's health care needs • Revise the Statement of Compliance document and the associated health plan statements of compliance to align with the MY 2024 Maryland MCO Systems Performance Standards and Guidelines.	↓

Domain	CFCHP Summary	Assessment
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Recommendations: In addition to reporting current metrics for the pediatric and female population, consider including additional monitoring for specific populations, especially if access falls below 100%, but still meets state standards.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access	Strengths: - Scores for compliance with routine care and urgent care appointment timeframes remained above the 80% minimum compliance score by 16.3 and 9.7 percentage points, respectively. - All online provider directory requirements exceeded the 80% minimum compliance score; therefore, no CAP is required.	↑
Quality, Access	Improvements: After implementing corrective action for MY 2024, CFCHP improved the accuracy of <i>PCP's Practice Telephone Number Matched Survey Response</i> by 11.7 percentage points from MY 2024 (78.0%) to MY 2025 (89.7%); therefore, Qlarant recommends the MY 2024 CAP to be closed.	↑
Quality, Access, Timeliness	Recommendations: - Monitor urgent care appointment timeframes due to the decrease in performance from MY 2024 to MY 2025 to ensure continued compliance in MY 2026. - Review and address root causes for the highest percentages of unsuccessful contacts due to <i>No Answer</i> (35.8%) and unsuccessful surveys due to <i>Not a PCP</i> (54.1%).	↓
	Encounter Data Validation	
Quality	Strengths: - Demonstrated 100% compliance for inpatient encounter type. - Consistently scored high in match rates for outpatient encounters over the trended period.	↑
Quality	Improvements: Improved inpatient match results by one percentage point, regaining MY 2022's 100% compliance.	↑
Quality	Recommendations: Office visit encounter types, while above compliance, did experience a decline from MY 2023, hovering closer to the compliance threshold (90%).	↓

Domain	CFCHP Summary	Assessment
	Investigate possible causes behind the decline in office visit encounter compliance rates. Work with providers and vendors to ensure full comprehension of claim requirements before submission.	
	Early and Periodic Screening, Diagnosis, and Treatment	
Quality, Access, Timeliness	Strengths: - CFCHP exceeded the 80% minimum compliance score for all components in MY 2024. - All elements comprising the <i>Comprehensive Physical Examination</i> component met or exceeded the 80% minimum compliance score.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component score improved from MY 2023 (79%) to MY 2024 (82%).	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for the consistent decline in component scores for <i>Comprehensive Physical Examination</i>, <i>Immunizations</i>, and <i>Health Education/Anticipatory Guidance</i> from MY 2022 to MY 2024. - Review and address root causes for the significant decrease in element scores for <i>Recorded Developmental Screening Tool</i> and <i>Depression Screening</i> in the <i>Health and Developmental History</i> component. - Review and address root causes for the significant decrease in element scores for <i>Graphed Head Circumference</i> and <i>Measured Head Circumference</i> in the <i>Comprehensive Physical Examination</i> component. - Review and address root causes for element scores falling below the 80% minimum compliance score for <i>9-11 Year Dyslipidemia Lab Test</i>, <i>12 Month Blood Lead Test</i>, <i>12 Month Anemia Test</i>, <i>24 Month Anemia Test</i>, and <i>HIV Test Per Schedule</i> for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for element scores falling below the 80% minimum compliance score for <i>Influenza</i>, <i>Human Papillomavirus</i>, and <i>Assessed Immunizations Up to Date</i> in the <i>Immunizations</i> component. - Review and address root causes for the <i>Documented Referral to Dentist</i> element score falling below the 80% minimum compliance score for the <i>Health Education/Anticipatory Guidance</i> component.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality	Strengths: Maintained star ratings in three performance areas (Care for Kids with Chronic Illness, Pregnancy and Infant Care, and Keeping Adults Healthy).	↑

Domain	CFCHP Summary	Assessment
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Described grievance, investigation, and resolution in case notes and resolution letter. - Appropriately categorized and resolved all resolutions. - Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Quality, Timeliness	Improvements: - Opportunities for improvement moved from two in MY 2023 to one in MY 2024. - Compliance with a reasonable attempt to provide oral notification of the denial of a request for an expedited appeal resolution exceeded the MDH compliance score of 95%. - Case notes reflect a reasonable attempt to provide the enrollee with oral notification of denial of a request for an expedited appeal resolution.	↑
Quality, Timeliness	Recommendations: - Routinely monitor timeframe compliance with written grievance acknowledgements. - Routinely audit a sample of grievance resolution letters to ensure the correct template is used. - Routinely audit a sample of appeal acknowledgment letters to ensure the correct resolution timeframe is stated and the calculated dates are accurate.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for CFCHP:

- PIP, PMV, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 119. CFCHP Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	CFCHP Addressed Recommendations
MY 2023 SPR	MY 2024 SPR	↑, ↓, or ●
Standard 7: Continued Quarterly CAP from MY 2020: In response to the MY 2020 review, CFCHP did not meet compliance for Component 7.8c for two consecutive years. CFCHP remained on a quarterly CAP for the MY 2023 review and still needs to demonstrate TAT compliance for written acknowledgement and written resolution of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the review period.	Qlarant recommended a CAP closure for Component 7.8c, as CFCHP achieved compliance during MY 2024's SPR.	↑
Standard 7: Continued Quarterly CAP from MY 2023: In response to the MY 2023 review, CFCHP did not meet compliance for Components 7.7c and 7.7e and a new quarterly CAP was implemented due to continued noncompliance for two consecutive years. For Component 7.7c, CFCHP still needs to demonstrate compliance with timeframes for written appeal acknowledgement and resolution/notification at or above the MDH compliance score of 95% on at least a quarterly basis for all four quarters of the review period. For Component 7.7e, CFCHP still needs to demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for an expedited appeal resolution. No denials of a request for an expedited appeal resolution were found in the sample review of 10 appeal records nor the 20 additional records reviewed. This component will be reviewed again in MY 2023 as there were no cases found in MY 2022's sample. This item will remain a <i>Partially Met</i> until a record review is completed that results in a <i>Met</i> finding.	CFCHP demonstrated progress in meeting this requirement, but due to multiple years of not meeting this requirement, must submit quarterly CAPs for both categories until compliance is achieved.	●

Recommendation	Assessment and Actions Taken	CFCHP Addressed Recommendations
MY 2024 NAV Focused Study Activities	MY 2025 NAV Telephone Surveys and Provider Directory Validations Action(s) Taken	↑, ↓, or ●
Ensure PCP's telephone numbers are accurate and updated in the online provider directory to improve enrollee access to contacting PCPs. CFCHP should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2025 performance.	CFCHP initiated a corrective action plan that was reviewed by both Qlarant and MDH. CFCHP was then found to be compliant with <i>PCP's Practice Telephone Number Matched Survey Response</i> . Qlarant recommends the MY 2024 CAP to be closed.	↑
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by one percentage point (79%), and therefore, CFCHP will be required to submit a CAP.	CFCHP initiated a CAP that was reviewed by both Qlarant and MDH. CFCHP was then found to be compliant with <i>Laboratory Tests/At-Risk Screenings</i> .	↑

Green and ↑ = MCO addressed the recommendation; Yellow and ● = MCO did not fully address the recommendation

JMS

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for JMS:

- PMV: MetaStar did not observe any formal improvements for HEDIS. CSS did not observe any formal improvements for either the adult or child surveys.
- SPR: JMS was not monitored for a MY 2023 CAP or *MwO* finding, so no quality, access, and/or timeliness improvements were observed.
- NAV: Qlarant did not observe any formal improvements for JMS' Telephone Surveys and Provider Directory Validations activities.
- EPSDT: Qlarant did not observe any formal improvements from the previous measurement year.
- CRC: Qlarant did not observe any formal improvements or recommend any formal actions as a result of the 2025 CRC activities.

Table 120. JMS Strengths, Improvements, and Recommendations

Domain	JMS Summary	Assessment
Quality, Access, and Timeliness	Strengths: • JMS' performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics.	↑

Domain	JMS Summary	Assessment
Quality and Access	Improvements: - JMS provided further details regarding provider barriers. - JMS provided each aspect of SMART in a clear and concise SMART objective statement. - JMS' performance has resulted in a steady increase in the W30 (15-30 Months) HEDIS rate from baseline MY 2022 to MY 2024.	↑
Quality and Timeliness	Opportunities: - Review data for accuracy. - Demonstrate statistically significant improvement for each HEDIS rate, as a result of implemented interventions.	NA
Quality	Recommendations: - Properly cite sources, such as using American Psychological Association format. - Continue modifying interventions as needed to address barriers to timeliness of prenatal care.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Access, Timeliness	Strengths: MetaStar observed the following strengths: - JMS' HEDIS team continually works to improve HEDIS processes year after year. The team was extremely responsive to auditor requests and provided information/documentation in a timely manner. The team served as subject matter experts for all organization functions and maintained oversight of the HEDIS reporting process. - Similar to the prior year, JMS met many of the HEDIS milestones prior to the deadlines, which resulted in completion of reporting well prior to the HEDIS submission deadlines.	↑
Quality, Access	Recommendations: MetaStar recommended the following actions: - JMS was able to successfully report the required Electronic Clinical Data Systems (ECDS) measures for HEDIS MY 2024. The auditor recommends that JMS continue to explore clinical data sources that will support the reporting of these ECDS measures. Additionally, as HEDIS reporting moves to more administrative data sources, such as electronic medical record data from various provider groups and Data Aggregation Validation (DAV), to improve data collection. - For the medical record review process, only records that passed or have the potential to pass are entered into the abstraction tool. Fails are mainly just tracked as received chases and do not have overreads conducted on them. While this is not considered an issue for the audit, since there is a possibility to mis-enter or misclassify these cases, it is recommended that JMS enter the dates and	↓

Domain	JMS Summary	Assessment
	values of the failed cases into the tool or have another method to track these cases. Additionally, it is recommended that the failed cases be validated.	
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality, Timeliness	Strengths: CSS observed the following strengths: Adult: Designated the overall best performing plan this year with top scores on six of the ten measures (<i>Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Coordination of Care, Customer Service, and How Well Doctors Communicate</i>). JMS had three scores in the top decile and three in the middle third. Child: - Designated the best performing plan among CCC measures with two of the highest scoring measures among all plans for <i>Personal Doctor Who Knows Child</i> in the top decile and <i>Coordination of Care for Children with Chronic Conditions</i>, while having no measures in the bottom decile. - Designated the best performing plan overall this year with four of the highest scoring non-CCC measures (<i>Rating of Personal Doctor</i> being statistically significantly higher than the HealthChoice Aggregate) and two of the highest scoring CCC measures.	↑
Quality	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: Performed in the bottom third for three scores. Child: CSS did not provide any observations for JMS' child surveys.	↓
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access, Timeliness	Strengths: - Resolved the vast majority of JMS' grievances, including administrative, in under five calendar days, which supports the provision of exceptional customer service to its enrollees. - Conducted studies evaluating the effectiveness of health education, which are robust and well-designed, with outcomes demonstrating a positive impact. - Comprehensively addressed the new requirements for disenrollment, consistent with Standard 12, in JMS' policies and procedures.	↑
Quality	Opportunities:	↓

Domain	JMS Summary	Assessment
	- Add the following potential reasons for disenrollment to “Section F. HealthChoice Eligibility/Disenrollment” of the enrollee handbook and the administrative policy and procedure document: changes to assistance category, not validly enrolled in MCO, and enrollee death. MwO: JMS must address the following opportunity to achieve compliance in MY 2025: - Provide evidence of notice and tagline postings when JMS interacts with the public during community events (e.g., pictures during enrollee health fairs, baby showers).	
Quality	Recommendations: - Add a section to the front page of each clinical practice guideline that indicates if the annual research review of the topic resulted in changes to the clinical practice guideline. - Add a version date and version number to the enrollee handbook. There is a date in the title, but not in the document itself.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: Results for all 33 indicators focused on network capacity achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Improvements: All indicators for network capacity achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations Maintain monitoring levels; however, provide all relevant metrics.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Access, Timeliness	Strengths: Scores for compliance with routine care and urgent care appointment timeframes remained above the 80% minimum compliance score by 14.1 and 13.4 percentage points, respectively.	↑
Quality, Access	Recommendations: - Review and address root causes for having the highest percentage of unsuccessful contacts due to <i>Did Not Reach Intended Provider</i> (63.0%). CAP. Performance has declined for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (75.0%). JMS must submit a CAP to achieve compliance in MY 2026.	↓

Domain	JMS Summary	Assessment
	Ensure staff responses regarding accepting new Medicaid patients for JMS align with the online provider directory. Enrollees use the online provider directory to search for new PCPs and should receive the same information when calling the provider directly.	
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: - Demonstrated 100% compliance for the inpatient encounter type year-over-year. - Consistently scored high in match rates for outpatient encounters over the trended period.	↑
Quality	Improvements: Improved outpatient encounter match rates by two percentage points from MY 2023, achieving 100% compliance.	↑
Quality	Recommendations - Office visit encounters declined eight percentage points from MY 2023; while still compliant, the score is hovering at the compliance threshold (90%). - Investigate the decline in office visit encounters to determine if a mitigation plan is needed for quality improvement of submitted claims.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, Timeliness	Strengths: - JMS has consistently exceeded the 80% minimum compliance score for all components from MY 2022 to MY 2024. - All component scores and the total composite score exceeded the HealthChoice aggregate scores for MY 2024. - All elements comprising the <i>Health and Developmental History</i>, <i>Immunizations</i>, and <i>Health Education/Anticipatory Guidance</i> components exceeded the 80% minimum compliance score.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for the consistent decline in element score for <i>Recorded Perinatal History</i> for the <i>Health and Developmental History</i> component. - Review and address root causes for the decrease of seven element scores for the <i>Comprehensive Physical Examination</i> component, with the most significant decrease for <i>Graphed Head Circumference</i>. - Review and address root causes for the <i>Newborn Metabolic Screen</i> element score remaining below the 80% minimum compliance score for the <i>Laboratory Tests/At-Risk Screenings</i> component.	↓

Domain	JMS Summary	Assessment
	- Review and address root causes for the decrease of five element scores for the <i>Laboratory Tests/At-Risk Screenings</i> component, with the most significant decrease of four percentage points for <i>Recorded TB Risk Assessment</i>. - Review and address root causes for the decrease of three element scores for the <i>Immunizations</i> component, with the most significant decrease of three percentage points for <i>Meningococcal</i> and <i>Human Papillomavirus</i>. - Review and address root causes for the decrease of four element scores for the <i>Health Education/Anticipatory Guidance</i> component, with the most significant decrease of five percentage points for <i>Documented Referral to Dentist</i>.	
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality, Access, Timeliness	Strengths: Maintained star ratings in three performance areas (Access to Care, Keeping Kids Healthy, and Keeping Adults Healthy).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - For three consecutive years, JMS has been compliant with all metrics for grievances and appeals. - Case notes and resolution letters describe grievance, investigation, and resolution. - Appropriately categorized and resolved all grievances. - Resolved ninety percent of grievances in <i>less than or equal to</i> five days in all categories for exceptional enrollee service. - Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Quality	Improvements: - Reduced the number of opportunities for improvement from two in MY 2023 to one in MY 2024. - Compliance with a reasonable attempt to provide enrollees with oral notification of an expedited appeal resolution exceeded the MDH compliance score (95%). - Consistently categorized and processed pharmacy preauthorization requests according to MDH requirements.	↑
Quality	Recommendations: Continue working with the pharmacy vendor to ensure urgent durable medical equipment requests are processed timely.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for JMS:

- PIP, PMV, SPR, EPSDT, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not provide MY 2024 recommendations for telephone surveys and provider directory validations activities that would require corrective action.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

KPMAS

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for KPMAS:

- PMV: MetaStar did not observe any formal improvements for HEDIS. CSS did not observe any formal improvements for either the adult or child surveys.
- NAV: Qlarant did not observe any formal improvements for KPMAS' Telephone Surveys and Provider Directory Validations activities.
- EPSDT: Qlarant did not observe any formal improvements from the previous measurement year.

Table 121. KPMAS Strengths, Improvements, and Recommendations

Domain	KPMAS Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • KPMAS' performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics.	↑
Quality, Access, and Timeliness	Improvements: • KPMAS clearly reported all MYs for the life of the PIP. • The disparate population was clearly defined in both prenatal and postpartum care PIP topics • KPMAS' performance has resulted in steady improvement of the PPC-CH, PPC-AD, and W30 (15-30 Months) HEDIS rates from baseline MY 2022 to MY 2024.	↑

Domain	KPMAS Summary	Assessment
Quality	Opportunities: - Ensure data is validated for each measure. - Ensure enrollee, provider, and MCO barriers are clearly identified and addressed.	NA
Quality	Recommendations: - Utilize the same methodology as the baseline year for the prenatal care PIP. - Conduct a barrier analysis to ensure barriers are addressing the enrollee, provider, and MCO for the postpartum care-related PIP topic.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Access	Strengths: MetaStar observed the following strengths: - KPMAS was able to report valid rates for all relevant measures to meet accreditation and State-reporting requirements. - KPMAS continues to promote a culture of quality improvement by maintaining its high-performance on many HEDIS measures, while continuing to identify and implement initiatives to improve its performance across the measure set. - KPMAS has robust processes to manage, code, and report performance measure rates, which likely positions the organization for success for digital reporting in the future. In addition, given the KPMAS model and use of a shared electronic medical record (EMR) across its care settings, KPMAS is able to capture nearly all data needed for performance measure reporting through administrative and supplemental data sources, which will allow KPMAS to maintain accuracy of data reporting when hybrid reporting is retired.	↑
Quality, Access	Recommendations: MetaStar recommended the following actions: - While there were no concerns with data reporting for MY 2024, the auditor recommended that KPMAS could improve its Administrative Data Inventory by adding its internal encounter data as a separate column and data source from external claims processes to better distinguish and delineate each process. - KPMAS should also continue to work with the State of Maryland and its behavioral health pharmacy data vendor to address data integrity concerns, which may allow for data integration in future years.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality	Strengths: CSS observed the following strengths:	↑

Domain	KPMAS Summary	Assessment
	• Adult: ○ Scored the highest for the <i>Rating of All Health Care</i> measure among all plans. ○ Scored in the top third for one measure and in the middle third for one measure. • Child: ○ Showed a positive directional trend over the previous two years for three non-CCC measures and two CCC measures.	
Quality, Timeliness	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: • Adult: ○ Declined in MCO performance compared to 2024 for the <i>Coordination of Care</i> measure. KPMAS is one of three MCOs with statistically significant declines. ○ Scored the lowest in three measures (<i>Getting Needed Care</i>, <i>Coordination of Care</i>, and <i>Shared Decision Making</i>) among all plans. ○ Scored in the bottom third for three measures and in the bottom decile for four measures. • Child: ○ Designated the worst performing plan among non-CCC measures, with three of the lowest scoring measures across all plans, with two of them scoring in the bottom decile and one of them (<i>Getting Care Quickly</i>) being statistically significantly worse than the HealthChoice Aggregate. ○ Performed poorly on the CCC measures, with two being the lowest scoring among all plans (<i>Getting Needed Information</i> and <i>Personal Doctor Who Knows Child</i>). Those two and an additional one (<i>Access to Specialized Services</i>) scored in the bottom decile.	↓
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access, Timeliness	Strengths: • Included a breakdown of the treatment of minors and associated consent capacities, by state, in the Assessment and Treatment for Minors Policy. • Implemented a comprehensive plan comprised of multiple initiatives to achieve a reduction in days per 1000 related to extended lengths of stay and readmissions. • Provided a comprehensive snapshot of health education-related activities for MY 2024, with a clear focus on continuous quality improvement through KPMAS' Maryland HealthChoice workplan. • Developed the Maryland Medicaid Disenrollment Policy, which is clearly written, concise, and easy to understand.	↑
Timeliness	Improvements:	↑

Domain	KPMAS Summary	Assessment
	Achieved compliance with the timeframe for written acknowledgement of provider appeals, at or above the MDH compliance score of 95%, on a quarterly basis for all four quarters of the review period.	
Quality, Timeliness	Opportunities: - Provide evidence of grievance reporting supplied to the Claims Appeal Board, inclusive of any opportunities for improvement addressed and documented through the grievance process. MwO: KPMAS must address the following opportunities to achieve compliance in MY 2025: - Review the language requirements for written policies and delete “strive to” within the operating protocol for required standards. (Component 5.7a) - Update the MD HealthChoice Pharmacy Service Authorizations Policy to include information from the MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days from receipt of the initial preauthorization request for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) - Revise the adverse determination notification timeframe in the MD HealthChoice Pharmacy Service Authorizations Policy from 24 hours from receipt of the preauthorization request to the date of determination. This is consistent with the availability of a 14-calendar day extension communicated in the MCO Transmittal No. 225. (Component 7.6a) - Revise the Provider Claims Appeals Policy – Maryland to specify the timeframe for resolving subsequent levels of provider appeals beyond the initial appeal. (Component 7.8b) - Provide documentation demonstrating specific initiatives have been implemented to address opportunities for improvement related to results from the CAHPS survey. (Component 7.9c) CAP: KPMAS must submit a CAP to achieve compliance in MY 2025: - Demonstrate reporting and analysis of Maryland HealthChoice grievance data to the Regional Quality Improvement Committee on a quarterly basis, consistent with KPMAS’ Mid-Atlantic States Non-Medicare Grievance and Appeals Policy. Reporting should include any identified opportunities for improvement and associated action plans. Eliminate the sole use of goals to determine if an opportunity for improvement exists. For example, the majority of grievances for the timeframes reported were related to attitude/service, which clearly represents an opportunity for improvement. (Component 5.1d) - Revise the Provider Claims Appeal Policy – Maryland to reflect consistency with the requirements of COMAR 10.67.13. (Element 7.10) - Include evaluation measures that are more indicative of the health of the enrollee population, such as the impact of health education on emergency room utilization, hospital admissions, utilization of preventive health services, and/or clinical measures. (Component 9.3a)	↓

Domain	KPMAS Summary	Assessment
	Show evidence of the Compliance Committee's review and approval of each delegate's Compliance Plan and fraud, waste, and abuse (FWA) policies and procedures. The delegate's Fraud, Waste, and Abuse and Compliance Plans must be dated in the MY under review. (Component 11.4c)	
Quality	Recommendations: Respond to identified opportunities from the Health Education Resources Survey to further promote the resources of the Health Engagement Department. KPMAS may want to consider providing evaluations of the effectiveness of various health education programs to support increased referrals.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: Results for all 80 indicators focused on time and/or distance standards achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations: Maintain monitoring levels; however, consider monitoring additional specialties.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access, Timeliness	Strengths: - Compliance with routine care appointment timeframes exceeded the 80% minimum compliance score by 14.4 percentage points. - Highest percentage of successful contacts (98.4%), accurate PCP addresses (98.4%), and <i>Accepts Listed MCO</i> (100%). - Lowest percentage of unsuccessful contacts due to <i>Wrong Location Listed for Provider</i> (0%). - One of three MCOs to not have unsuccessful surveys due to <i>Not a PCP</i>. - All online provider directory requirements exceeded the 80% minimum compliance score; therefore, no CAP is required.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for having the lowest percentage for <i>Accepts New Medicaid Patients Listed for MCO</i> (64.0%). - Review and address root causes for having the second-highest percentage for unsuccessful contacts due to <i>Hold Time Greater than Five Minutes</i> (21.1%) and <i>No Answer</i> (31.6%).	↓

Domain	KPMAS Summary	Assessment
	- Review and address the root causes for having the highest percentage of unsuccessful surveys due to <i>Does Not Accept Insurance</i> (93.8%). CAP. KPMAS initiated a corrective action plan that was reviewed by both Qlarant and MDH. Despite implementing corrective action, KPMAS' scores remain below the compliance score for urgent care appointment timeframes (71.2%) and <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (78.4%). Due to multiple years of not meeting this requirement, KPMAS must submit quarterly CAPs for both categories to achieve compliance in MY 2026. - Ensure provider offices are meeting requirements for urgent care appointment scheduling within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. - Ensure staff responses regarding accepting new Medicaid patients for KPMAS align with responses provided in the online provider directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.	
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: - Demonstrated 100% compliance each year of the trended period for outpatient encounters. - Demonstrated 100% compliance in inpatient encounters for MY 2022 and MY 2023. - Showed minimal fluctuation in compliance scores year-over-year in both inpatient and office visits, varying in difference only between one to two percentage points.	↑
Quality	Improvements: Improved outpatient encounter match rates by one percentage point from MY 2023, resulting in 100% compliance.	↑
Quality	Recommendations: - Office visit encounters score the lowest in compliance compared to other encounter types; while still achieving scores well within compliance, this encounter type consistently scores the lowest over the trended period. - Investigate possible reasoning behind the difference in office visit scores and other encounter scores. Work with providers and vendors to ensure full comprehension of claim requirements before submission.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, or Timeliness	Strengths: KPMAS exceeded the 80% minimum compliance score for all components in MY 2024.	↑

Domain	KPMAS Summary	Assessment
	All elements comprising the <i>Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> components exceeded the 80% minimum compliance score.	
Quality, Access, or Timeliness	Recommendations: - Review and address root causes for all component scores declining from MY 2022 to MY 2024. - Review and address root causes for the decline in element scores from MY 2022 to MY 2024 for the <i>Recorded Maternal Depression Screening</i> and <i>Depression Screening</i> falling below the 80% minimum compliance score for the <i>Health and Developmental History</i> component. - Review and address root causes for the decline in element score for the <i>Vision Assessment</i> element score from MY 2022 to MY 2024 for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the decline in element scores for <i>Recorded TB Risk Assessment</i> and <i>9-11 Year Dyslipidemia Lab Test</i>, which fell below the 80% minimum compliance score for the <i>Laboratory Tests/At-Risk Screenings</i> component.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality	Strengths: Maintained star ratings for three performance areas (Keeping Kids Healthy, Pregnancy and Infant Care, and Keeping Adults Healthy).	↑
Quality, Access	Improvements: Improved star ratings for two performance areas (Doctor Communication and Service and Care for Kids with Chronic Illness).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Grievance resolution TAT metric consistently exceeded compliance thresholds. - Case notes and resolution letters described grievance, investigation, and resolution. - Appropriately categorized and resolved all grievances. - Wrote all adverse determination letters in easy-to-understand language.	↑
Quality, Timeliness	Improvements: - For this year's standard non-emergency appeals resolution TAT, there is an improvement (93%) from performance in Q3 2024, when the compliance rate was 71.4%. In MY 2023, compliance with Emergency Medically Related grievances fell to 92% for the year and was 80% in Q1 2024. In the remainder of MY 2024, all TAT metrics exceeded the compliance score. - Demonstrated consistent compliance with expedited appeal resolution notification timeframe during the record review.	↑

Domain	KPMAS Summary	Assessment
	Demonstrated consistent compliance with notifying enrollees orally and in writing of the denial of a request for an expedited resolution.	
Quality, Timeliness	Recommendations: - Monitor resolution TAT for both expedited and standard appeals monthly, until compliance is reached. - Routinely monitor enrollee appeal resolution letters to ensure they are written in easy-to-understand language. Provide training, as needed.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. Pink and ↓ Domain experienced a negative impact from MCOs' performance. Gray and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for KPMAS:

- PIP, PMV, EPSDT, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 122. KPMAS Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	KPMAS Addressed Recommendations
MY 2023 SPR	MY 2024 SPR	↑, ↓, or ●
Standard 5: Continued MwO Finding from MY 2023: In response to the MY 2021 review, KPMAS did not meet compliance in Component 5.1d and a new annual CAP was implemented. KPMAS required a quarterly CAP in the MY 2022 review due to consecutive years of noncompliance. As a result of a MwO finding for the MY 2023 review, KPMAS still needs to eliminate sole use of goals to determine if an opportunity for improvement exists. For example, it was noted that the majority of grievances for the first quarter of 2021 through the first quarter of		↑

Recommendation	Assessment and Actions Taken	KPMAS Addressed Recommendations
2023 were related to attitude/service. This would clearly represent an opportunity for improvement.		
Standard 7: Continued Quarterly CAP from MY 2020: In response to the MY 2020 review, KPMAS did not meet compliance for Component 7.8c for two consecutive years. KPMAS remained on a quarterly CAP for the MY 2023 review and still needs to demonstrate compliance with written acknowledgement of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the review period, as required by Maryland Medicaid.	Qlarant recommended a CAP closure for Component 7.8c, as KPMAS achieved compliance during the MY 2024 review.	↑
MY 2024 NAV Focused Study Activities	MY 2025 NAV Telephone Surveys and Provider Directory Validations Action(s) Taken	↑, ↓, or ●
KPMAS' urgent care appointment timeframes score remains below the minimum compliance threshold (77.7% for MY 2023 to 79.3% for MY 2024). To achieve compliance in the MY 2025 validations, KPMAS must submit quarterly CAPs to address provider offices accommodating requirements for urgent care appointment scheduling within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. KPMAS must review the root causes for the decline in performance and address the identified issues to improve performance. KPMAS' scores for <i>Specifies if PCP Accepts New Medicaid Patients & Directory Matched Survey Response</i> decreased by 11.2 percentage points. To achieve compliance in the MY 2025 validations, KPMAS must submit CAPs to address staff responses regarding accepting new Medicaid patients for KPMAS align with responses provided in the online directory through provider staff education.	KPMAS initiated a CAP that was reviewed by both Qlarant and MDH. Despite implementing corrective action, KPMAS' scores remain below the compliance score for urgent care appointment timeframes (71.2%) and <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (78.4%). Due to multiple years of not meeting this requirement, KPMAS must submit quarterly CAPs for both categories to achieve compliance in MY 2026.	↓

Green and ↑ = MCO addressed the recommendation; Pink and ↓ = MCO did not address the recommendation; Yellow and ● = MCO did not fully address the recommendation

MPC

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for MPC:

- PIP: Qlarant did not observe any formal opportunities as a result of the MY 2024 PIP activities.
- PMV: MetaStar did not observe any formal improvements for HEDIS. CSS did not observe any formal improvements for either the adult or child surveys.
- NAV: Qlarant did not observe any formal improvements for MPC's Telephone Surveys and Provider Directory Validations activities.
- CRC: Qlarant did not observe any formal improvements or recommend any formal actions as a result of the 2025 CRC activities.

Table 123. MPC Strengths, Improvements, and Recommendations

Domain	MPC Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • MPC's performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics. • MPC achieved performance within the ninetieth percentile for the PPC-CH HEDIS rate.	↑
Quality, Access, and Timeliness	Improvements: • MPC demonstrated how all aspects of CLAS are being implemented within each intervention specifically. • MPC's performance resulted in steady improvement for the PPC-CH, W30 (0-15 Months), and W30 (15-30 Months) HEDIS rates.	↑
Quality	Recommendations • MPC may consider performing a root cause analysis to determine if other barriers can be overcome to improve performance for the W30 and CIS-3 HEDIS rates. • Maintain performance within the ninetieth percentile for the PPC-CH rate.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Access, and Timeliness	Strengths: <i>MetaStar observed the following strengths:</i>	↑

Domain	MPC Summary	Assessment
	- MPC was able to report valid rates for all relevant measures to meet accreditation and State-reporting requirements - MPC has an exceptional team dedicated to HEDIS reporting, who demonstrates strong project management to achieve all key milestones timely, and has robust processes for data capture, analysis, mapping, and quality review. - MPC implemented efforts to improve performance on the Lead Screening in Children (LSC) measure.	
Access	Recommendations: MetaStar recommended the following action: While there were no concerns with reported rates for MY 2024, MPC should continue to explore opportunities to obtain data via administrative or supplemental data streams for integration as hybrid measures as NCQA continues on its timeline to retire hybrid methodology in the future.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality, Timeliness	Strengths: CSS observed the following strengths: Adult: - CSS did not observe any strengths for MPC's adult surveys. Child: - Scored the highest for three measures (<i>Getting Needed Care</i>, <i>Getting Care Quickly</i>, and <i>Shared Decision Making</i>). - Scored statistically significantly higher than the HealthChoice Aggregate for the <i>Getting Care Quickly</i> measure.	↑
Quality	Improvements: CSS observed the following improvements: Adult: CSS did not observe any improvements for MPC's adult surveys. Child: Improved performance compared to the prior year for two measures (<i>Rating of Personal Doctor</i> and <i>Shared Decision Making</i>). MPC is one of two MCOs with statistically significant gains.	↑
Quality	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: - Declined in MCO performance compared to 2024 for the <i>Rating of Specialist Seen Most Often</i> measure. MPC is one of three MCOs with statistically significant declines.	↓

Domain	MPC Summary	Assessment
	- Did not score higher than the bottom third in any measures. Two scores were the lowest among all plans (<i>Rating of All Health Care</i> and <i>How Well Doctors Communicate</i>), though none scored statistically significantly below the HealthChoice Aggregate. Child: - Scored the lowest for the <i>Rating of Health Plan</i> measure. - Scored in either the bottom or middle third.	
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access, Timeliness	Strengths: - CAHPS and Provider Satisfaction survey action plans that provide a clear and comprehensive snapshot of utilization management-related opportunities, associated interventions, and quarterly updates on the status of interventions. - An extremely comprehensive Prevention and Wellness Workplan that allows MPC to monitor progress toward identified goals on a quarterly basis and develop recommendations based upon identified barriers and opportunities. - The Member Disenrollment Policy explains in detail the potential reasons MPC would request enrollee disenrollment and comprehensively outlines the reasons for enrollee voluntary disenrollment.	↑
Timeliness	Improvements: Demonstrated timeframe compliance with expedited appeal resolution notifications above the MDH compliance score of 95% for all four quarters of MY 2024.	↑
Quality, Timeliness	Opportunities: - Demonstrate compliance with the timeframe for written grievance acknowledgement, at or above the MDH compliance score of 95%, on at least a quarterly basis throughout the MY. MwO: MPC must address the following opportunities to achieve compliance in MY 2025: - Revise the Member Grievance Process Policy to identify the timeframe for acknowledgement of receipt of an enrollee grievance. (Component 5.1a) - Revise the Pharmacy Prior Authorization Policy to include providing up to 14-calendar days for providers to submit additional information, if needed, to make an authorization decision. (Component 7.4c) - Revise the Pharmacy Prior Authorization Policy timeframe for enrollee written notice of the determination by replacing “from 24 hours of receipt of request” to “24 hours from the decision” in view of MCO Transmittal No. 225 allowing for this 14-calendar day extension. (Component 7.6a)	↓

Domain	MPC Summary	Assessment
	○ Revise the Corrective Managed Care Program Description to provide for the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy. (Component 7.11a) ○ Revise the Corrective Managed Care Program Description's stated timeframe for submitting additional information to 20 days from the date of the notice to be consistent with COMAR 10.67.12.02. (Component 7.11a) ○ Educate providers on the Screening, Brief Intervention, and Referral to Treatment Program and Release of Information for Substance Use Disorder, at a minimum, in the provider newsletter and directly on the MPC provider website. Other options for education include presentations at the time of the new provider's orientation. (Element 8.6) ○ Further explore opportunities to evaluate the effectiveness of MPC's various health education programs on process and outcome measures based upon pre and post enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures. (Component 9.3a) ● CAP: MPC must submit a CAP to achieve compliance in MY 2025: ○ Improve the timeliness of enrollee grievance acknowledgement letters. (Component 5.1g)	
Quality	Recommendations: ● Include the timeliness of grievance acknowledgement letter in its Key Indicator Report to ensure consistent monitoring of compliance. ● Expand committee reporting by including additional initiatives that are underway to address opportunities to positively impact overutilization and underutilization, even though they are outside of the two specific overutilization and underutilization projects tracked through the NCQA Quality Improvement Activity Form. ● Revise the methodology for evaluating the effectiveness of health education delivered during baby showers on perinatal measures as the majority of baby shower attendees were outside of the perinatal timeframes. Perhaps a baby shower or similar event could be held prior to delivery to more clearly evaluate the impact of health education on timely receipt of postpartum care and compare the rate to those pregnant enrollees who did not attend the baby shower.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: ● Results for all 26 indicators focused on network capacity achieved a validation rating of <i>High Confidence</i> with validation scores equaling 100%.	↑

Domain	MPC Summary	Assessment
	Results for all 81 indicators focused on time and/or distance standards achieved <i>High Confidence</i> with validation scores equaling 100%.	
Quality, Access, Timeliness	Improvements: All indicators for network capacity and time and distance standards achieved <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations: Maintain monitoring levels.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access, Timeliness	Strengths: - Compliance with routine care and urgent care appointment timeframes exceeded the 80% minimum compliance score by 6.8 and 9.3 percentage points, respectively. - One of three MCOs to not have unsuccessful surveys due to <i>Not a PCP</i>. - All online provider directory requirements exceeded the 80% minimum compliance score; therefore, no CAP is required.	↑
Quality, Access, Timeliness	Recommendations: - Monitor routine care and urgent care appointment timeframes due to the decrease in performance from MY 2024 to MY 2025 to ensure continued compliance in MY 2026. - Monitor performance for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> to ensure continued compliance in MY 2026.	↓
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: - Achieved 100% compliance for outpatient encounter type. - Showed minimal fluctuation in compliance scores each year of the trended period in both inpatient and office visits, with only one to two percentage points in difference.	↑
Quality	Improvements: - Improved compliance scores in each encounter type. - Outpatient encounter type improved by two percentage points to achieve 100% compliance.	↑
Quality	Recommendations: - Office visit encounters show a pattern of being the lowest compliance area; while still well within compliance, this is consistently the lowest-scoring encounter type each year of the trended period. - Coordinate with provider offices and vendors to ensure understanding of claim requirements to improve the quality of claim submissions.	↓

Domain	MPC Summary	Assessment
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, Timeliness	Strengths: All element scores met or exceeded the 80% minimum compliance score for the <i>Health Education/Anticipatory Guidance</i> component.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component increased from 78% in MY 2023 to 79% in MY 2024.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for all component scores declining from MY 2022 to MY 2024. - Review and address root causes for the <i>Laboratory Tests/At-Risk Screenings</i> component score remaining below the 80% minimum compliance score. - Review and address root causes for the <i>Recorded Perinatal History</i> and <i>Recorded Maternal Depression Screening</i> elements consistently falling below the 80% minimum compliance score from MY 2022 to MY 2024 for the <i>Health and Developmental History</i> component. - Review and address root causes for the <i>Graphed Head Circumference</i> element score significantly decreasing from MY 2023 to MY 2024, falling below the 80% minimum compliance score for the <i>Comprehensive Physical Examination</i> component. - Review and address root causes for the <i>Newborn Metabolic Screen</i>, <i>Recorded Cholesterol Risk Assessment</i>, <i>9-11 Year Dyslipidemia Lab Test</i>, <i>18-21 Year Dyslipidemia Lab Test</i>, <i>12 Month Blood Lead Test</i>, <i>12 Month Anemia Test</i>, and <i>HIV Test Per Schedule</i> element scores falling below the 80% minimum compliance score for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the <i>Influenza</i> element score consistently falling below the 80% minimum compliance score from MY 2022 to MY 2024 for the <i>Immunization</i> component. - Review and address root causes for 11 of the 14 element score for the <i>Immunization</i> component declining from MY 2022 to MY 2024. - Review and address root causes for all element scores comprising the <i>Health Education/Anticipatory Guidance</i> component declining from MY 2022 to MY 2024.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality, Access, Timeliness	Strengths: Maintained star ratings in four performance areas (Access to Care, Care for Kids with Chronic Illness, Pregnancy and Infant Care, and Keeping Adults Healthy).	↑

Domain	MPC Summary	Assessment
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Decreased the total number of enrollee grievances in MY 2024 by 42%, as compared to MY 2023, as a result of provider and enrollee education. - Described grievance, investigation, and resolution in case notes and resolution letter. - Appropriately categorized and resolved all grievances. - Appeal resolution letters include detailed reasons for both upheld and overturned decisions. - Wrote appeal and adverse determination letters in easy-to-understand language.	↑
Quality, Timeliness	Improvements: - Reduced the number of opportunities for improvement from three in MY 2023 to one in MY 2024. - Improved TAT with expedited appeals; in MY 2023, the rate was 92% and in MY 2024 it is 100%. - Exceeded the MDH compliance score for documentation of reasonable attempt to provide enrollee with oral notification of denials of an expedited request.	↑
Quality, Timeliness	Recommendations: Routinely monitor compliance with timeliness of acknowledgment letters.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for MPC:

- PIP, PMV, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not provide MY 2024 recommendations for telephone surveys and provider directory validations activities that would require corrective action.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 124. MPC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	MPC Addressed Recommendations
MY 2023 SPR	MY 2024 SPR	↑, ↓, or ●

Recommendation	Assessment and Actions Taken	MPC Addressed Recommendations
Standard 7: Continued Quarterly CAP from MY 2023: In response to the MY 2022 review, MPC did not meet compliance in the MY 2023 review for Component 7.7c and a new quarterly CAP was implemented. MPC still needs to demonstrate compliance with the timeframe for written expedited appeal resolutions, within the MDH compliance score of 95%, for each quarter of the review period.	Qlarant recommended a CAP closure for Component 7.7c, as MPC achieved compliance during the MY 2024 review.	↑
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by two percentage points (78%), and therefore, MPC will be required to submit a CAP.	MPC initiated a CAP that was reviewed by both Qlarant and MDH. Despite an increase of one percentage point, MPC's <i>Laboratory Tests/At-Risk Screenings</i> component score remained below the 80% minimum compliance score. Due to multiple years of not meeting the requirements, MPC is required to submit a CAP and a focused provider education project for two calendar years to improve quality, access, and timeliness for <i>Laboratory Tests/At-Risk Screenings</i> component elements.	↓

Green and ↑ = MCO addressed the recommendation; Pink and ↓ = MCO did not address the recommendation

MSFC

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for MSFC:

- PIP: Qlarant did not observe any formal opportunities as a result of the MY 2024 PIP activities.
- PMV: CSS did not observe any formal improvements for either the adult or child surveys.
- SPR: MSFC was not monitored for an MY 2023 CAP or *MwO* finding, so no quality, access, and/or timeliness improvements were observed.

- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not observe any formal improvements for MSFC's Telephone Surveys and Provider Directory Validations activities.
- GAD: Qlarant did not observe any formal improvements from the previous MY.

Table 125. MSFC Strengths, Improvements, and Recommendations

Domain	MSFC Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • MSFC's performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics.	↑
Quality and Timeliness	Improvements: • MSFC provided a clear narrative regarding comparisons to goals, benchmarks, or state averages for prenatal care PIP topic. • MSFC's performance resulted in steady improvement for the W30 (0-15 Months) and W30 (15-30 Months) HEDIS rates from baseline MY 2022 to MY 2024.	↑
Quality	Recommendations: • MSFC should review PIP submissions to ensure accuracy and format. • Identify and overcome root causes for performance decreasing from MY 2023 to MY 2024 for the PPC-CH rate despite implemented interventions.	↓
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Timeliness	Strengths: MetaStar observed the following strengths: • No issues were identified with the completion of the Roadmap General Information or Appendix Sections. MSFC provided a standardized and well-documented HEDIS MY 2024 Roadmap on time, which greatly facilitated both the offsite and virtual onsite phases of the HEDIS Compliance Audit. • MSFC utilized a software vendor with NCQA-certified measures. The auditor confirmed via the IDSS that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the GUIDs. In addition, there were no Tier 4 warnings identified by NCQA for MSFC. • MSFC maintained excellent communication with the auditor throughout the audit process. • MSFC provided all required documents, databases, and rate files on or prior to the required deadlines. MSFC also provided all requested audit follow-up items in a timely manner.	↑
Quality, Timeliness	Improvements:	↑

Domain	MSFC Summary	Assessment
	MetaStar observed the following improvements: For MY 2023 reporting, MSFC was partially compliant for IS M – Medical Record Review Processes and IS Standard R – Data Management and Reporting. MSFC’s experienced HEDIS staff left in February 2024. This resulted in a breakdown in the health plan’s reporting process, deadlines being missed, and left relatively new staff responsible for critical tasks. MRR abstraction also had some critical errors. These issues almost resulted in measures not being able to be reported. MSFC will need to have appropriate staffing for future reporting to ensure all tasks are completed properly, and timelines are met. The issues appear to have been resolved, as MSFC maintained excellent communication with the auditor throughout the audit process, completed all tasks on or ahead of the timelines, and passed all aspects of the HEDIS Compliance Audit for MY 2024.	
Quality	Recommendations: MetaStar recommended the following actions: The auditor solicited further explanation as needed for rates that were above the ninetieth percentile or below the tenth percentile, or rates that changed by more than five percentage points from the prior year. With experienced staff in the HEDIS area leaving, the remaining staff for MSFC attempted to determine the reasons for rates changes. Some of the reasons appeared unknown or unanswered. This was expected due to the staff changes, but MSFC will still need to be able to track quality improvement projects and identify issues and improvements for future reporting for all rate changes.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality	Strengths: CSS observed the following strengths: Adult: Designated the second-best performing plan overall with two measures as the highest scoring among all plans (<i>Rating of Health Plan</i> and <i>Shared Decision Making</i>) and being the only other plan to have a measure score in the top decline (<i>Customer Service</i>), with four in the middle third. Child: Scored in the top third for one CCC measures.	↑
Quality	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: - CSS did not provide any observations for MSFC’s adult surveys. Child: - Scored the lowest among all plans for two non-CCC measures (<i>Customer Service</i> and <i>How Well Doctors Communicate</i>).	↓

Domain	MSFC Summary	Assessment
	Scored in the bottom decile for three non-CCC measures, in the bottom third for five non-CCC measures, in the middle third for one non-CCC measure, in the bottom decile for one CCC measure, in the bottom third for one CCC measure, and in the middle third for two CCC measures.	
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access	Strengths: - A comprehensive analysis of grievance trends, a detailed barrier analysis, and targeted interventions to address identified opportunities for improvement, as detailed in the 2023 Annual Evaluation of Grievances and Appeals. - A very comprehensive Newborn Enrollment Policy and work from the Newborn Coordinator. The policy outlines various enrollment situations and how MSFC would work through these processes to get newborns into care. - Review of services for potential overutilization and underutilization, which is comprehensive in scope and occurs at each Quality Improvement Council meeting. - The most comprehensive provider exclusion queries of the Maryland MCOs, which includes reviewing exclusion lists from all 50 states.	↑
Quality, Timeliness	Opportunities: MwO: MSFC must address the following opportunity to achieve compliance in MY 2025: - Update the Utilization Management Process Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a decision about a covered outpatient drug, if additional clinical information is requested. (Component 7.4c) CAP: MSFC must submit a CAP to achieve compliance in MY 2025: - Clearly identify which committee, the Executive Operations Committee or Quality Improvement Committee, serves as the governing body with authority to make decisions regarding the Quality Improvement Plan. (Element 2.1) - Show in meeting minutes the governing body is taking an active part in monitoring Quality Improvement Plan initiatives, establishing priorities, assessing performance barriers, and developing action plans for improvement. (Element 2.5) - Demonstrate consistent compliance with the timeframe for grievance acknowledgement letters, at or above the MDH compliance score of 95%, on at least a quarterly basis throughout the MY under review. (Component 5.1g)	↓

Domain	MSFC Summary	Assessment
	○ Demonstrate compliance with provider appeal acknowledgement letters and written resolution, at or above the MDH compliance score, on at least a quarterly basis throughout the MY under review. (Component 7.8c) ○ Present results of the annual Provider Satisfaction Survey to the appropriate oversight committee identified in MSFC's policy. (Component 7.9b) ○ Demonstrate the Health Education Plan is in place for the entire MY under review (Component 9.1a) ○ Demonstrate MSFC has a written methodology for evaluating the impact of its Health Education Plan on process and outcome measures, using either comparison groups or comparing individual process or outcome measures pre and post participation in health education activities. (Component 9.3a)	
Quality, Timeliness	Recommendations: • Revise the Prior Authorization/Non-Formulary Medication Request form to eliminate the statement "MSFC-Maryland must render a decision within 24 hours. If medical records are incomplete, the request is subject to denial." This is inconsistent with MCO Transmittal No. 225.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: • Results for all 28 indicators focused on network capacity achieved <i>High Confidence</i> with validation scores equaling 100%. • Results for all 84 indicators focused on time and/or distance standards achieved <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Improvements: • All indicators for network capacity achieved <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations: • Maintain monitoring levels.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access, Timeliness	Strengths: • Compliance with routine care and urgent care appointment timeframes exceeded the 80% minimum compliance score by 11.1 and 4.4 percentage points, respectively. • One of the three MCOs to not have unsuccessful surveys due to <i>Not a PCP</i>.	↑

Domain	MSFC Summary	Assessment
	- All online provider directory requirements exceeded the 80% minimum compliance score; therefore, no CAP is required. - Highest percentage for <i>Accepts New Medicaid Patients Listed for MCO</i> (91.9%).	
Quality, Access, Timeliness	Recommendations: - Monitor timeframes for urgent care appointments due to the decrease in performance from MY 2024 to MY 2025 to ensure continued compliance in MY 2026. - Review and address root causes for having the second highest percentage for unsuccessful surveys due to <i>Wrong Location Listed for Provider</i> (25.0%). - Review and address root causes for performance for <i>Specifies Ages of Patients Seen</i> to ensure continued compliance.	↓
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: - Demonstrated consistent 99% compliance year-over-year for outpatient encounter type. - Showed limited fluctuations within inpatient encounter type scores, with only one percentage point in difference.	↑
Quality	Improvements: Demonstrated a one-percentage-point improvement for inpatient encounter types.	↑
Quality	Recommendations: - While still above the compliance threshold, MSFC exhibits a steady decline in compliance scores within the office visit encounter type. - Coordinate with provider offices and vendors to ensure understanding of claim requirements to improve the quality of claim submissions.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, Timeliness	Strengths: - MSFC exceeded the 80% minimum compliance score for all components in MY 2024. - All elements have consistently scored above the 80% minimum compliance score from MY 2022 to MY 2024 for the <i>Comprehensive Physical Examination</i> and <i>Health Education/Anticipatory Guidance</i> components.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component increased from 73% in MY 2023 to 82% in MY 2024.	↑

Domain	MSFC Summary	Assessment
Quality, Access, Timeliness	Recommendations: - Review and address root causes for the consistent decline in the <i>Health Education/Anticipatory Guidance</i> component score from MY 2022 to MY 2024. Element scores consistently declined for <i>Documented Health Education/Referral for Identified Problems/Tests</i> and <i>Documented Referral to Dentist</i> from MY 2022 to MY 2024. - Review and address root causes for the consistent decline in score of the <i>Depression Screening</i> element from MY 2022 to MY 2024, and for the <i>Recorded Autism Screening Tool</i> element score having the most significant decrease from MY 2023 to MY 2024, falling below the 80% minimum compliance score for the <i>Health and Developmental History</i> component. - Review and address root causes for the consistent decline in scores for the <i>Vision Assessment</i> and <i>Hearing Assessment</i> elements from MY 2022 to MY 2024 for the <i>Comprehensive Physical Examination</i> component. - Review and address root causes for the <i>Newborn Metabolic Screen, 9-11 Year Dyslipidemia Lab Test, 18-21 Year Dyslipidemia Lab Test, 12 Month Blood Lead Test, 24 Month Blood Lead Test, 12 Month Anemia Test, 24 Month Anemia Test, and HIV Test Per Schedule</i> element scores falling below the 80% minimum compliance score for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the Influenza element score remaining below the 80% minimum compliance score for the <i>Immunizations</i> component.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality	Strengths: Maintained star rating in one performance area (Care for Kids with Chronic Illness).	↑
Quality, Access, Timeliness	Improvements: Improved star ratings for two performance areas (Access to Care and Doctor Communication and Service).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Consistently exceeds compliance threshold with grievance resolution TAT in all categories. - Exceeded the performance threshold for both standard/non-emergency and expedited appeals resolution timeframes. - Exceeded performance requirements in all categories for both pre-service denial determination and notification timeframes. - Appropriately categorized all grievances.	↑

Domain	MSFC Summary	Assessment
Quality	Recommendations: - Audit grievance resolution letters to ensure appropriate grievance resolution. - Routinely monitor compliance with timeframe for expedited appeal resolution/notification. - Retrain staff as there is no “urgent” category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements. - Revise Prior Authorization/Non-Formulary Medication Request form to eliminate requirement for a decision within 24 hours, preventing any requests for additional information if submission is incomplete. Retrain staff to allow requests for additional information under a 14-calendar day extension.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. Pink and ↓ Domain experienced a negative impact from MCOs' performance

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for MSFC:

- PIP, SPR, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year. NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not provide MY 2024 recommendations for telephone surveys and provider directory validations activities that would require corrective action.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 126. MSFC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	MSFC Addressed Recommendations
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by seven percentage points (73%), and therefore, MSFC will be required to submit a CAP.	MSFC initiated a CAP that was reviewed by both Qlarant and MDH. MSFC was then found to be compliant with <i>Laboratory Tests/At-Risk Screenings</i> .	↑

Green and ↑ = MCO addressed the recommendation. Pink and ↓ Domain experienced a negative impact from MCOs' performance.

PPMCO

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for PPMCO:

- PMV: MetaStar did not observe any formal improvements for HEDIS.
- SPR: Qlarant did not identify any recommendations as a result of MY 2024's comprehensive SPR.
- NAV: No formal strengths or improvements were identified for PPMCO's Provider-to-Enrollee Ratios and Time and Distance Standards activities. Qlarant did not observe any formal improvements for PPMCO's Telephone Surveys and Provider Directory Validations activities.
- CRC: Qlarant did not observe any formal improvements or recommend any formal actions as a result of the 2025 CRC activities.

Table 127. PPMCO Strengths, Improvements, and Recommendations

Domain	PPMCO Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	↑ or ↓
Quality, Access, and Timeliness	Strengths: • PPMCO's performance resulted in a confidence level of <i>High Confidence</i> for both PIP topics.	↑
Quality, Access, and Timeliness	Improvements: • PPMCO provided further details regarding the impact or effectiveness of its postpartum intervention. • PPMCO's performance resulted in steady improvement for the CIS-3 HEDIS rate from baseline MY 2022 to MY 2024.	↑
Quality and Timeliness	Opportunities: • Demonstrate statistically significant improvement, as a result of the implemented interventions, for the PPC-CH HEDIS rate.	↓
Quality	Recommendations: • Review PIP submissions for format accuracy before submitting. • PPMCO should ensure sources cited are within a ten-year timeframe.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Timeliness	Strengths: <i>MetaStar observed the following strengths:</i> • PPMCO HEDIS team provided all required and requested documentation in a timely manner. The team was dedicated to ensuring successful reporting and maintained robust oversight of data processes involved in HEDIS reporting.	↑

Domain	PPMCO Summary	Assessment
	PPMCO HEDIS audit scope was expanded to include additional submissions, and all submissions were successfully reported.	
Quality, Access, Timeliness	Recommendations: MetaStar recommended the following actions: - It is recommended that PPMCO investigate and incorporate additional supplemental data sources for future reporting periods. This includes such sources as the health information exchange data. Such data sources would reduce the burden of MRR and possibly improve data completeness. - PPMCO enrollees who are dually enrolled in multiple product lines were reported in all product lines. For example, enrollees dually enrolled in commercial and Medicaid were reported in both product lines. It is recommended that PPMCO work to incorporate a unique enrollee ID across all product lines to ensure accurate reporting of enrollees. Additionally, PPMCO should investigate removing segments of dual enrollment as required by the HEDIS specifications. - It is recommended that the plan implement a process to review reports generated post integration in CitiusTech to confirm that there are no gaps in the data prior to measure runs. - For the HEDIS Roadmap, it is recommended that the plan ensure that the data sources integrated for HEDIS are noted in the Administrative Data Inventory and Clinical Data Inventory based on how each source is deemed. It is recommended that HEDIS stakeholders in the organization should review attachments and Roadmap content prior to submission to the auditor to avoid multiple iterations of documents.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality, Access	Strengths CSS observed the following strengths: Adult: Performed in the top third for one measure, which was the highest scoring among all plans (<i>Rating of Specialist Seen Most Often</i>); and in the middle third for three measures. Child: Designated one of the best performing plans on CCC measures, with two of the highest scores among all plans (<i>Access to Prescription Medicines and Getting Needed Information</i>).	↑
Access	Improvements: CSS observed the following improvements: Adult: CSS did not observe any improvements for PPMCO's adult surveys. Child: Improved performance compared to the prior year for the <i>Access to Prescription Medicines</i> measure. PPMCO is one of two MCOs with statistically significant gains.	↑
Quality, Timeliness	Recommendations:	↓

Domain	PPMCO Summary	Assessment
	CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: • Adult: Performed in the bottom third for two measures and in the bottom decile for three measures. • Child: ○ Scored the lowest among all plans for two non-CCC measures (<i>Coordination of Care</i> and <i>Shared Decision Making</i>). ○ Scored in the bottom decile for one non-CCC measure, in the bottom third for four non-CCC measures, in the middle third for four non-CCC measures, and in the bottom decile for one CCC measure.	
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access	Strengths: • PPMCO's commitment to health equity. PPMCO is actively participating in the centralized Johns Hopkins Medicine Health Equity Advisory Committee, where representatives from all of Johns Hopkins Health Systems entities work collaboratively on policies, initiatives, and programs designed to improve health equity. The committee is actively coordinating and sharing changes in strategy and operational workflows among various enrollee entities to ensure accurate sociodemographic data collection, with particular focus on collection of race, ethnicity, language, sexual orientation, and gender identity for enrollees and patients. Johns Hopkins Health Plans furthered its commitment to health equity by developing and deploying mandatory training for all staff on the basics of health equity in addition to boosting several smaller forums to discuss health equity and disability awareness. • Multiple interventions in place to address areas of overutilization and underutilization beyond those reported specifically for overutilization and underutilization, including several HEDIS measures. Barriers, interventions, and improvements in these measures also are described in meeting minutes. • A very comprehensive health education program supported by 185 education programs on 24 different topics, well-qualified and experienced staff, effective communication strategies to keep enrollees and providers informed about educational opportunities, and ongoing solicitation of feedback from enrollees and providers relating to classes/programs attended or offered. • A comprehensive approach to notifying both enrollees and providers of available health education activities.	↑
Quality, Access	Improvements: • Developed the Health Education Dashboard by Condition, which displays outcome metrics by selected conditions both pre and post class attendance.	↑

Domain	PPMCO Summary	Assessment
	Submitted session evaluations completed by individual enrollees, not aggregate results, for a sample of health education programs demonstrating positive responses.	
Quality, Timeliness	Opportunities: - Provide clear evidence the enrollee grievance report is presented to the Consumer Advisory Board, on at least an annual basis, and include actions taken to address identified opportunities for improvement. - Add the following potential reasons for disenrollment to the enrollee handbook, “Section F. HealthChoice Eligibility/Disenrollment”: changes to assistance category, not validly enrolled in MCO, and enrollee death. MwO: PPMCO must address the following opportunities to achieve compliance in MY 2025: - Review the QAPI Program Description and Work Plan and the QAPI Program Evaluation in the first quarter of the year. This allows for more timely analysis to detect the need for program change. (Component 1.2b) - Ensure the QAPI Committee reviews, approves, and documents, in meeting minutes, its quarterly oversight of delegates, as written in policy and the QAPI Committee Charter. (Component 3.3a) - Identify the specific overutilization and underutilization measures PPMCO is addressing through the development of PPMCO’s interventions and monitor not only the progress of interventions, but also how those interventions are having an impact on those measures that they are designed to address. For example, to address overutilization of services and resources for enrollees with diabetes, emergency room and inpatient utilization metrics could be assessed to determine the impact of interventions. (Component 7.3c) - Remove reference to the assumption of a five-day timeframe for mailing within the appeal filing timeframe in adverse determination notices (Component 7.5b) - Eliminate the “expedited” category for provider administrative (claims) appeals. (Component 7.8c) - Revise the Member and Provider Experience with the Utilization Management Process Policy to identify the “appropriate oversight committee” referenced in this policy. (Component 7.9a) - Educate providers on the Screening, Brief Intervention, and Referral to Treatment process and Release of Information procedures in any of the following sources: the provider manual, new provider orientation program, the provider website, or in provider newsletters. (Element 8.6) - Analyze negative outcomes, such as the increase in emergency room visits following class attendance, to understand the root cause(s); and determine any needed enhancements to class offerings. (Component 9.3a) CAP: PPMCO must submit a CAP to achieve compliance in MY 2025:	↓

Domain	PPMCO Summary	Assessment
	- Identify the specific quality committee(s) required to receive complaint and grievance data on a quarterly basis. (Component 5.1d) - Demonstrate identification of opportunities for improvement based upon analysis of grievance data and interventions to address identified opportunities. (Component 5.1d) - Demonstrate compliance with the timeframes for acknowledgement letters and resolution, by grievance category, at or above the MDH compliance score of 95% for all four quarters of the MY. (Component 5.1g) - Document appropriate grievance resolutions in case notes. (Component 5.1g) - Demonstrate compliance with PPMCO's timeframe for grievance resolution letters, at or above the MDH compliance score of 95%, for all four quarters of the MY. (Component 5.1h) - Document appropriate resolutions in grievance resolution letters. (Component 5.1h) - Demonstrate consistent compliance, at or above the MDH compliance score of 95%, for preauthorization determination timeframes and 24-hour prescriber notification, no less than quarterly for the entire MY. (Component 7.4c) - Demonstrate compliance with the timeframes for adverse determination notifications, at or above the MDH compliance score of 95%, on at least a quarterly basis for the entire MY. (Component 7.6b) - Document annual review of CAHPS and Provider Satisfaction Survey results by the appropriate oversight committee, as specified in PPMCO's Member and Provider Experience with the Utilization Management Process Policy. (Component 7.9b)	
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Recommendations: Maintain monitoring levels; however, provide all relevant metrics.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Access, Timeliness	Strengths: Compliance with routine and urgent care appointment timeframes exceeded the 80% minimum compliance score by 15.7 and 9.6 percentage points, respectively.	↑
Quality, Access, Timeliness	Recommendations: Review and address root causes for having the second-highest total of unsuccessful contacts due to "No Contact" and "PCP Response."	↓

Domain	PPMCO Summary	Assessment
	- Monitor urgent care appointment timeframes due to the decrease in performance from MY 2024 to MY 2025 to ensure continued compliance in MY 2026. CAP. Performance has declined for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (73.3%) and <i>Specifies Ages of Patients Seen</i> (0%). PPMCO must submit a CAP for each requirement to achieve compliance in MY 2026. - Ensure staff responses regarding accepting new Medicaid patients for PPMCO align with the online provider directory. Enrollees use the online provider directory to search for new PCPs and should receive the same information when calling the provider directly. - Update the online provider directory to clearly specify age ranges seen by provider.	
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: Demonstrated minimal fluctuations within inpatient and office visit encounter type scores, therefore maintaining general consistency in match rates.	↑
Quality	Improvements: Demonstrated a four-percentage-point increase in compliance for the outpatient encounter type from MY 2023 to MY 2024.	↑
Quality	Recommendations: - While still meeting the established compliance rate for inpatient encounters at 99%, this is a decline from the 100% compliance demonstrated in both MY 2022 and MY 2023. - Investigate the decline to determine if a mitigation plan is needed for quality improvement of submitted claims or if the slight decline is due to an outlier.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, Timeliness	Strengths: - PPMCO has exceeded the 80% minimum compliance score for the <i>Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> components from MY 2022 to MY 2024. - All elements comprising the <i>Comprehensive Physical Examination</i> component exceeded the 80% minimum compliance score from MY 2022 to MY 2024.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component increased from 75% in MY 2023 to 81% in MY 2024.	↑

Domain	PPMCO Summary	Assessment
Quality, Access, Timeliness	Recommendations: - Review and address root causes for the consistent decline in component scores from MY 2022 to MY 2024 for the <i>Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> components. - Review and address root causes for the consistent decline in the <i>Recorded Medical History, Recorded Family History, Recorded Perinatal History, Recorded Maternal Depression Screening, and Recorded Psychosocial History</i> element scores from MY 2022 to MY 2024 for the <i>Health and Developmental History</i> component. - Review and address root causes for the consistent decline in the <i>BMI Graphing</i> element score from MY 2022 to MY 2024 for the <i>Comprehensive Physical Examination</i> component. - Review and address root causes for the 9-11 Year <i>Dyslipidemia Lab Test, 12 Month Blood Lead Test, 24 Month Blood Lead Test, 3-5 Year (Baseline) Blood Lead Test, Conducted Anemia Risk Assessment, 12 Month Anemia Test, 24 Month Anemia Test, and 3-5 Year Anemia Test</i> element scores falling below the 80% minimum compliance score for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for the consistent decline in the <i>Haemophilus Influenzae Type B (Hib), Pneumococcal (PCV-7 or PCV-13) [Prevnar], and Influenza</i> element scores from MY 2022 to MY 2024 for the <i>Immunizations</i> component. - Review and address root causes for the consistent decline in the <i>Documented Referral to Dentist</i> element score falling below the 80% minimum compliance score from MY 2022 to MY 2024 for the <i>Health Education/Anticipatory Guidance</i> component.	↓
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality, Access, Timeliness	Strengths: Maintained star ratings in three performance areas (Access to Care, Keeping Kids Healthy, Pregnancy and Infant Care).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Described grievances in case notes and enrollee acknowledgement and resolution letters. - Appropriately categorized all grievances. - Wrote appeal and adverse determination letters in easy-to-understand language.	↑
Timeliness	Improvements:	↑

Domain	PPMCO Summary	Assessment
	- Met compliance with timeframe for notification of expedited appeal resolution and reasonable attempt to provide verbal notification of expedited resolution at the MDH-established compliance score. - Wrote appeal resolution and adverse determination notifications in easy-to-understand language (no undefined medical terms, no use of acronyms).	
Quality, Timeliness	Recommendations: - Provide explanation for non-emergency medically related enrollee grievance performance. - Routinely audit grievance resolution letters to ensure resolutions are appropriate. - Ensure grievances are referred timely to Provider Relations for resolution. Establish a TAT for Provider Relations to respond to grievances to ensure grievance resolution TATs are met. - Routinely audit adverse determination letters to ensure the elimination of the assumption of five days for mailing in the appeal filing timeframe. - Audit letters sent to providers in response to an adverse determination preauthorization request to ensure correct appeal filing requirements.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for PPMCO:

- PIP, PMV, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not provide MY 2024 recommendations for telephone surveys and provider directory validations activities that would require corrective action.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 128. PPMCO Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	PPMCO Addressed Recommendations
MY 2023 SPR	MY 2024 SPR	↑, ↓, or ●
Standard 9: Continued MwO Finding from MY 2022: As a result of a MwO finding for Component 9.5b during the MY 2022 and MY 2023 reviews, PPMCO still needs to submit session evaluations completed	PPMCO received a <i>Met</i> finding during MY 2024's SPR.	↑

Recommendation	Assessment and Actions Taken	PPMCO Addressed Recommendations
by individual enrollees, not aggregate results, for a sample of health education programs.		
Standard 9: Continued MwO Finding from MY 2023: As a result of a MwO finding for Component 9.3a during the MY 2023 review, PPMCO still needs to provide a more robust evaluation of the impact of PPMCO's health education classes on enrollees with specific prevalent health conditions, which include process and outcome measures. For example, HEDIS data could be used pre- and post-program participation, emergency room visits, or avoidable hospital admissions pre and post for select diagnoses, such as diabetes or hypertension.	As a result of a MwO finding during MY 2024's SPR, PPMCO still needs to demonstrate analysis of negative outcomes, such as the increase in emergency room visits following class attendance, to understand the root cause(s) and determine any needed enhancements to class offerings.	●
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by five percentage points (75%), and therefore, PPMCO will be required to submit a quarterly CAP and a two-year focused Provider Education Project, as per MDH's Performance Monitoring Policy, due to performing below the compliance threshold of 80% for two consecutive years.	PPMCO initiated a CAP that was reviewed by both Qlarant and MDH. PPMCO was then found to be compliant with <i>Laboratory Tests/At-Risk Screenings</i> .	↑

Green and ↑ = MCO addressed the recommendation; Pink and ↓ = MCO did not address the recommendation; Yellow and ● = MCO did not fully address the recommendation

UHC

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for UHC:

- PIP: Qlarant did not observe any formal strengths as a result of the MY 2024 PIP activities.
- PMV: CSS did not observe any formal improvements for either the adult or child surveys.
- SPR: UHC was not monitored for an MY 2023 CAP or MwO finding, so no quality, access, and/or timeliness improvements were observed.
- NAV: Qlarant did not observe any formal improvements for UHC's Telephone Surveys and Provider Directory Validations activities.

- EPSDT: Qlarant did not observe any formal improvements from the previous measurement year.

Table 129. UHC Strengths, Improvements, and Recommendations

Domain	UHC Summary	Assessment
	Performance Improvement Project Validation	
Quality and Access	Improvements: • UHC improved performance for Data Collection Procedures. • UHC incorporated CLAS standards on an interventional level. • UHC's performance resulted in steady improvement for the PPC-AD and CIS-3 HEDIS rates from baseline MY 2022 to MY 2024.	↑
Quality and Access	Opportunities: • Demonstrate statistically significant improvement, as a result of implemented interventions. • Identify and address root causes for the steady decline in performance for the PPC-CH HEDIS rate despite implemented interventions. • Incorporate each component of CLAS in more detail addressing Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability on an interventional level to ensure interventions are culturally and linguistically appropriate. • Briefly summarize the impact or effectiveness of its strategies for the postpartum PIP topic. • Review and identify confounding variables that could have an impact on outcomes for the prenatal care PIP topic.	↓
Quality and Access	Recommendations: • UHC should consider reviewing calculations for accuracy. • Identifying contributing factors that warranted new/modified interventions. • Review the provided aim statement in the quarterly templates or PIP Orientation Manual. • Utilize the same intervention titles for tracking purposes. • Identify confounding variables, which should be different from the identified barriers. • UHC should continue to identify and address barriers to enrollee and provider engagement.	NA
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Access, Timeliness	Strengths: MetaStar observed the following strengths: • UHC's HEDIS team was extremely responsive to auditor requests and provided information/documentation in a timely manner. The team served as subject matter experts for all	↑

Domain	UHC Summary	Assessment
	organization functions and was dedicated to ensuring successful reporting. There was robust oversight of data used for HEDIS reporting.	
Quality, Timeliness	Improvements: MetaStar observed the following improvements: For MY 2024 reporting, UHC consolidated the various state immunization and lead registry supplemental data sources based on the file types and methods that they are received. This streamlined the review process of these sources.	↑
Quality	Recommendations: MetaStar recommended the following actions: - UHC was able to successfully report the required ECDS measures for HEDIS MY 2024. As NCQA and state requirements move to more ECDS reporting, it is recommended that UHC investigate the reporting of other ECDS measures to prepare for the phasing out of MRR for a number of measures. - The MRRV process noted one error in the sample reviewed for measure Group D due to an abstraction error by the MRR vendor. It is recommended that UHC work to increase the percentage of records overread by the vendor and internal team to ensure issues are identified prior to audit evaluations of the final MRR cases.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality, Timeliness	Strengths: CSS observed the following strengths: Adult: Showed a positive directional trend over the previous two years for five measures, though none were statistically significant. Performed in the middle third for three scores. Child: - Scored the highest among all plans for two non-CCC measures (<i>Rating of Specialist Seen Most Often</i> and <i>Coordination of Care</i>). - Showed a positive directional trend over the previous two years for six non-CCC measures and one CCC measure.	↑
Quality	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: - Declined in MCO performance compared to 2024 for the <i>Rating of All Health Care</i> measure. UHC is one of three MCOs with statistically significant declines. - Performed in the bottom third for four scores.	↓

Domain	UHC Summary	Assessment
	Child: - Designated an average scoring plan with five non-CCC measures scoring in the middle third and four in the bottom third. - Scored in the bottom decile for three CCC measures and in the bottom third for two CCC measures. None was the highest or lowest, nor were they statistically significant.	
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality	Strengths: - UHC's resolution letters, which provide the enrollee with an extremely detailed description of their grievance and the resolution. - Extremely detailed and comprehensive case notes in the sample of grievances reviewed, which describe the grievance, investigation, and resolution. - UHC's comprehensive Population Health Management assessment, which includes identification of the needs of specific subpopulations within UHC's membership and a review to determine if those needs are being addressed by available programs/activities.	↑
Quality, Timeliness	Opportunities: - Review and approve each delegate's FWA/Special Investigations Units (SIU) activities on a quarterly basis. This review must be clearly documented in the Compliance Committee meeting minutes and in relevant Compliance Program policies and procedures. MwO: UHC must address the following opportunities to achieve compliance in MY 2025: - Revise the MD Member Appeal, Grievance, and State Fair Hearing Policy to specify the appropriate quality committee(s) responsible for analyzing grievance data to identify opportunities for improvement and developing and monitoring action plans in response to identified opportunities. (Components 5.1d) - Ensure meeting minutes of the appropriate quality committee(s) for grievance reporting reflect identified opportunities and actions taken. (Components 5.1d) - Clearly document the Compliance Committee's annual review and approval of FWA policies and procedures and Compliance Plan for each of its delegates. The Compliance Committee Charter and Compliance Program Policy must include the role of the Compliance Committee in this oversight of delegate Compliance Plans/FWA policies. (Component 11.4c) CAP: UHC must submit a CAP to achieve compliance in MY 2025: - Demonstrate compliance with required timeframes for written grievance acknowledgement and resolutions, by category, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY. (Component 5.1g)	↓

Domain	UHC Summary	Assessment
	○ Demonstrate compliance with required timeframes for written grievance resolutions, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY. (Component 5.1h) ○ Revise the appropriate policy to include content found in MCO Transmittal No. 225, dated October 3, 2024, which allows up to 14 calendar days, including the original 24-hour decision timeframe, when additional information is requested in response to a preauthorization request for a covered outpatient drug. (Component 7.4c) ○ Provide evidence in case notes of fax notification of the outcome of a preauthorization request for a covered outpatient drug is sent to the prescriber within 24 hours of receipt. (Component 7.4c) ○ Revise the Pharmacy Turnaround Time Technical Assistance Team report to replace “final determination within 24 hours of receipt of preauthorization request” to “final determination within 24 hours of the decision” and add “determination within 24 hours of receipt of additional information not to exceed 14 calendar days from date of receipt”; and change faxed notification from “24 hours from the determination” to “24 hours from receipt of the preauthorization request.” (Component 7.4c) ○ Revise the MD Medical Technical Assistance Team Report to replace “case closure” with “determination”; clarify that the written notification of expedited request is “within 72 hours of receipt of the preauthorization request.” (Component 7.4c) ○ Demonstrate compliance with providing an enrollee timely oral notice and written notice of denial of a request for an expedited appeal resolution within two calendar days of the denial. (Component 7.7e) ○ Demonstrate compliance with resolution timeframes for provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY. (Component 7.8b) ○ Demonstrate compliance with timeframes for acknowledgement and written resolution of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY. (Component 7.8c) ○ Demonstrate UHC evaluates the effectiveness of UHC’s Health Education Plan on process and/or outcome measures. (Component 9.3a) ○ Clearly document the Compliance Committee’s annual review and approval of FWA policies and procedures and Compliance Plan for each of its delegates. The Compliance Committee Charter and Compliance Program Policy must include the role of the Compliance Committee in this oversight of delegate Compliance Plans/FWA policies. (Component 11.4d)	
Quality	Recommendations:	↓

Domain	UHC Summary	Assessment
	- Indicate “revised” and identify the revision when sending a revised grievance letter to an enrollee. In the sample reviewed, a revised acknowledgment letter was sent to the enrollee after the category and the resulting timeframe for resolution were changed. - Explore ways to engage small and mid-size practices in referring UHC enrollees in need of health education.	
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access	Strengths: - Results for all 22 indicators focused on network capacity achieved <i>High Confidence</i> with validation scores equaling 100%. - Results for all 75 indicators focused on time and/or distance standards achieved <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access, Timeliness	Improvements: All indicators for network capacity and time and distance standards achieved <i>High Confidence</i> with validation scores equaling 100%.	↑
Quality, Access	Recommendations: Maintain monitoring levels.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access, Timeliness	Strengths: Compliance with routine and urgent care appointment timeframes exceeded the 80% minimum compliance score by 18.3 and 11.9 percentage points, respectively.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for having the highest percentage of unsuccessful contacts due to <i>Hold Time Greater Than Five Minutes</i> (21.1%). CAP. UHC’s performance has declined for <i>Specifies if PCP Accepts New Medicaid Patients and Directory Matched Survey Response</i> (78.5%). UHC must submit a CAP to achieve compliance in MY 2026. - Ensure staff responses regarding accepting new Medicaid patients for UHC align with the online provider directory. Enrollees use the online provider directory to search for new PCPs and should receive the same information when calling the provider directly.	↓

Domain	UHC Summary	Assessment
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: Demonstrated consistent compliance scores within outpatient encounter types at 99% over the trended period.	↑
Quality	Recommendations: CAP: UHC's total score for the inpatient encounter type fell below the established compliance threshold of 90% by two percentage points and, therefore, is required to complete a CAP to identify and mitigate future issues. - While total match scores have remained above the compliance threshold for office visit percentages, there is a notable decline by three percentage points from MY 2022 to MY 2024. - Work with hospital facilities to ensure proper documentation for each admission is captured within patient charts to support claims submitted, improving the validity of inpatient encounter claims.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓
Quality, Access, Timeliness	Strengths: The <i>Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> component scores have exceeded the 80% minimum compliance score from MY 2022 to MY 2024.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for all component scores decreasing from MY 2022 to MY 2024, with the <i>Laboratory Tests/At-Risk Screenings</i> component falling below the 80% minimum compliance score. - Review and address root causes for the <i>Recorded Family History, Recorded Perinatal History, and Recorded Maternal Depression Screening</i> element scores falling below the 80% minimum compliance score for the <i>Health and Developmental History</i> component. - Review and address root causes for consistent declines in seven of the 11 element scores from MY 2022 to MY 2024, with the most significant decrease of sixteen percentage points for the <i>Recorded Perinatal History</i> element for the <i>Health and Developmental History</i> component. - Review and address root causes for all element scores declining from MY 2022 to MY 2024, with the <i>Hearing Assessment, BMI Graphing, and Graphed Head Circumference</i> element scores falling below the 80% minimum compliance score for the <i>Comprehensive Physical Examination</i> component.	↓

Domain	UHC Summary	Assessment
	- Review and address root causes for 12 of the 16 element scores falling below the 80% minimum compliance score, with the lowest element score of 53% for the <i>9-11 Year Dyslipidemia Lab Test</i> for the <i>Laboratory Tests/At-Risk Screenings</i> component. - Review and address root causes for 11 of the 14 element scores declining from MY 2022 to MY 2024, with the <i>Influenza</i> (56%) and <i>Assessed Immunizations Up to Date</i> (78%) element scores remaining below the 80% minimum compliance score. - Review and address root causes for the <i>Documented Referral to Dentist</i> element score significantly decreasing from MY 2023 (92%) to MY 2024 (72%), falling below the 80% minimum compliance score.	
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality	Strengths: Maintained star ratings in two performance areas (Doctor Communication and Service and Keeping Adults Healthy).	↑
Quality, Access, Timeliness	Improvements: Improved star ratings in two performance areas (Access to Care and Keeping Kids Healthy).	↑
Quality, Access, or Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Quality, Timeliness	Strengths: - Provided extremely detailed descriptions of grievance and resolution in resolution letters. - Grievance case notes were extremely comprehensive. - Appropriately categorized and resolved grievances. - Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Quality, Timeliness	Improvements: - Expedited appeal resolution TAT improved from 84% in MY 2023 to 92% in MY 2024. - Met compliance with grievance acknowledgement timeframe at the MDH-established compliance score. - Met compliance with timeframe for written notification of expedited appeal resolution at the MDH-established compliance score. - Used the appropriate grievance acknowledgement template. - Included the complete Language Accessibility Statement with all grievance, appeal, and pre-service adverse determination notifications. In addition to English, only two other languages were included in the Language Accessibility Statements accompanying all grievance, appeal, and adverse determination notifications.	↑

Domain	UHC Summary	Assessment
Quality, Timeliness	Recommendations: - Monitor TAT compliance monthly for Category 1: Emergency Medically Related and Category 2: Non-Emergency Member grievances, and expedited appeals resolution. - Based upon what appears to be a large number of Customer Service grievances, implement coaching of individual Customer Service reps and consider review on a systemic level. - When revising any enrollee letter, note REVISED and indicate where change was made. - Routinely monitor compliance with timeframes for appeal acknowledgement and written notice of denial of expedited request and oral notice of expedited resolution until compliance is demonstrated in three consecutive quarters.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for UHC:

- PIP, PMV, SPR, CRC, and EDV There were no formal recommendations that required corrective action from the previous measurement year.
- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities. Qlarant did not provide MY 2024 recommendations for telephone surveys and provider directory validations activities that would require corrective action.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 130. UHC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	UHC Addressed Recommendations
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Test/At-Risk Screenings</i> fell below the MDH-established threshold by five percentage points (75%), and therefore, UHC will be required to submit a CAP.	UHC initiated a CAP that was reviewed by both Qlarant and MDH. There was a decrease by one percentage point for the <i>Laboratory Tests/At-Risk Screenings</i> component score, which remained below the 80% minimum compliance score. Due to multiple years of not meeting the requirements, UHC is required to submit a CAP and a focused provider education project for two calendar years to	↓

Recommendation	Assessment and Actions Taken	UHC Addressed Recommendations
	improve quality, access, and timeliness for the <i>Laboratory Tests/At-Risk Screenings</i> component elements.	

Pink and ↓ = MCO did not address the recommendation

WPM

Quality, Access, and Timeliness

The following tasks did not have formal strengths, improvements, or recommendations for WPM:

- PMV: CSS did not observe any formal improvements for either the adult or child surveys.
- NAV: No formal strengths or improvements were identified for WPM's Provider-to-Enrollee Ratios and Time and Distance Standards activities. Qlarant did not observe any formal improvements for WPM's Telephone Surveys and Provider Directory Validations activities.

Table 131. WPM Strengths, Improvements, and Recommendations

Domain	WPM Summary	Assessment
Quality, Access, or Timeliness	Performance Improvement Project Validation	
Quality, Access, and Timeliness	Strengths: WPM incorporated quarterly feedback and recommendations by continuing to demonstrate and enhance efforts towards the health equity focus.	↑
Quality and Timeliness	Improvements: - WPM included a comparison of the NHM and identified opportunities for improvement for the postpartum care PIP topic. - WPM's performance resulted in steady improvement for the PPC-AD HEDIS rate from baseline MY 2022 to MY 2024.	↑
Quality and Access	Opportunities: - Review and proofread work to ensure a finalized draft is submitted for review. - Demonstrate the incorporation of CLAS within each intervention. - Demonstrate statistically significant improvement, as a result of implemented interventions.	↓
Quality and Access	Recommendations:	NA

Domain	WPM Summary	Assessment
	- Review the confounding variables, as some are described as barriers to the interventions, such as socio-economic barriers and provider constraints. - Include all remeasurement years for analysis comparison. - Include the root cause analysis tool used for interventions in the prenatal care PIP topic.	
Quality, Access, or Timeliness	Healthcare Effectiveness Data and Information Set (PMV)	↑ or ↓
Quality, Access	Strengths: MetaStar observed the following strengths: WPM continues to maintain a centralized process across all corporate markets for MRR, which includes oversight of abstraction, as well as conducting training and on-going quality checks.	↑
Quality	Improvements: MetaStar observed the following improvements: WPM further updated the supplemental data documentation to provide Roadmap documentation in a more consolidated fashion. Updates on the sources applicable to MD Medicaid were provided through the supplemental data review process.	↑
Quality, Timeliness	Recommendations: MetaStar recommended the following actions: WPM had approximately 859 supplemental data sources submitted for MY 2024, which increased from the prior year. The initial supplemental data impact was determined based on the prospective HEDIS runs for determining sources with potential impact to MD Medicaid since supplemental data had not yet been fully loaded to the MY 2024 HEDIS build utilized for reporting. WPM used supplemental data sources utilized for all Elevance markets as potential supplemental data sources. Several times through the audit process, the WPM supplemental data team provided updates of sources relevant to MD Medicaid based on membership. However, final impact reports were not available until April 2025, after the supplemental data approval deadline, thus requiring audit review of a substantial number of sources that ultimately had no impact on the MD Medicaid HEDIS submission. It is recommended that WPM continue to investigate approaches to determining more timely and accurate supplemental impact reports. Additionally, it is recommended that WPM ensure that enrollee IDs are accurately linked to enrollees for the supplemental data and sources with impact be identified more timely.	↓
Quality, Access, or Timeliness	Consumer Assessment of Healthcare Providers and Systems (PMV)	↑ or ↓
Quality	Strengths: CSS observed the following strengths:	↑

Domain	WPM Summary	Assessment
	Adult: Performed in the middle third for four measures, though none were statistically significantly different from the HealthChoice Aggregate. Child: Designated an average performing plan with one of the highest scoring non-CCC measures (<i>Rating of Health Plan</i>, which was also statistically significantly higher than the HealthChoice Aggregate).	
Quality, Timeliness	Recommendations: CSS did not recommend any formal actions; however, the following observations provide opportunities for improvement: Adult: Held the worst scores in two measures (<i>Getting Care Quickly</i> and <i>Customer Service</i>). Performed in the bottom third for one measure and in the bottom decile for four measures, though none were statistically significantly different from the HealthChoice Aggregate. Child: - Declined in performance compared to the previous year for the <i>Rating of Specialist Seen Most Often</i> measure. WPM is the only MCO with a statistically significant decline for any plans on any measures. - Scored one of the lowest rates among non-CCC measures for <i>Getting Needed Care</i>. - Scored in the bottom decile for four measures, in the bottom third for three measures, and in the middle third for two measures.	↓
Quality, Access, or Timeliness	Systems Performance Review	↑ or ↓
Quality, Access	Strengths: Best Practice: The Delegated Vendor Oversight and Management Program Policy, which is a best practice; it includes very detailed factors and examples for considering whether a delegate is the right decision for the organization. - WPM's approach to displaying key utilization metrics, using bar charts and line graphs accompanied by bullet results and actions, provides an effective snapshot of priority areas for further investigation. - A creative and informative provider education slide deck on Screening, Brief Intervention, and Referral to Treatment program. - A comprehensive Health Education Plan with a clearly defined purpose and objectives, supporting activities, effective use of data to identify enrollees in need of special educational efforts, and creative approaches to responding to enrollee and provider communication preferences in the digital age. - WPM's comprehensive explanation of disenrollment requirements through its policies and procedures.	↑

Domain	WPM Summary	Assessment
Quality, Access, Timeliness	Improvements: - Revising the timeframe for written grievance resolution in the Member Grievances Policy and demonstrating compliance with the timeframe throughout MY 2024. - Submitting the IRO Check Request Process Desktop Procedure, which outlines steps for processing IRO invoices and follow-up to ensure timely payment. - Analyzing reports, consistent with WPM’s Health Education Plan, to identify key demographic variables and common health conditions to inform selection of focus areas for health education activities.	↑
Quality, Timeliness	Opportunities: - Revise the timeframe for written grievance acknowledgment within WPM’s Member Grievances – MD Policy to be consistent with the MDH requirement which allows waiver of the acknowledgement letter only if a grievance is resolved within the regulatory timeframe or within five calendar days, whichever is less, or WPM’s own policy if more stringent. - Submit a report on enrollee grievances to the Consumer Advisory Board, on at least an annual basis, including any actions taken to address identified opportunities for improvement. - Add the following potential reasons for disenrollment to the enrollee handbook, “Section F. HealthChoice Eligibility/Disenrollment”: changes to the assistance category, not validly enrolled in MCO, and death. - Add the following language to WPM’s Government Business Division Disenrollment Policies and Procedures document: “WPM will submit to MDH, within 30 days of discovering a discrepancy, a list of enrollees who are known to the MCO to have reasons to be disenrolled for any reason listed in the referenced COMAR regulations for the HealthChoice Program. WPM will report any discrepancies to mdh.hcenrollment@maryland.gov for resolution.” - Include specific language in the Government Business Division Disenrollment Policies and Procedures document that outlines the method WPM uses to ensure it does not request disenrollment for reasons other than those permitted under the contract. Qlarant recommends that WPM consider a checklist as one of those methods. MwO: WPM must address the following opportunities to achieve compliance in MY 2025: - Revise the Member Grievances – MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the enrollee’s case record. (Component 5.1c) - Improve staff understanding of what constitutes an emergency medically related or non-emergency, medically related grievance. Routine audits of categorization should be conducted until compliance with appropriate categorization is achieved in three consecutive quarters. (Component 5.1g)	↓

Domain	WPM Summary	Assessment
	○ Include the role and responsibilities of the Clinical Services Committee in its Over/Under-Utilization of Services Policy. (Component 7.3a) ○ Demonstrate that action plans to address areas of overutilization and underutilization are presented to the identified committees, consistent with its Over/Under-Utilization of Services Policy. (Component 7.3b) ○ Change the timeframe of enrollee notification of an approval or denial from “closed date” to “date of determination.” (Component 7.6a) ○ Revise the Provider Claim Payment Dispute Process Policy to specify WPM’s timeframe for sending the provider a written appeal resolution for each level of appeal, which would allow sufficient time for a second level of appeal if the provider so chooses. (Component 7.8c) ○ Clearly document in Compliance Committee meeting minutes, quarterly review and approval of the delegate’s FWA activity. If an SIU Report is given that addresses delegate oversight of their SIU FWA activity, the name of the delegate and the date of that oversight should be documented in Compliance Committee meeting minutes. (Component 11.4d) ● CAPs: WPM must submit a CAP to achieve compliance in MY 2025: ○ Demonstrate WPM conducts an analysis of grievance data to identify opportunities for improvement and develops action plans to address identified opportunities, consistent with the Member Grievances – MD Policy. (Component 5.1d) ○ Demonstrate that Utilization Management staff participated in annual training on the interpretation and application of utilization management criteria/guidelines, which includes training content and attendees. (Component 7.2e) ○ Demonstrate that action plans to address overutilization and underutilization of services are routinely monitored to determine their effectiveness and reported to the committee(s) specified in WPM’s Over/Under-Utilization of Services Policy. (Component 7.3c) ○ Provide compliance results for prescriber notifications of the review outcome (approval, denial, or request additional information), by telephone or other telecommunication device, within 24 hours of receipt of a preauthorization request for a covered outpatient drug, on at least a quarterly basis for the entire MY. (Component 7.4c) ○ Update the Pharmacy Prior Authorization Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a determination about a covered outpatient drug if additional clinical information is requested. (Component 7.4c) ○ Demonstrate compliance with adverse determination notification timeframes for medical and pharmacy preauthorization requests no less than quarterly throughout the MY. (Component 7.6b)	

Domain	WPM Summary	Assessment
	○ Demonstrate compliance with the timeframe for written expedited appeal resolution, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY. (Component 7.7c) ○ Revise the Provider Claim Payment Dispute Process Policy to include missing COMAR requirements. (Component 7.8a) ○ Demonstrate development and implementation of action plans to address utilization management related opportunities to improve satisfaction based on CAHPS and Provider Satisfaction Survey results and provide updates to the quality committees at the frequency identified in WPM's Member Satisfaction Survey Policy and Practitioner/Provider Satisfaction Survey Policy. (Component 7.9c) ○ Provide an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures that demonstrate the effectiveness of health education by comparing individual rates pre and post receipt of health education or comparing rates of those who received health education versus those who did not on process and/or outcome measures. (Component 9.3a) ○ Ensure the Compliance Committee reviews and approves each delegate's FWA policies and procedures and Compliance/Anti-Fraud Plans at a minimum annually. Evidence must be clearly documented in Compliance Committee meeting minutes. (Component 11.4c)	
Quality	Recommendations: • Review delegation policies and procedures to remove Anthem and Amerigroup references and ensure the terminology for oversight structures is consistent. For example, remove references to Delegated Vendor Oversight Management Committee if the committee is the Delegation Oversight Committee. • Explore opportunities to educate WPM's membership on a much broader scale to address top grievance categories related to lack of enrollee knowledge/understanding. • Retrain staff on what constitutes an emergency, medically related or non-emergency, grievance. Routine audits of categorization should be conducted until compliance with appropriate categorization is achieved in three consecutive quarters. • Develop an Overutilization and Underutilization workplan, which identifies the areas of overutilization/underutilization, the root causes/barriers, action plans, responsible parties (departments), and quarterly status updates. This may facilitate routine reporting and also provide a vehicle for other departments to contribute their initiatives, such as Population Health and care management.	↓
Quality, Access, or Timeliness	Network Adequacy Validation	↑ or ↓

Domain	WPM Summary	Assessment
Quality, Access, or Timeliness	Provider-to-Enrollee Ratios and Time and Distance Standards	↑ or ↓
Quality, Access, Timeliness	Recommendations: Monitor PCPs as one group, including PCP specialties.	↓
Quality, Access, or Timeliness	Telephone Surveys and Provider Directory Validations	↑ or ↓
Quality, Access, Timeliness	Strengths: - Compliance with routine care and urgent care appointment timeframes exceeded the 80% minimum compliance score by 15.8 and 16.4 percentage points, respectively. - Highest percentage for compliance with urgent care appointment timeframes (96.4%).	↑
Quality, Access	Recommendations: - Review and address root causes for having the highest percentage of unsuccessful surveys due to <i>Refused to Participate</i> (40.0%). - Ensure staff responses regarding accepting new Medicaid patients for WPM align with the online provider directory. Enrollees use the online provider directory to search for new PCPs and should receive the same information when calling the provider directly. - Review and address the root causes for performing below the minimum compliance score in areas requiring a quarterly CAP.	↓
Quality, Access, or Timeliness	Encounter Data Validation	↑ or ↓
Quality	Strengths: - Demonstrated full compliance (100%) consistently over the trended period for inpatient encounters. - Exhibited an increase in compliance, achieving full compliance for the outpatient encounter type in MY 2024.	↑
Quality	Improvements: Demonstrated a three-percentage-point increase in outpatient match rates, resulting in 100% compliance in MY 2024.	↑
Quality	Recommendations: - Office visit encounters show a pattern of being the lowest compliance area; while still well within compliance, this is consistently the lowest-scoring encounter type each year of the trended period. - Coordinate with provider offices and vendors to ensure understanding of claim requirements to improve the quality of claim submissions.	↓
Quality, Access, or Timeliness	Early and Periodic Screening, Diagnosis, and Treatment	↑ or ↓

Domain	WPM Summary	Assessment
Quality, Access, Timeliness	Strengths: - WPM has exceeded the 80% minimum compliance score for the <i>Health and Developmental History</i>, <i>Comprehensive Physical Examination</i>, <i>Immunizations</i>, and <i>Health Education/Anticipatory Guidance</i> components consistently from MY 2022 to MY 2024. - All elements comprising the <i>Comprehensive Physical Examination</i> component have consistently met or exceeded the 80% minimum compliance score from MY 2022 to MY 2024.	↑
Quality, Access, Timeliness	Improvements: The <i>Laboratory Tests/At-Risk Screenings</i> component increased by five percentage points from MY 2023 (75%) to MY 2024 (80%), bringing performance into compliance.	↑
Quality, Access, Timeliness	Recommendations: - Review and address root causes for being unable to obtain records from difficult to reach providers. - Review and address root causes for consistent decline in the <i>Health and Developmental History</i>, <i>Comprehensive Physical Examination</i>, and <i>Health Education/Anticipatory Guidance</i> component scores from MY 2022 to MY 2024. - Review and address root causes for the <i>Recorded Perinatal History</i>, <i>Recorded Developmental Screening Tool</i>, and <i>Recorded Autism Screening Tool</i> element scores falling below the 80% minimum compliance score for the <i>Health and Developmental History</i> component. - Review and address root causes for all element scores comprising the <i>Comprehensive Physical Examination</i> component declining from MY 2022 to MY 2024, with the most significant decrease of 16 percentage points for the <i>BMI Graphing</i> element. - Review and address root causes for ten of the 16 element scores comprising the <i>Laboratory Tests/At-Risk Screenings</i> component declining from MY 2022 to MY 2024, with the <i>Newborn Metabolic Screen</i>, <i>9-11 Year Dyslipidemia Lab Test</i>, <i>18-21 Year Dyslipidemia Lab Test</i>, <i>12 Month Blood Lead Test</i>, <i>Conducted Anemia Risk Assessment</i>, and <i>12 Month Anemia Test</i> element scores falling below the 80% minimum compliance score. - Review and address root causes for ten of the 14 element scores comprising the <i>Immunizations</i> component declining from MY 2022 to MY 2024, with the <i>Influenza</i> element score decreasing by six percentage points from MY 2023 (68%) to MY 2024 (62%), remaining below the 80% minimum compliance score. - Review and address root causes for consistent decline in the <i>Documents Age-Appropriate Anticipatory Guidance</i> and <i>Documented Health Education/Referral for Identified Problems/Tests</i> element scores from MY 2022 to MY 2024, with the <i>Documented Referral to Dentist</i> element score falling below the 80% minimum compliance score.	↓

Domain	WPM Summary	Assessment
Quality, Access, or Timeliness	Consumer Report Card	↑ or ↓
Quality	Strengths: Maintained star ratings in four performance areas (Doctor Communication and Service, Keeping Kids Healthy, Care for Kids with Chronic Illness, and Pregnancy and Infant Care).	↑
Quality, Access, Timeliness	Improvements: Improved star rating in one performance area (Access to Care).	↑
Quality, Access, and Timeliness	Grievance, Appeal, and Denial Focused Study	↑ or ↓
Timeliness	Strengths: - Achieved compliance in all performance metrics, except provider administrative grievance resolution TAT. - Case notes fully describe grievance, investigation, and resolution. - Appropriate grievance resolutions. - Grievance resolution letters described grievance and resolution. - Wrote all appeal and adverse determination letters in easy-to-understand language.	↑
Quality, Timeliness	Improvements: - Verbal notice of the denial of a request for an expedited appeal resolution exceeded the MDH compliance score. - Used correct letter template for appeal acknowledgement letters.	↑
Quality	Recommendations: - Retrain staff on what constitutes a medically related grievance, specifically when there is a grievance related to difficulty obtaining a prescription. - Routinely audit to ensure appropriate categorization, until there are no incorrect categorizations for three consecutive quarters.	↓

Green and ↑ = Domain experienced a positive impact from MCO's performance. **Pink** and ↓ Domain experienced a negative impact from MCOs' performance. **Gray** and NA Qlarant provided additional guidance for enhancing MCOs' performance and reporting.

Assessment of Previous Recommendations

The following tasks did not have formal recommendations for WPM:

- PIP, PMV, CRC, and EDV: There were no formal recommendations that required corrective action from the previous measurement year.

- NAV: Assessments of previous recommendations are only included for telephone surveys and provider directory validations activities, as CAPs are not currently issued for Protocol 4 activities.
- GAD: MY 2023 to MY 2024: Any corrective action needed to address non-compliant findings were requested during the annual SPR.

Table 132. WPM Assessment of Previous Annual Recommendations

Recommendation	Assessment and Actions Taken	WPM Addressed Recommendations
MY 2023 SPR	MY 2024 SPR	↑, ↓, or ●
Standard 5: Continued Annual CAP from MY 2022: In response to the MY 2022 SPR, WPM did not meet compliance in Component 5.1h and a new annual CAP was implemented. WPM's MY 2022 CAP required revision of the Member Grievances – MD Policy to specify a timeframe for providing the enrollee written notice of grievance resolution for each grievance category. WPM must also demonstrate compliance with these timeframes, at or above the MDH compliance score, on at least a quarterly basis for all four quarters of the review period. As a result of a <i>MwO</i> finding in the MY 2023 review, WPM still needs to report compliance with WPM's written resolution timeframe for administrative grievances, consistent with its Member Grievances – MD Policy. This would require two categories, one within 5 business days of the decision and the other one within 30 calendar days of the grievance receipt for those written resolutions that would not meet the five-business-day timeframe due to the timing of the resolution.	WPM received a <i>Met</i> finding during MY 2024's SPR.	↑
Standard 7: Continued Quarterly CAP from MY 2022: In response to the MY 2022 review, WPM did not meet compliance in Element 7.10, and a new quarterly CAP was implemented due to continued noncompliance for two consecutive years. WPM's MY 2022 CAP required inclusion of all MCO requirements for supporting the IRO dispute	WPM received a <i>Met</i> finding during MY 2024's SPR.	↑

Recommendation	Assessment and Actions Taken	WPM Addressed Recommendations
resolution process in its Provider Claim Payment Dispute Process Policy. This includes documenting a process for assuring IRO invoices are paid within 60 calendar days of receipt. As a result of a <i>MwO</i> finding in the MY 2023 review, WPM still needs to indicate the frequency and position responsible for review of IRO invoice logs. A copy of this log must also be submitted for the MY 2024 review.		
Standard 7: Continued Quarterly CAP from MY 2023: In response to the MY 2022 review, WPM did not meet compliance in Component 7.7c and a new annual CAP was implemented. WPM required a quarterly CAP in the MY 2023 review due to consecutive years of noncompliance. WPM still needs to demonstrate compliance with timeframes for written appeal acknowledgement and written resolution, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the review period.	As a result of an <i>Unmet</i> finding during MY 2024's SPR, WPM still needs to demonstrate compliance with the timeframe for written expedited appeal resolution, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY.	↓
Standard 9: Continued Annual CAP from MY 2022: In response to the MY 2022 review, WPM did not meet compliance in Element 9.2, and a new annual CAP was implemented. WPM's MY 2022 CAP required demonstration of data analysis, such as diagnoses, utilization, and Health Risk Assessment results to identify the health education needs of WPM's enrollees. Programs must be based on identified needs. As a result of a <i>MwO</i> finding in the MY 2023 review, WPM still needs to demonstrate analysis of the following annual reports to determine areas of focus for health education, consistent with WPM's Health Education Plan: • Quality Management Evaluation • HEDIS rates	WPM received a <i>Met</i> finding during MY 2024's SPR.	↑

Recommendation	Assessment and Actions Taken	WPM Addressed Recommendations
- Whole Health Population/Demographic Tool (Social Determinants of Health/Disparities Data) - Care Management Program Evaluation		
MY 2024 NAV Focused Study Activities	MY 2025 NAV Telephone Surveys and Provider Directory Validations Action(s) Taken	↑, ↓, or ●
WPM's score for the provider directory validation requirement <i>Specifies if PCP Accepts New Medicaid Patients & Directory Matched Survey Response</i> (71.2%) fell below the MDH-established minimum compliance threshold. To achieve compliance in MY 2025, WPM must submit a CAP to address staff responses regarding accepting new Medicaid patients for WPM align with responses provided in the online directory through provider staff education.	WPM initiated a corrective action plan that was reviewed by both Qlarant and MDH. Despite implementing corrective action, WPM's score remains below compliance. Due to multiple years of not meeting this requirement, WPM must submit a quarterly CAP to achieve compliance in MY 2026.	↓
MY 2023 EPSDT Recommendation	MY 2024 EPSDT Assessment and Actions Taken	↑, ↓, or ●
In MY 2023, <i>Laboratory Tests/At-Risk Screenings</i> (75%) fell below the MDH-established threshold by five percentage points, and therefore, WPM will be required to submit a CAP.	WPM initiated a CAP that was reviewed by both Qlarant and MDH. WPM was then found to be compliant with <i>Laboratory Tests/At-Risk Screenings</i> .	↑

Green and ↑ = MCO addressed the recommendation; Pink and ↓ = MCO did not address the recommendation; Yellow and ● = MCO did not fully address the recommendation

Appendix B: MY 2024 Maryland Standards Crosswalks and Guidelines

Guidelines

SPR Standards and Guidelines

As seen in the *MY 2024 MCO Orientation Manual* as the “MY 2024 Maryland MCO Systems Performance Standards and Guidelines Final.”

*Rows highlighted in blue identify NCQA deemable elements/components. Within the highlighted sections, italicized elements/components are eligible for deeming.

Standard 1: Systematic Process of Quality Assessment and Improvement – The Quality Assessment and Performance Improvement (QAPI) Plan objectively and systematically monitors and evaluates the Quality of Care (QOC) and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.

Previously deleted standards:

- Element 1.6: Deleted in measurement year (MY) 2017.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.1	The [Quality Assurance Plan] QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population. a. The monitoring and evaluation of care reflect the population served by the MCO in terms of age, disease categories, and special risk status. b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.	The MCO demonstrates the ability to capture and analyze data that describe the demographic, health status, and utilization patterns of the enrolled population. The MCO documents processes used to prioritize problems and develop a timeframe for QAP studies and projects.	• Quality Assurance (QA) Plan • Policies & Procedures • Data Analysis • Population Assessment Data • Member Profiles (demographic; medical; pharmacy; and utilization data) • Quality Assurance Committee (QAC) Meeting Minutes • QA Timeline/Work Plan • Outreach Plan	42 CFR: • §438.330 • §438.330(b)(4) COMAR: • 10.67.04.03A(3)(c)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.2	The QAP's written guidelines for the MCO's QOC studies and related activities require the use of quality indicators. a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience. b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.	QOC study designs or project plans contain indicators based on sound clinical evidence or guidelines. The methodology and frequency of data collection will be evaluated to determine if they are sufficient to detect change.	- QA Plan - Policies & Procedures - QOC Study Designs - QOC Project Plans - Quality Indicators, including HEDIS and CAHPS reports - Data Analysis	42 CFR: §438.330 §438.330(c) COMAR: 10.67.04.03B(2)
1.3	The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines. a. Deleted in MY 2018. b. <i>Clinical practice guidelines are based on evidence-based practices or professional standards of practice and are developed or reviewed by MCO providers.</i> c. <i>The guidelines focus on the process and outcomes of health care delivery and access to care.</i> d. <i>A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs.</i> e. <i>The guidelines are included in the provider manuals or</i>	There must be a comprehensive set of guidelines that address preventive care and the range of the populations enrolled in the MCO. Clinical practice guidelines provide the basis for QOC studies and related QA activities. There is evidence that these guidelines are based on reasonable evidence-based practice and have been developed or reviewed by plan providers. The guidelines in use allow for the assessment of the process and outcomes of care. The MCO must have a mechanism in place for reviewing the guidelines at least every two years and updating them as appropriate. There must be evidence that the MCO disseminated guidelines to provider and, upon request, to members and potential members.	- QA Plan - Policies & Procedures - Practice Guidelines - Proof of Guidelines Disseminated to Providers - QA/Quality Improvement Committee (QIC)/MCO's Internal Provider/Medical Advisory Committee (MAC) Meeting Minutes - Clinical Care Standards - QOC Study Designs - QOC Study Tools - QOC Project Plans - Quality Indicators - Data Analysis	42 CFR: §438.236 NCQA: - MED 2 Element A-C - UM 2 Element C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>disseminated to the providers (electronically or faxed) as they are adopted.</i> f. There are guidelines to address preventive health services for children and adults. g. <i>The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.</i> h. <i>The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for utilization management (UM) decisions, member education, and coverage of services.</i>	Decisions for UM, member education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical guidelines.	Population Assessment Results	
1.4	The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. a. The QAP has written guidelines to evaluate the quality of care provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through the review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are	The QA Plan and/or related documents describe the methodology for monitoring the quality of care provided by the MCO's providers. This may be through a study of clinical care and services through individual case reviews, provider utilization studies, and practice pattern analysis. The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities those areas requiring improvement are identified and acted upon.	- QA Plan - Data Analysis - Policies & Procedures - QA/QIC/MCO's internal Provider/Medical Advisory Committee (MAC) Meeting Minutes - QA/QIC/MAC Membership - QA/QIC/MAC Attendance Records	42 CFR: §438.330b(3)-b(4)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	identified through activities described in a. and b. above. e. Deleted for MY 2023. f. Mechanisms to address the quality and appropriateness of the care provided to members with special health care needs.			
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include: a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur.	The QA Plan specifies the process for identifying problems and taking appropriate corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of this element. This would include the identification, development, implementation, and monitoring of Corrective Action Plans (CAPs).	• QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs	42 CFR: • §438.330 Health Care Quality Improvement System (HCQIS): • II.E.1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	g. The procedures for terminating health professionals, providers, or staff (as appropriate).			
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to members.	The QA Plan describes the method to be used to assure that the QAP is routinely reviewed to assess its scope and content. Documentation must be provided to substantiate that QA activities have resulted in improvements to care. And if not, what is being done to address areas of opportunity for improvement. QOC study data, analysis, reports and findings may support these improvements.	- QA Plan - Policies and Procedures - QAC Meeting Minutes - QOC Studies - QAP Annual Report	42 CFR: §438.330(e)
1.8	<i>A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:</i> a. <i>QA studies and other activities undertaken, results, and subsequent actions.</i> b. <i>Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results.</i> c. <i>Analysis of aggregate data on utilization and quality of services rendered.</i> d. <i>Demonstrated improvements in quality.</i>	The annual report on the QAP must include all required components. Note: Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP's continuity, effectiveness, and current acceptability.	- Annual QAP Evaluation Report - QAC Meeting Minutes - Governing Body Meeting Minutes	42 CFR: §438.330(e) NCQA: - QI 1 Elements C and D

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>e. Areas of deficiency.</i> <i>f. Recommendations for improvement to be included in the subsequent year's QA Work Plan.</i> <i>g. An evaluation of the overall effectiveness of the QAP.</i>			
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	QAP Organizational Chart	42 CFR: §438.330
1.10	The MCO must have a Continuity of Operations Plan and a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust continuity of operations and disaster recovery plans in place to ensure that the services provided will be maintained in the event of disruption to the MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.	- Disaster Recovery Plan - Continuity of Operations Plan - Evidence that subcontractor disaster recovery plans are in place.	COMAR: 10.67.04.15(l) MCO Agreement: Section II.A.5

Standard 2: Accountability to the Governing Body – The governing body of the MCO is the Board of Directors (BOD) or, where the Board's participation with the quality improvement (QI) issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.

Previously deleted standards:

- Element 2.6: Deleted in MY 2019.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
2.1	There is documentation that the governing body has oversight of the	The governing body is the BOD or the designated entity of senior management that has accountability and oversight of	- QA Plan - MCO Organizational Chart	COMAR: 10.67.04.15E(4)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	QAP and approves the annual QA Plan/Description and QA Work Plan.	the operations of the MCO, including but not limited to the QAP. The QA Plan/Description must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect the review and approval of the annual QA Plan/Description and the annual QA Work Plan.	- QA Organizational Chart - Governing Body Meeting Minutes	
2.2	The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA or has formally decided to provide oversight as a committee.	Documentation must be provided to indicate what committee or body the governing body has designated as the entity accountable for oversight of QA activities. Note: When the BOD or the designated entity of senior management does not choose to provide direct oversight of the day-to-day operations of the QAP, it must formally designate in writing a committee or other entity to provide such oversight. For example, this may be the MCO's Quality Committee. However, the governing body must continue to perform all of the responsibilities noted in Standard 2.0.	- Governing Body Meeting Minutes - QA Plan - QAC Meeting Minutes - QA Organizational Chart	COMAR: 10.67.04.15E(4) 10.67.04.03A
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC. Reporting to the governing body should occur according to the timeframes documented in the QA Plan (e.g., monthly, quarterly, etc.).	- Governing Body Meeting Minutes - QA Plan	COMAR: 10.67.04.03A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.	- QAP Annual Evaluation Report - Governing Body Meeting Minutes	COMAR: 10.67.04.03A
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate a review of findings and issues of concern within the MCO.	The governing body receives regular written reports from the QAP delineating actions taken and improvements made (Element 2.3). As a result, the governing body takes action and provides follow-up when appropriate. These activities are documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QAP.	- QA Plan - Governing Body Meeting Minutes - QAC Meeting Minutes	COMAR: 10.67.04.03A
2.7	The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of: a. UM activities and findings, and b. Evaluation of UM progress.	The UM Plan provides a clear definition of the overall authority and responsibility of the governing body.	- Governing Body Meeting Minutes - UR Plan	COMAR: 10.67.04.03A

Standard 3: Oversight of Delegated Entities and Subcontractors – The MCO remains accountable for all function, even if certain functions are delegated to other entities.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
3.1	The MCO must ensure that delegates have detailed agreements and are notified of the grievance and appeal system. a. The MCO must ensure that there is a written description of	Delegates are subcontractors that administer a critical benefit on behalf of the MCO that impacts members directly (e.g., vision, claims, UM, pharmacy). Subcontractors are individuals or entities that have a contract with an MCO that	- Delegation Contract - Delegation Policies & Procedures	COMAR: 10.67.04.17A(3)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. b. The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	relates directly or indirectly to the performance of the MOC's obligations under its contract with the state related to Medicaid (e.g., contractors providing outreach services, call center activities, or mobile laboratory vendors). Vendors are subcontractors that administer a function that does not directly impact member services or benefits (e.g. mail room, print services, and janitorial services). The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, the evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared with the delegate, and the delegate's acknowledgment of receipt. The only delegates required for Standard 3 are those who are delegated UM, claims, and/or appeals and grievances for mandatory services, such as vision, drug, radiology, and physical therapy (PT).		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.	The MCO has policies and procedures in place to monitor and evaluate the delegated functions and for verifying the care provided.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities	COMAR: • 10.67.04.17D
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: - Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc. - Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. - Review and approval of claims payment activities at least semi-annually, where applicable. - Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. - Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.	There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract. The MCO must provide evidence of items a. through e.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities • Delegation Committee Meeting Minutes • Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable • Delegated Entities' Claims Payment Monitoring Reports, where applicable • Delegated Entities' Utilization Activity Reports, where applicable	42 CFR: • §438.230 (a & b) COMAR: • 10.67.04.17C • 10.67.04.17D • 31.10.11 • 31.10.23.01 Ins. Art.: • §15-1004 • §15-1005

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or members.	When the MCO terminates a subcontract, the MCO shall provide the Department with written notice regarding the termination that complies with the requirements of COMAR 10.67.04.17B(5).	- Subcontractor Policies & Procedures - Subcontractor Termination Notices	COMAR: 10.67.04.17B(5)

Standard 4: Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.

Note: As of October 1, 2021, the minimum compliance score changed from 100% to 95% for credentialing and recredentialing timeliness requirements.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.1	The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process. b. <i>The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions.</i> c. <i>The Credentialing Plan must identify the practitioners who fall</i>	The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority. Within 30 days of receipt of a completed application, the MCO shall send to the provider at the address listed in the application written notice of the MCO's:	- Credentialing Plan - Credentialing Process in QA Plan - Governing Body Meeting Minutes - Credentialing Policies & Procedures	42 CFR: §438.214 COMAR: 10.67.04.02M 10.67.04.17 HCQIS: - IX A-D Ins. Art. §15-112: (a)(4)(ii)(9) (d) NCQA: - CR 1 Element A-B - CR 2 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>under its scope of authority and action.</i> <i>d. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).</i>	• Intent to continue to process the provider's application to obtain necessary credentialing information. • Rejection of the provider for participation in the MCO's provider panel. If the MCO provides notice to the provider of its intent to continue to process the provider's application, the MCO, within 120 days after the date the notice is provided, shall: • Accept or reject the provider for participation on the MCO's provider panel. • Send written notice of the acceptance or rejection to the provider at the address on the application. After the MCO receives the completed application, the MCO is subject to the aforementioned timeframes for completed application processing. When an "online credentialing system" is utilized by the MCO the following applies: • The MCO is required to track the date of the application, i.e. query the online credentialing system so that dates of credentialing can be calculated.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		- The “10-Day Letter” is not applicable since the entire application must be completed prior to exiting the application. - The “30-Day Letter” still applies with the above-mentioned timeframes. If an MCO does not accept applications through an “online credentialing system”, notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received that the application is complete.		
4.2	There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes: - Written policies and procedures for the suspension, reduction, or termination of practitioner privileges. - A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. - Deleted in MY 2019.	There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented. The policies and procedures must identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place.	- Credentialing Plan - Recredentialing Plan - Credentialing Policies & Procedures - Provider Appeal Policy & Procedure - Provider Appeals Files - Facility Site Reviews (completed forms/files)	COMAR: 10.67.04.02K-L 10.67.09.03 HCQIS: - IX H-J
4.3	If the MCO delegates credentialing/recredentialing	The contract for delegated services includes a description of the delegated	- Delegation Contract - Delegate Progress Reports to the MCO	42 CFR: §438.214

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	activities, the following must be present: - A written description of the delegated activities. - A description of the delegate's accountability for designated activities. - Evidence that the delegate accomplished the credentialing activities.	activities and the delegate's accountability for designated activities. The delegate provides reports to the MCO according to the contract requirements.	MCO Monitoring/Auditing Documents	HCQIS: IX G
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include: - A review of a current valid license to practice. - A review of a valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable. - A review of graduation from medical/ancillary (NP, PT, OT, SLP, etc.) school and completed residency or post-graduate training, as applicable. - A review of work history. - A review of a professional and liability claims history. - A review of current adequate malpractice insurance according to the MCO's policy. - Deleted as of the MY 2017 SPR.	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required in components a-k for the credentialing process. Note: (h) is applicable to those primary care providers (PCPs) who deliver preventive health care services to members less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network who see patients under age 21 are EPSDT certified.	- Credentialing Plan - Credentialing Policies & Procedures - Sample Credentialing Records - Written correspondence to providers - Screenshots from ePREP showing validation of provider enrollment in Medicaid - Provider agreement (for new contracts)	42 CFR: \$438.214 (c-e) COMAR: 10.67.04.02L 10.67.05.05 HCQIS: - IX E.1-7 Ins. Art. §15-112: (a)(4) (d) MCO Transmittal: - PT 10-19 MDH Provider Verification System

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	h. A review of Early Periodic Screening Diagnosis and Treatment (EPSDT) certification. i. Adherence to the timeframes set forth in the MCO's policies regarding credentialing date requirements. j. Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d). k. Verification that the provider is actively enrolled in Medicaid at the time of credentialing.			
4.5	The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include: a. Any revocation or suspension of a state license or a DEA/Bureau of Narcotics and Dangerous Drugs (BNDD) number. b. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records). c. Any sanctions imposed by Medicare and/or Medicaid.	The credentialing plan and policies and procedures require that the MCO request information required in components a-d from recognized monitoring organizations.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes	42 CFR: • §438.214(d) HCQIS: • IX E. 8-12

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. Information about the practitioner from the National Practitioner Data Bank (NPDB) and the Maryland Board of Physicians (MBP).			
4.6	The credentialing application includes the following: a. The use of illegal drugs. b. Any history of loss of license. c. Any history of loss or limitation of privileges or disciplinary activity. d. Attestation to the correctness and completeness of the application.	The credentialing plan and policies and procedures describe the application process. This process includes the requirement that the applicant must provide a statement that includes components a-d. There must be evidence in the credentialing files that this statement is completed. Type of credentialing application must be reviewed and in compliance with Maryland Insurance Administration (MIA) regulatory requirements noted.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Completed Application • Completed Uniform Credentialing Form	42 CFR: • §438.214 COMAR: • 31.10.26.03 HCQIS: • IX E.13.a-e
4.7	<i>There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the Americans with Disabilities Act (ADA) and the MCO's standards.</i>	The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping, and that these practices are in conformance with the MCO's standards. Such standards should consider: • Handicapped designated parking clearly marked and close to the entrance. • Ramps for wheelchair access.	• Credentialing Plan • Credentialing Policies & Procedures • Site Visit Tool • Sample Completed Site Visit Tools • Sample Credentialing Records • Applicable Reports of On-site Visits • Credentialing Committee Meeting Minutes	CFR: • Chapter 1, Part 36 HCQIS: • IX E.1428 NCQA: • <u>MED 3</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		- Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. - Elevator availability for practices above ground level.		
4.8	There is evidence that recredentialing is performed at least every three years and: - Includes a review of information from the NPDB. - Deleted in MY 2019. - Includes all items contained in element 4.4 a–h, except 4.4 d (work history). - Includes all items contained in 4.6 a–d. - Meets the timeframes set forth in the MCO's policies regarding recredentialing decision date requirements. - Ensures the MCO is verifying that the provider is actively enrolled in Medicaid at the time of recredentialing.	The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years. The recredentialing process requires a review of components contained in a-f. There is evidence in individual provider credentialing files that this has occurred. This information is used to decide whether to renew the participating physician agreement.	- Credentialing Plan - Recredentialing Policies & Procedures - Sample Credentialing Records - Credentialing Committee Meeting Minutes <u>Screenshots from ePREP showing validation of provider enrollment in Medicaid.</u>	42 CFR: §438.214 COMAR: 10.67.04.02N HCQIS: - IX F.1-2 Ins. Art.: §15-112 (d) MCO Transmittal: - PT-10-19
4.9	There is evidence that the recredentialing process includes a review of the following: - Member complaints/grievances. - Results of quality reviews. - Deleted in MY 2018. - Office site compliance with ADA standards, if applicable.	There is evidence in provider recredentialing records in which complaints, grievances, and the results of quality reviews were reviewed prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when:	<u>NCQA Med (if applicable)</u> - Recredentialing Policies & Procedures - Sample Recredentialing Records - Credentialing Plan	42 CFR: §438.214 HCQIS: - IX F.3 a – e

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		- Provider relocates to a site that has not previously been evaluated and approved as being ADA-compliant, or - There is evidence of ADA non-compliance issues with a particular site of care delivery.		
4.10	The MCO must have policies and procedures regarding the selection and retention of providers. a. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. b. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.	Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained within the Medicaid network.	- Credentialing Plan - Credentialing Policies & Procedures	42 CFR: §438.207 §438.214
4.11	The MCO must ensure that members' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP. a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.	The MCO must include in the notification: - An explanation of the EPSDT preventive screening services to which a member is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); - Importance of accessing the EPSDT preventive screening services; and - Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.	- Policies & Procedures - Letters to Parents/Guardians	COMAR: 10.67.05.05 MCO Transmittal: <u>No. 221</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSTD certified physician and they have the option to switch to a certified EPSTD PCP if desired.			
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	MCO must be compliant with the following COMAR 10.67.04.17B(4) requirements for notifying and reporting provider terminations: - When an MCO and provider terminate their contract, the MCO shall provide the Department with a written notice regarding the termination. - If the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided at the later of: 30 calendar days before the effective date of the termination; or 15 calendar days after receipt or issuance of the termination notice. - If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider.	- Network Provider Termination Policies & Procedures - Network Provider Termination Notices to MDH - Examples of completed MDH-required forms - Evidence of terminated provider notices to members.	42 CFR: §438.10 COMAR: 10.67.04.17B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		d. If 50 to 99 members are affected, the notice shall contain the: i. Date of termination; ii. Name or names of providers or subcontractors terminating; iii. Number of members affected; and iv. MCO's plan for transitioning members to other providers. e. If more than 99 members are affected, the MCO shall provide the Department with a Department-approved termination survey. f. In determining the number of members affected under §B(4)(d) and (e) of this regulation, the MCO shall consider: i. For PCPs, the number of members assigned to the PCP; and ii. For all other providers, the number of members who are in active treatment or who have had an encounter with the provider in the previous 12 months. Additionally, per 42 CFR §438.10, the MCO must make a good faith effort to give written notice of termination of contracted providers to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The MCO must provide notice to members by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		days after receipt of issuance of the termination notice.		

Standard 5: Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.

Note: As of October 1, 2021, the minimum compliance score changed from 100% to 95% for credentialing and recredentialing timeliness requirements.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.1	The MCO has a system linked to the QAP for resolving members' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04. a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure.	Timeframes for resolving grievances in the policy and procedure must be in accordance with the following: - Emergency medically related grievances not > 24 hours. - Non-emergency medically related grievances not > 5 days. - Administrative grievances not > 30 days. The policy and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how a member can get assistance from the MCO in completing the form. The MCO must have a documented procedure for written notification of the MCO's determination:	- Grievance Policies & Procedures - Grievance Form - Grievance Logs - Grievance Reports - Grievances Files - TAT Grievance Compliance Reports for acknowledgment letters, resolution, and resolution letters monthly or quarterly for the entire review period. - Grievance Committee meeting minutes - QAC/QIC Meeting Minutes - Consumer Advisory Board (CAB) Meeting Minutes - Quarterly Complaints/Grievances	42 CFR: §438.402 (a & b) §438.406 (a & b) §438.408 (a-f) COMAR: 10.67.09.02 10.67.09.04 10.67.09.05 HCQIS: - X.E

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in MY 2018. f. There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record. g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%. h. The MCO ensures members receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and	- To the member who filed the grievance - To those individuals and entities required to be notified of the grievance - To the Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program If closing the grievance case due to not being able to contact the member via phone, the MCO must notify the member in writing that their grievance is being closed. The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of individuals within the MCO who have authority to require corrective action. A sample of selected grievances is reviewed to assure that the process is complete and is being followed. The policies and procedures describe the process to be used for data collection and analysis <u>for quality improvement</u>. This must include timeframes for collection and	Sample Grievance Letters to members	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	within the MDH established threshold of 95%. i. Written resolution letters describe the grievance and the resolution in easy-to-understand language.	reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly). The policies and procedures must include the notification of results to the provider involved, if applicable, the Consumer Advisory Board, and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution. The state-specified threshold for timeliness of all grievance acknowledgment letters, resolutions, and resolution letter decisions is 95%. A sample of grievance files must be reviewed for compliance with state and MCO (for resolution letter) specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
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.	COMAR 10.67.05.01C states that all written materials must: • Use language and a format that is easily understood; • Be available in alternative formats and through the provision of auxiliary aids and services; • Be available in an appropriate manner that takes into consideration the special needs of members or potential	• Member Informational Materials	42 CFR: • §438.10 • §438.206(c)(2) COMAR: • 10.67.04.02H • 10.67.05.01 HCQIS: • <u>X.H</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		members with disabilities or limited English proficiency. Member information including, but not limited to, member handbook, newsletters, and health education materials are written at the appropriate reading comprehension level for the Medicaid population. The SMOG formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability.		
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: a. <i>Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.</i> b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented. The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.	- Medical Records Policies & Procedures - Confidentiality Policies & Procedures - Sample Provider Contracts - Sample Provider Site Visit Evaluation Tool - Credentialing Policies & Procedures - Tools Related to Assessing Confidentiality of Patient Medical Records - Sample of MCO Employee Confidentiality Statement - Signed MCO Employee Confidentiality Statements	42 CFR: §438.100 §438.224 HCQIS: - X Health-General: §§4-301 HIPAA NCQA: - MED 4 Elements A - C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. Must hold confidential all information obtained by its personnel about members related to their care and shall not divulge it without the member's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Deleted in 2023. e. May disclose member records, with or without the member's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual member in any report of research or otherwise disclose participant identity in any manner.		Sample Vendor Contracts	
5.4	The MCO has written policies and procedures regarding the appropriate treatment of minors, including minor consent to treatment and confidentiality requirements. Without the consent of or	The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor's right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and sexually transmitted diseases.	Treatment of Minors Policy and associated procedures	HCQIS: - X.J Health General: 20-102 HIPAA

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion.			
5.5	As a result of the member satisfaction surveys, the MCO: - Identifies and investigates sources of dissatisfaction. - Implements steps to follow up on the findings. - Informs practitioners and providers of assessment results. - Reevaluates the effects of b. above at least quarterly.	There is a process in place for identifying sources of dissatisfaction. The MCO must have mechanisms in place to identify problems, develop plans to address problems, and provide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed. There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.	- Patient Satisfaction Evaluation Policies & Procedures - Patient Satisfaction Evaluation Tool - Patient Satisfaction Survey Data Analysis - Corrective Action Plans - Appropriate Committee Meeting Minutes Showing CAHPS Results Review	42 CFR: §438.206 (c) HCQIS: - X.K.3 a-c - X.K.4
5.6	The MCO has systems in place to assure that new <u>members</u> receive required information within established timeframes. <i>Policies and procedures are in place that address the content of new</i>	Policies and procedures address the content of new member information packets and timeframes for receipt of the packets. At a minimum, new member information packets contain: - Member ID card - Member Handbook - Provider Directory	- Member Handbook - Member Notices - Sample New Member Information Packet - New Member Policies & Procedures - Committee Meeting Minutes	42 CFR 438.10 COMAR: 10.67.02.02 10.67.04.02.G(3) 10.67.05.02 Ins. Art.:

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>member packets of information and specify the timeframes for sending such information to the member.</i> b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's identification (ID) card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. d. The MCO includes the Continuity of Health Care Notice in the new member packet. e. The MCO must have all Member Handbook templates approved by MDH and use all member notice templates provided by MDH.	The MCO uses State-developed model member handbooks and notices. New member information packets are provided to new members within 10 calendar days of MDH's notification to the MCO of enrollment. The packet includes the Continuity of Health Care Notice that is required by §15-140(f) of the Insurance Article. The MCO has written procedures that track and monitor timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure. There is a documented process for newborn enrollment that includes timeframes. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.	• ID Card Fulfillment Reports • ID Card Fulfillment Tracking and Trending Analysis	• §15-140
5.7	The MCO must have an active Consumer Advisory Board (CAB).	An MCO shall establish a CAB to facilitate the receipt of input from members. The CAB membership shall consist of members and members' family members, guardians, or caregivers. It is to be comprised of no	• Policies & Procedures • Committee Charter • CAB Meeting Minutes • CAB Annual Summary	COMAR: • 10.67.04.12 • 10.67.04.15 • <u>10.67.09.02(C)(7)(a)(iii)</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. The MCO's CAB membership must reflect the special needs population requirements. b. The CAB must meet at least six times a year. c. The MCO must have a mechanism for tracking member feedback from the meetings. d. <u>The MCO provides a report on member grievances to the Consumer Advisory Board on at least an annual basis, including actions taken to address identified opportunities for improvement.</u>	less than 1/3 representation from the MCO's special needs populations, or their representatives. Pursuant to regulation, the CAB shall annually report its activities and recommendations to the MDH. The CAB Annual Report will, at a minimum, include the following information: • CAB Charter or P&P • Mission/Vision Statement for the CAB • Goals for the CAB • Structure of and member composition of the CAB • Dates, times, and locations for each CAB meeting • Summary of topics/issues discussed • Member feedback/concerns • Accomplishments/Resolutions • Opportunities for Improvement/Follow-up		
5.8	The MCO must notify members and prospective members about their nondiscrimination rights. a. <i>Materials critical to obtaining services that are distributed by the MCO to the member will include a nondiscrimination notice and a language accessibility statement in</i>	The MCO shall notify members of the following services and make them available free of charge to the member: 1. Written materials in the prevalent non-English languages identified by the State; 2. Written materials in alternative formats; 3. Oral interpretation services in all non-English languages; and 4. Auxiliary aids and services, such as:	• Member Handbook • Provider Directory • Member Information/ Material • Screen Shot of the MCO Website • Pictures of Notices and Taglines posted at member events • Websites • Online Directories	42 CFR: • §438.10 45 CFR: • §92.101 COMAR: • 10.67.05.01 NCQA: • MED 12 Element D-H • MED 13 Element B-C • NET 5 Element J

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency in Maryland.</i> b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page. c. Notices and Taglines must be posted in significant communications and publications. d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. e. MCO's electronic information provided to members must meet requirements set forth in COMAR.	a. Teletypewriter/Telecommunication Device for the Deaf (TTY/TTD); and b. American Sign Language. The MCO shall include taglines with its written materials that: 1. Explain the availability of written translation or oral interpretation to understand the information provided; and 2. Provide the toll-free and TTY/TTD telephone number of the MCO's customer service unit. MCOs must take steps to notify members and prospective members about their rights under Section 1557 of the ACA. Specifically, MCOs must post a nondiscrimination Notice in English and in at least the top 15 non-English languages spoken by the individuals with limited English proficiency of the relevant State or States. MCOs may combine the content of the Notice with other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Small-size material (trifold brochures) must have statements and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement. The Notice and Taglines must be posted in a conspicuously-visible font size in a		• ME 7 A-B • ME 2 Element A-B • UM 3 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		conspicuous location of covered entity websites accessible from the home page, in written materials critical to obtaining services, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public. This applies to, but is not limited to: Marketing materials, member communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, a summary of benefits, and appeal and grievance notices. COMAR 10.67.05.01.D states that if the MCO provides member information electronically (provider directory, EOB, member handbook), the following requirements must be met: 1. The format is readily accessible; 2. The information is placed in a location on the MCO's website that is prominent and readily accessible; 3. The information is provided in an electronic form which can be electronically retained and printed; 4. The information is consistent with the content and language requirements of this section;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		5. The member is informed that the information is available in paper form without charge upon request; and 6. Should the member request it, the MCO provides the information in paper form within 5 business days. MCOs should be prepared to provide evidence of materials referring members to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and printable; and information/reports that are uploaded to the MCO website should be 508c accessible.		
5.9	The MCO must maintain written policies and procedures for advance directives. a. The MCO must educate staff regarding advance directives policies and procedures. b. The MCO must provide adult members with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618).	The MCO must have written policies and procedures for advance directives. Advance directives are written instructions, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. MCOs must educate staff on advance directives. Staff should include clinical staff, case management, member services, and outreach staff that would interact with members and advance directives. Additionally, network management staff should be educated since they have contact with the provider network.	• Policies & Procedures • Member Handbook • Member Notices • Staff Notices • Evidence of staff training	42 CFR: • §438.3(j)(1) • §438.10(g)(2)(xii) • §489.100 COMAR: • 10.67.04.02 Health General Article: • §5-601-618

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	MCO must provide examples of completed staff training such as signed attestations and rosters of staff showing dates of annual training completed.		
5.10	MCO must comply with the marketing requirements of COMAR 10.67.04.23. a. An MCO may not have face-to-face contact with a recipient who is not a member of the MCO unless contact is authorized by the Department or contact is initiated by the recipient. b. An MCO cannot engage in marketing activities without prior approval of the Department. c. Deleted in MY 2018.	The MCO's marketing policies and procedures comply with the requirements of COMAR 10.67.04.23. An MCO may not have face-to-face or telephone contact with a recipient, or otherwise solicit a recipient who is not a member of the MCO, unless authorized by the Department or the recipient initiates the contact. Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may involve campaigns using but not limited to Television; Radio; Newspaper; Informational booths at public events; Billboards and other public displays; Addressee-blind informational mailings, but only when mailed to the MCO's entire service area; Magazines; Airborne marketing displays; or public conveyances.	- Marketing Policies & Procedures - Marketing Requests and Approvals from the Department	42 CFR: §438.104 COMAR: 10.67.04.23
5.11	The MCO has implemented policies and procedures to	The MCO has written policies and procedure to ensure:	- Policies & Procedures - Provider manual	42 CFR: §438.102

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient.	a. that it does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following: i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. ii. Any information the member needs to decide among all relevant treatment options. iii. The risks, benefits, and consequences of treatment or non-treatment. iv. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. b. that if the MCO objects to providing, reimbursing for, or providing coverage of a counseling of referral service on moral or religious grounds for the requirements in 5.11, section a, then the MCO must furnish information about the services it does not cover to MDH consistent with the requirements in § 438.102(b)(1)(i)(A)(B)	• Member handbook	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		c. members are informed how they can obtain information from the State to access the service(s) excluded in 5.11, section a.		

Standard 6: Availability and Accessibility – The MCO has established measurable standards for access and availability.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. a. The MCO has developed and disseminated written access and availability standards. b. <i>The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.</i> c. The MCO has established policies and procedures for the operations of its customer/member services and has developed standards/indicators to monitor, measure, and report on its performance. d. The MCO has documented a review of the Member Services Call Center performance.	The MCO has established access and availability standards that comply with HCQIS and COMAR requirements and demonstrates that these standards have been disseminated to providers. These standards must include: • routine appointments • urgent appointments • emergency care/services • telephone appointments • advice • member service lines • outreach • clinical and pharmacy access The MCO must monitor against the above standards. The following should be included to ensure compliance with standards: • Quarterly calls to be conducted to a sample of providers to ensure compliance with all access and availability standards including but	• Access and Availability Standards • Access and Availability Policies & Procedures • Provider Manual • Newsletters • Monitoring and Evaluation Processes • Committee Meeting Minutes • Monitoring Reports • Performance Trends • Evidence of Quarterly Monitoring of Access and Availability Standards	42 CFR • §438.68(c)(1)(vii) • §438.68(c)(1)(viii) • §438.206(c)(1) • §438.206(c)(2) • §438.206(c)(3) • §438.210 COMAR • 10.67.05.03-08 • 10.67.05.07.B(2) CMS's Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability HCQIS • XI NCQA:

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		not limited to the validation of provider directory information, compliance with appointment availability, and after hour requirements. - Quarterly survey results should be reviewed, reported, and trended by the MCO. - Providers failing the survey for not meeting access standards will be provided education and included in a survey within the next 6th months to ensure compliance. If the provider fails the following survey, they will be placed on a Corrective Action Plan by the MCO. The MCO has also established policies and procedures for the operations of its internal customer/member services. Performance standards have been developed, such as telephone answering time, wait time, abandoned call rates, and timeframes for response to members' inquiries. Such standards are measured for performance and identification of issues that affect member services and are reported through established channels, such as committees.		NET 1 Element B-C
6.2	<i>The MCO has a list of providers that are currently accepting new members.</i>	The MCO must conduct annual geo mapping to calculate the average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access	- Provider Directory - Provider Manual - New Member Packet - New Member Orientation Materials	42 CFR: §438.10 (f) (2-6) §438.10 (h) (1) (i-viii) §438.206 (b)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. <i>The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population.</i> b. <i>At the time of enrollment, members are provided with information about the MCO's providers.</i> c. <i>The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.</i> d. <i>The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.</i>	requirements are defined in COMAR 10.67.05.05.B and COMAR 10.67.05.06.B-D. Some of these are listed below: • Member to physician ratio for local access area = 200:1 • Travel distance (urban) - 10-mile radius • Travel distance (suburban) – 20-mile radius • Travel distance (rural) - 30-mile radius. Annually compare percentages of network providers who communicate in non-English languages most common among members. As defined in COMAR, the MCO must make available a listing of individual practitioners who are the MCO's primary and specialty care providers. Information must include: • Name as well as any group affiliation • Street address • Telephone number • Website URL, as appropriate • Specialty, as appropriate • An indication of whether or not the provider is accepting new Medicaid patients	• Availability & Access Standards • Access and Availability Policies & Procedures • Monitoring Methodology • Monitoring Reports • Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Member Complaint Reports • Documentation of any CAPs • Online Provider Directories • Provider Directory Machine Readable Format and File • Link to Online Provider Directory • Screenshots of Online Provider Directory	• §438.207 • §438.236 COMAR: • 10.67.05.01A(3) • 10.67.05.02C • 10.67.05.05B • 10.67.05.06B-D HCQIS: • XI NCQA: • NET 1 Elements A-C <u>Appendix F of HealthChoice Agreement</u> <u>PT 17-25</u> <u>PT 31-24 Doula Network Adequacy Standards for the Maryland HealthChoice Program Correction</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		- The provider's cultural and linguistic capabilities (including American Sign Language) - An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of members the provider will serve) - An indication of whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms(s), and equipment The MCO must perform a quarterly review of the number of participating providers in the plan by type, geographic location, specialty, and acceptance of new patients. The directory must also include: - A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the member's county with their addresses and services provided. Provider directories must be made available on the MCO's website in a machine-readable file and format. Hardcopy provider directory updates must be made quarterly if the MCO has a		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		mobile-enabled electronic provider directory. Hardcopy provider directory updates must be made monthly if the MCO does not have a mobile-enabled electronic provider directory. Electronic provider directories must be updated no later than 30 calendar days after the MCO receives updated provider information. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its population in all care settings. The methodology includes: • A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. • Follow-up activities and progress toward resolution that are evident. • Direct access to specialists. Each MCO must have a mechanism in place to allow members with special health care needs who have been determined to need a course of treatment or regular care		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		monitoring to directly access a specialist as appropriate for the member's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits. "An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its members, including, but not limited to, the delivery of services and information to members: In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying members of due dates for wellness services. a. Deleted in MY 2019. b. Deleted in MY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and	Policies and procedures must be in place and address trending and analysis of wellness services. The analysis must be included in the QAP with CAPs developed as appropriate. Documentation must be provided to substantiate that timeframes are adhered to and that tracking procedures are in place. The MCO has a written procedure/methodology that tracks and	- Scheduling of IHA Policies & Procedures - IHA completion analysis - QAP	42 CFR: §457.495 COMAR: 10.67.03.06 10.67.05.03 10.67.05.07 HCQIS: - XI

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	procedures, with CAPs developed as appropriate.	monitors timeliness of Initial Health Assessments (IHAs). Such monitoring is analyzed and if un-timeliness is identified, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure.		
6.4	The MCO has implemented policies and procedures to ensure coverage and payment of emergency services and post-stabilization care services for members.	Policies and procedures must be in place to ensure payment is not denied for emergency and post-stabilization treatment obtained under the following circumstances: - A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in §438.114(a)(b)(c)(1)(i)(ii). - A representative of the MCO instructs the member to seek emergency services. - Emergency services obtained outside of the primary care case management system regardless of whether the case manager referred the member to the provider that furnishes the services. - Regardless of whether the servicing provider has a contract with the MCO. Documentation must be provided to indicate that the MCO does not:	- Availability & Access Standards - Access and Availability Policies & Procedures - Claims Payment Policies & Procedures - Emergency Department (ED) Policies & Procedures - Member handbook - Provider manual	42 CFR: §438.114 10.67.04.20B 10.67.05.08B 10.67.06.28

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		a. Limit what constitutes an emergency medical condition. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or MCO of the member's screening and treatment within 10 calendar days of presentation for emergency services. c. Hold liable a member who has an emergency medical condition for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. d. Bind the determination of the attending emergency physician or the provider actually treating the member, for who is responsible in determining when the member is sufficiently stabilized for transfer or discharge as responsible for coverage and payment.		

Standard 7: Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through collection and analysis of data in order to achieve overall improvement.

Note: As of October 1, 2021, the minimum compliance score changed from 100% to 95% for credentialing and recredentialing timeliness requirements.

Previously deleted standards:

- Element 7.12: Deleted in MY 2019.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.1	<i>There is a comprehensive written UR Plan.</i> a. <i>This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.</i> b. <i>The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.</i> c. <i>There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.</i>	The UR Plan is comprehensive and addresses components a-c. Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	• UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes • <u>Member</u> Handbook • Provider Manual • UR Staff signed affirmations	42 CFR: • §438.236 • §485.66 10.67.03.06 10.67.04.03 10.67.06.07 HCQIS: • XIII A NCQA: • UM 1 Element A • UM 2 Element A
7.2	The UR Plan specifies criteria for UR/UM decisions. a. <i>The criteria used to make UR/UM decisions must be based on acceptable medical practice.</i> b. <i>The UR Plan must describe the mechanism or process for the periodic updating of the criteria.</i> c. <i>The UR Plan must describe the involvement of participating providers in the review and updating of criteria.</i>	There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.	• UR Plan • Documentation of review/approval of new medical necessity criteria/updates • Policies & Procedures for Criteria Review/Revision, annual IRR assessment, and annual training on UM criteria	42 CFR: • §438.210(a) COMAR: • 10.67.06.01 HCQIS: • XIII A NCQA: • UM 1 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. <i>There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.</i> e. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines. f. <i>There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria on at least an annual basis.</i>		- UR Committee Meeting Minutes - Sign-in sheets, training logs, certificates of completion of annual training on UM criteria - Documentation of annual assessment of IRR among UM staff/physicians	UM 2 Element A and C
7.3	The written UR Plan has mechanisms in place to detect overutilization and underutilization of services. a. Services provided must be reviewed for overutilization and underutilization. b. UR reports must provide the ability to identify problems and take the appropriate corrective action. c. Corrective measures implemented must be monitored.	The UR Plan describes the process to be used for detecting overutilization and underutilization of services. UR reports and data analysis must be available and should demonstrate the ability to identify problems. There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.	- UR Plan - UR Policies & Procedures - Data Reports and Analysis - CAPs - UR Committee Meeting Minutes - Provider Profiles	42 CFR: §438.330(b) COMAR: 10.67.06.01 HCQIS: - XIII
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation. a. <i>Any decision to deny a service authorization request or to</i>	MCO policies and procedures must be compliant with the requirements of COMAR 10.67.09.04. The MCO must demonstrate that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than	- UR Plan - UR Policies & Procedures - UR Organizational Charts - UM Position Descriptions	42 CFR: §438.210 (c & d) §438.236 COMAR: 10.67.09.04

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.</i> b. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. For standard preauthorization requests, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the member and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. If additional clinical information is required, it must be requested within 2 business days of receipt of the request. For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a timely manner so as not to adversely affect the health of the member and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. For outpatient drug preauthorization decisions, the MCO shall approve, deny, or request additional information by telephone or other telecommunication device to the requesting provider within 24 hours of request.	• UM Staffing Plan • UR Committee Meeting Minutes • Delegate Reports to MCO • MCO Monitoring of Delegate Reports • TAT Compliance Reports monthly or quarterly for the entire review period.	HCQIS: • XIII.C 1-7 NCQA: • UM 4 Element A-B, F

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The member, member's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified members in writing of the extension and the reason, as well as members' right to file a grievance if they disagree with the MCO's decision. The state-specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.5	Adverse determination letters include a description of how to file an appeal. a. All adverse determination letters are written in easy-to-understand language. b. Adverse determination letters include all required components.	There must be documented policies and procedures for appeals. Such policies and procedures must comply with the requirements stated in COMAR 10.67.09.04F. The required adverse determination letter components include: 1. Explanation of the requested care, treatment, or service. 2. Clear, full, and complete factual explanation of the reasons for the	• Member Adverse Determination Letter Policies and Procedure documenting required letter components • Sample Member Adverse Determination Letters • Selected UR Cases	42 CFR: • §438.404 • §438.406 COMAR: • 10.67.09.02 • 10.67.09.04F HCQIS: • XIII.C 1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		denial, reduction, or termination in understandable language. Conclusive statements such as “services included under another procedure” and “not medically necessary” are not legally sufficient. 3. Use of the phrase “nationally recognized medical standards” is acceptable; however, the exact clinical guideline reference must be included. 4. Availability of a free copy of any guideline, code, or similar information MCO used to decide and the MCO contact number including TTY/TTD. 5. Description of any additional information MCO needs for reconsideration, if appropriate from member and/or provider. 6. Statement of the availability and contact information of the MCO representative who made the decision if the member’s provider would like to contact him/her. 7. The member’s right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO’s action. This includes a copy of the member’s medical record, provided free of charge.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		8. Direction to the member to call the HealthChoice Help Line for assistance. 9. The member may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of the adverse determination notice. 10. Explanation to the member that if he/she is currently receiving ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the member's appeal is denied, he/she may be required to pay for the cost of the services received during the appeal process. 11. Statement that the member may represent themselves or use legal counsel, a relative, a friend, or another spokesperson. 12. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. 13. A statement explaining the availability of the expedited review process, MCO phone number, and timeframe for making a determination. 14. A statement that the member or their representative may request an		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		extension of the timeframe for appeals by up to 14 calendar days. 15. A statement of availability of the letter in other languages and alternate formats. 16. Notice of Nondiscrimination and Appeals and Grievance Rights document.		
7.6	The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials. a. The MCO maintains policies and procedures pertaining to the timeliness of adverse determination notifications in response to preauthorization requests as specified by the State. b. The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	MCOs shall notify the member and the provider in writing whenever the provider's request for preauthorization for a service is denied. Written notice of the decision to deny initial services must be provided to the member: • within 24 hours of the expedited authorization determination, and • within 72 hours of receipt of the request, and • within 72 hours <u>of the determination</u> for standard requests and outpatient drug decisions. For any previously authorized service, written notice to the member must be provided at least 10 days prior to reducing, suspending, or terminating a covered service. The state-specified threshold for all adverse determination notifications is 95%. A sample of adverse determination notifications must be reviewed for	• UR Plan • UR Policies & Procedures • UR Committee Meeting Minutes • Selected UR Cases • Member Notices • Turnaround Time (TAT) Compliance Reports monthly or quarterly for the entire review period.	42 CFR: • §438.10g COMAR: • 10.67.09.04 HCQIS: • XIII.C 1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.7	The MCO must have written policies and procedures pertaining to member appeals. a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05. b. <i>The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.</i> c. <i>The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes.</i> d. <i>The MCO's appeal policies must include procedures for how the MCO will assist members with the appeal process.</i> e. Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.	There is evidence that appeals are resolved, and notification is provided within the timeframes established by the State. Timeframes for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: - Expedited Appeals must be resolved and written notification of the decision provided within 72 hours of receipt. The MCO must also make reasonable efforts to provide oral notice of the decision. - Standard Appeals must be resolved and written notice provided within 30 days unless extended pursuant to 438.408 b & c. - Appeals may be extended up to 14 days. The MCO must ensure that decision-makers on an appeal were not involved in previous levels of review or decision-making, were not subordinates of decision-makers involved in previous	- UR Organizational Charts - UM Position Descriptions - QM Committee Meeting Minutes - Member Appeals Policies & Procedures - Contract - Appeals Forms & Logs - Appeals Reports including TAT compliance monthly or quarterly for the entire review period. - Appeal Records - Member Notices	42 CFR: §438.402(c)(3)(ii) §438.404(b) §438.406 (a & b) §438.408 (a-f) COMAR: 10.67.09.02 10.67.09.05 HCQIS: - XIII.C 1-7 NCQA: - UM 8 Element A - UM 9 Element A - MED 10 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<i>f. Written notifications to members include appeal decisions that are documented in easy-to-understand language.</i> <i>g. The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.</i>	levels of decision-making, and are health care professionals with clinical expertise in treating the member's condition or disease. The method to collect information for review decisions is documented. A selected sample of member appeals, or provider appeals submitted on behalf of the member, will be reviewed to assure that the policies and procedures are being followed. The state-specified threshold for all member appeal acknowledgment and resolution letters is 95%. A sample of member appeals must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.8	The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.	Compliant with the requirements of COMAR 10.67.09.03, the MCO must have written policies and procedures for provider appeals. The state-specified threshold for all provider appeal resolution is 95%. The MCO must provide evidence that it is monitoring compliance with written acknowledgment, resolution at each level, and written resolution timeframes through routine reports (i.e. weekly, monthly, or quarterly) consistent	- Provider Administrative Appeals Policies & Procedures - TAT Tracking logs for monitoring compliance with written acknowledgment and written resolution of provider appeals	COMAR: 10.67.09.03 HCQIS: - XIII.C 1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are member appeal. c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	with the MCO's policies that includes the compliance percentage for each of the regulatory timeframes. The MCO can include either all provider appeals or a statistically valid sample in reporting compliance. If using a sample, the MCO must use a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The MCO must include in its provider complaint process at least the following elements: An appeal process which: • Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; • Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; • Allows providers 90 business days from the date of a denial to file an initial appeal; • Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; • Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO;	• TAT Compliance Reports for written acknowledgment and written resolution monthly or quarterly for the entire review period.	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Pays claim within 30 days of the appeal decision when a claim denial is overturned; • Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer or the chief executive officer's designee; • Provides timely written notice to the provider of the results of the internal appeal consistent with the timeframe documented in its policies.		
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on member satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using member satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates a review of the data on member satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	The intent of this element is to provide a mechanism for members and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on member and provider satisfaction and/or other appropriate measures. If the MCO conducts any independent surveys, data sources must include both the MCO's independent survey results and MDH-coordinated member and provider satisfaction survey results.	• Member & Provider Satisfaction Policies and Procedures Relating to UR Program • Member and Provider Satisfaction Surveys Evaluating UR Program • Data Reports Evidencing Review of member and provider satisfaction with UR survey results • Trending Reports • Action Plans to specifically address UR satisfaction opportunities for improvement • Committee Meeting Minutes	COMAR: • 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		It is expected that the MCO will review the results of member and provider satisfaction surveys and develop and implement action plans to address identified opportunities for improvement timely in order to have some impact on subsequent survey results.	demonstrating review of member and provider satisfaction survey results, identification of opportunities for improvement, and action plans to address	
7.10 (Formerly 7.7)	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.	"Independent review organization" means an entity that contracts with the Department to conduct independent review of managed care organizations' adverse decisions. The MCO's specific responsibilities under the Maryland Medicaid Managed Care Independent Review Services process are as follows and should be included in the policy and procedure: 1. Establish an online account with the IRO and provide all required information through this account. 2. Upload the complete case record for each medical case review request within five (5) business days of receipt of the request from the IRO. 3. Upload any additional, case-related documentation requested by the IRO within two (2) business days of receipt of notification of a request for additional information from the IRO. 4. Agree to pay the fixed case fee should the IRO rule against the MCO	• Complaint Resolution/IRO Policy & Procedure • MCO Independent Review Organization Agreement • Online Account • Sample Case Record • Logs documenting IRO invoices are paid within 60 days. • Documented process for ensuring IRO invoices are paid within 60 days, such as a policy or desktop procedure	COMAR: • 10.67.13

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		and has a documented process to assure IRO invoices are paid within 60 days per COMAR 10.67.13.07C(2).		
7.11 (Formerly 7.8)	The MCO must have written policies and procedures for establishing a corrective managed care plan for member abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. a. The MCO's policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation. b. The MCO must provide evidence of implementation of the corrective managed care plan.	The MCO must have documented policies and procedures for a corrective managed care plan for abuse of pharmacy benefits consistent with COMAR 10.67.12. An MCO's corrective managed care plan shall cover member abuse of medical assistance pharmacy benefits. For all pharmacy benefit abuse covered by an MCO's corrective managed care plan, the plan shall: • Use the criteria as described in Regulation .01B of this regulation to determine if members have abused benefits; • Provide for a medical review of the alleged abuse consistent with §C of this regulation; • Provide that a member found to have abused pharmacy benefits will be enrolled in the program for 24 months; • Provide that a member who has been enrolled in a 24-month plan and is subsequently found to have abused MCO pharmacy benefits shall be enrolled in the plan for an additional 36 months;	• Corrective Managed Care Plan Policies & Procedures • Corrective Managed Care Plans • Notices to and Correspondence with Members • Evidence of Record Reviews Completed by Licensed Medical Professionals	COMAR: • 10.67.12.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Provide for the MCO to select any participating pharmacy that meets the requirements of COMAR 10.67.12.02B(5) to serve as the member's designated pharmacy provider for members in corrective managed care; • Require a member to obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR 10.67.05.06B and .07C(2) unless the prescription is: a) Pursuant to an emergency department visit; b) Pursuant to hospital inpatient treatment; or c) A specialty drug as defined in COMAR 10.67.06.04; • Provide members determined to have abused pharmacy benefits the ability to suggest pharmacy providers; • Require the MCO to accept the member's suggestion referenced in §B(7) of this regulation unless the MCO determines that the recipient's choice of provider would not serve the member's best interest in achieving appropriate use of the health care systems and benefits available through the MCO;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Provide a member determined to have abused pharmacy benefits 20 days from the date of the notice to present additional documentation to explain the facts that serve as the basis for the MCO's determination of benefit abuse, consistent with §D of this regulation; • Provide for the designation of a new pharmacy provider if the member moves out of the service area of the current pharmacy provider; • Provide for prompt reporting to the Department the name of any member enrolled in the MCO's program, the duration of enrollment, or any change in the duration of enrollment; and • Be submitted to the Department for review and approval: a) Within 60 days of the effective date of this regulation; and b) Before the implementation of any modification.		

Standard 8: Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management (CM).

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
8.1	Members with special needs and/or those with complex health care needs must have access to CM according to established criteria and	The MCO must have policies and procedures in place to identify members with special needs and/or complex health care needs, such as diabetes, severe asthma and high-risk pregnancy, and to	• CM Plan • CM Criteria/ • Standards • CM Policies & Procedures	42 CFR: • <u>§438.208(b)</u> • §438.208(c)(1,2) COMAR:

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	must receive the appropriate services.	enroll them into CM according to the MCO's established criteria. This system must allow the member to access the appropriate services provided by the MCO. Per COMAR 10.67.04.04B, special needs populations are identified as: 1. Children with special health care needs. 2. Individuals with a physical disability. 3. Individuals with a developmental disability. 4. Pregnant and postpartum women. 5. Individuals who are homeless. 6. Individuals with HIV/AIDS. 7. Children in State supervised care. Specifically, the MCO has documented evidence of the following: • CM Plan that describes the MCO's CM program and/or CM policies and procedures. • CM criteria and/or standards for the following: ○ Identification of children and adult members with special needs ○ Assessments ○ Plans of care ○ Caseload • Committee reporting structure.	• CM Cases • Committee Meeting Minutes (e.g., QA/UR) • Job Descriptions • Reports and Analysis • Orientation/ • Training Materials	• 10.67.04.04-11

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		- Minimum qualifications for case managers and case manager supervisors. - Orientation/Training for case managers. - Number of FTEs allocated for CM.		
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering Health Services Needs Information (HSNI) data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	There is documented evidence of HSNI: - data collection methodology - data analysis activities, and - evidence that follow-up based on the results of the analysis is occurring in a timely manner. If MDH does not transmit HSNI for a member to the MCO within 10 calendar days of enrollment, the MCO shall make at least two attempts to conduct an initial screening of the member's needs, within 90 calendar days of the effective date of enrollment. At least one of these attempts shall be during non-working hours. If the MCO does not receive the HSNI within the 10-day window, the MCO should attempt to perform the screening. NOTE: The HSNI is completed at the time of enrollment into HealthChoice and this data is sent to the MCO from the state. The HSNI is NOT the Health Risk Assessment (HRA) performed by CM.	- HSNI Policies & Procedures - Reports and Analysis of TATs	42 CFR: <u>§438.208(b)(3)</u> COMAR: 10.67.02.03 10.67.05.07
8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health	The MCO must have policies and procedures in place to assure the coordination of services for its members, including coordination of care/services	Continuity of Care Policies & Procedures	42 CFR: §438.208(b)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	programs, and other frequently involved community-based organizations (CBOs).	with the member's PCP, LHDs (ACCU/Ombudsman, and transportation), school-based health centers, and other CBOs where coordination with the MCO is necessary to ensure member services are coordinated. Other CBOs might include Chase Brexton for HIV/AIDS, homes and domestic violence shelters, etc. Collaboration with other department activities such as quality and outreach.		
8.4	<i>The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).</i>	There is documented evidence of monitoring activities. This includes the collection and analysis of data.	- Continuity of Care Policies & Procedures (e.g. hospitalizations, prenatal care) - Data Analysis - QA & UR Committee Meeting Minutes	NCQA: QI 3 Element A
8.5	The MCO must monitor the effectiveness of the CM Program.	- Methodology to evaluate the effectiveness of the CM program. - Methodology for monitoring the plans of care. - Methodology for evaluating plans of care.	- CM Evaluation Studies - Analysis and Reports - Computer Screen Shots of CM Software or Actual Demonstration of CM System - Case Records	42 CFR: <u>§438.208(b)</u> COMAR: <u>10.67.04.03</u> <u>10.67.04.04-11</u> <u>10.67.06.01B</u>
8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.	The MCO has policies and procedures for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation through documentation of coordination in member records.	- Coordination with Behavioral Health and Substance Use Vendors Policy and Procedures - Member Records	COMAR: <u>10.67.04.14E</u> MCO Agreement: - Section II.G

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		For members with behavioral health conditions, coordination of care should include but not be limited to: - Cooperation with the Department's high utilizer pilot program, - Assistance with the development and coordination of appropriate treatment plans for Members - Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, - Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and - Provider education for Member identification and referrals to the Administrative Services Organization (ASO) or core service agencies for behavioral health services.	- Provider Education Materials - Provider Newsletters - Screenshots of the MCO's website - Provider Manual	
8.7	The MCO must comply with providing the Continuity of Health Care Notice to members and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by members.	The MCO has policies and procedures for complying with the Continuity of Health Care Notice and provides documentation of compliance. Evidence of compliance is not showing the Continuity of Health Care Notice in the Member Handbook. Examples of evidence may be derived from care management notes, documentation of single case agreements with out-of-network providers, member letters to show continued approval of a service	- Policies & Procedures - Care management notes, single case agreements with out-of-network providers, member letters	Ins. Art.: §15-140(f) MDH Provider Transmittal: (PT) 12-99 (PT) 22-05

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		received through an out-of-network provider, etc.		

Standard 9: Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the member population.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.1	The MCO has a comprehensive written Health Education Plan (HEP), which must include: a. The education plan’s purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying members and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and members.	The MCO’s HEP must contain all of the components listed in a-d. There must be an indication of how the objectives were established. MCOs may review these resources for guidance in developing/improving its HEP: Cultural and Linguistic Competency, Health Disparities and Health Literacy Training Modules AHRQ: Health Literacy Tools AHRQ: Health Literacy Publications	• HEP Description • Health Education Schedule of Events • Health Education Work Plan • Health Education Materials • Member/Provider Notification Methodology • Samples of member and provider notifications of available educational activities. • Descriptions of group and individual educational activities targeted at both members and providers	COMAR: • 10.67.03.09
9.2	The HEP incorporates activities that address needs identified through the analysis of member data.	The MCO must provide evidence that member data were analyzed to determine the need for certain health education programs.	• HEP • Member Data Analysis • Health Education Calendar of Events	COMAR: • 10.67.03.09

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.3	The MCO's HEP must: - Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. - Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. - Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals.	The HEP must describe the qualifications of the staff or external providers that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietitian, or certified mental health provider). The education plan must describe how a provider can access a health educator/educational program through the MCO (e.g., the MCO may designate a contact person to assist the provider in connecting the member to a health educator or program).	- Data Analysis and Studies - HEP and Work Plan - Impact Evaluation Methodology that includes process and outcome measures - Annual evaluation of the impact of the HEP on process and/or outcome measures - Provider Manual - Provider newsletters - Sample of provider referrals of members for health education - Job descriptions of health education staff - Brochures of health education programs from external organizations demonstrating qualifications of program presenters.	COMAR: 10.67.03.09
9.4	The MCO must have mechanisms in place to identify members in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.	Mechanisms to identify members in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the member with complex medical needs, the homebound member, and the noncompliant member with health issues.	- Special Educational Need Identification Mechanisms - Evidence that mechanisms are in place and functioning to identify members in special need of education efforts	COMAR: 10.67.03.09

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	Note: This component is not limited to individuals in a special needs population.			
9.5	The MCO must make the education program available to the member population and demonstrate that members have attended. The MCO must provide: - Samples of notifications, brochures, and mailings. - Attendance records and session evaluations completed by members. - Provider evaluations of health education programs.	The MCO must demonstrate that members are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate member educational sessions and the overall health education program.	- Member Mailings such as brochures, postcards, flyers - Member attendance records - Completed Session <u>Evaluations by individual attendees (aggregate results are not an acceptable option)</u> - Program Evaluations - Completed Provider Evaluations of the MCO's health education programs, <u>such as surveys of providers or review/discussion of the MCO's HEP at provider advisory committee meetings.</u>	COMAR: <u>10.67.03.09</u>

Standard 10: Outreach Plan (OP) – The MCO has developed a comprehensive written outreach services plan to assist members in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
10.1	The MCO has developed a written OP that describes the following: a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. b. MCO's organizational capacity to provide both broad-based and member-specific outreach. c. Unique features of the MCO's member outreach initiatives. d. Community partnerships. e. Role of the MCO's provider network in performing outreach. f. MCO's relationship with each of the LHDs and Administrative Care Coordination Units (ACCUs).	Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the individual MCO's approach to providing outreach. This written plan must provide an overview of outreach activities that include components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum, the populations must include: • Those in need of wellness/preventive services. • Those children eligible for EPSDT services. • Those members (both adults and children) who are difficult to reach or miss appointments. • Those members comprising the following special populations defined in COMAR 10.67.04.04 B: 1) Children with special health care needs. 2) Individuals with a physical disability. 3) Individuals with a developmental disability. 4) Pregnant and postpartum women.	• Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts	COMAR: • 10.67.04.04 • 10.67.04.25 • 10.67.05.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		5) Individuals who are homeless. 6) Individuals with HIV/AIDS. 7) Children in State supervised care. The OP must briefly describe common health problems within the MCO's membership (i.e., diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, member services, CM, DM, health education, and delegated entities in the performance of outreach activities. The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software used to identify, track, and report outreach activities.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The OP briefly describes any unique educational activities related to the populations served, such as: • Languages in which materials are printed and availability of interpreter services. TTD/TTY services for those who are hearing impaired. • Any unique educational activities such as CM or DM programs related to special populations (e.g., mother/baby programs, substance abuse programs for pregnant women, asthma management programs, etc.). • Any other unique services related to education. The OP briefly describes any community partners and their role in providing outreach activities to assist the MCO in bringing members into care (e.g., church groups, YMCA, homeless shelters, community-based school programs, parks and recreation programs, medical societies and/or associations such as the American Diabetes Assoc., etc.). The community partner may provide educational health fairs or screenings, educational materials, speakers, personnel who assist the member in completing necessary medical paperwork or who assist the member in		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		locating special services to facilitate bringing the member into care, etc. (Do not include the role of the local health departments, since they are addressed in 10.1f) The OP must include a brief description of the role and responsibilities of providers for participating in outreach activities. The OP must demonstrate the MCO's relationship with the LHD/ACCU regarding collaborative efforts being undertaken (i.e. methods of referral). The description must include: • The LHD's responsibilities in outreach. • How results of the LHD's efforts are conveyed to the MCO.		
10.2	The MCO has implemented policies and procedures for: - The provision of outreach services for new and existing members for wellness/preventive health services. - Deleted in MY 2019. - The provision of outreach via telephone, written materials, and face-to-face contact. - Monitoring of all outreach activities, including those	There must be evidence that the MCO has policies and procedures implemented for each of the activities in 10.2 a-d. The MCO identifies those members in need of wellness/preventive services and initiates activities to encourage the utilization of these services. There is evidence that the MCO implements a system to track and monitor access to these services. For example, the MCO identifies and notifies members of due dates for preventive services such as	• Data Reports • Outreach Logs • Member Mailings • Educational Materials • LHD Reports	COMAR: • 10.67.05.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	delegated or subcontracted to other entities.	mammograms and cervical cancer screenings through reminder notices such as letters or postcards. The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that these processes are being followed. There must be evidence that the MCO utilizes a systematic process to provide outreach services that employ: • Telephone contact. • Written materials. • Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with members, the MCO must have a mechanism for monitoring outcomes of these activities (i.e., number of members referred for LHD outreach and number successfully reached).		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
10.3	The MCO has implemented strategies: a. Deleted in MY 2019. b. Deleted in MY 2019. c. To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services. d. To bring members into care who are difficult to reach or who miss appointments.	There must be evidence that the MCO has implemented strategies to provide outreach to the populations in 10.3 c and d. The MCO identifies and tracks children (up to 21 years of age) who are eligible for EPSDT services or treatment. The MCO identifies those members due for services, members who miss appointments, and non-compliant members. There is evidence that the MCO provides outreach to schedule those children in need of EPSDT services and/or to bring those children who miss appointments into care.	• Outreach Work Plan • Data Reports • Tracking/Referral logs • Member Mailings • Provider Mailings	COMAR: • 10.67.05.03

Standard 11: Fraud and Abuse – The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:	The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed policies, procedures, education, and training. The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission,	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Compliance Officer Job Description and Qualifications • Compliance Committee Membership	42 CFR: • §438.608 COMAR: • 10.67.07 • 31.04.15 CMS: • Publication – “Guidelines for Constructing a

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. b. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, members, and providers. e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a	claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/member education materials. The MCO documents its processes used to detect and identify incidences of fraud and abuse. The MCO documents its processes used to ensure services were actually provided to the member. There must be evidence of the process such as policies and procedures, reports, trending, meeting minutes, studies, call scripts, data results, etc.	- Compliance Committee Meeting Minutes - Communication Between Compliance Officer & Compliance Committee - Routine and Random Audit Reports for Fraud and Abuse - Reports tracking the receipt and dispensation of all incidences of reported suspected fraud and abuse <u>Report presented for Verification of Services.</u>	Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" Resource Handout - "Medicaid Managed Care: Compliance Program Requirements" HealthChoice Managed Care Organization Agreement

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were actually received by the member.			
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and members the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse.	The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and members to sanction fraud and abuse offenses. The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and members to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Staff orientation, education, and training protocols pertaining to fraud and abuse • Sign-in rosters for employee training sessions regarding fraud and abuse • <u>Report presented for Verification of Services.</u>	42 CFR: • §438.608 COMAR: • 10.67.07 • 31.04.15 CMS: • Publication – “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” • Resource Handout - “Medicaid Managed Care: Compliance Program Requirements” HealthChoice Managed Care

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. e. A documented process for enforcement of standards through clear communication of well-publicized guidelines to members regarding sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal. g. A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal. h. A documented process for reporting by members of the MCO suspected fraud and abuse within the organization without fear of reprisal.			Organization Agreement
11.3	The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent	The MCO documents its processes for reporting and tracking suspected incidences of fraud and abuse to the appropriate State and Federal agencies within the appropriate timeframes and its cooperation with those agencies investigating those alleged incidents.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Documentation of reported incidences of	42 CFR: • §438.608 COMAR: • 10.67.07 • 31.04.15

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	activities, and abusive patterns. It must include: a. A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report. b. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse are investigated.		fraud and abuse to State Medicaid Agency Documentation of collaboration and cooperation with the State Medicaid Fraud Control Unit	CMS: - Publication – “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” - Resource Handout- “Medicaid Managed Care: Compliance Program Requirements
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP.	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	- Compliance Committee Minutes - Routine and Random Fraud and Abuse Reports - CAPs - CAP Implementation Reports - Delegate Fraud and Abuse Reports	42 CFR: \$438.608 COMAR: 10.67.07 31.04.15 CMS: - Publication – “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. Evidence of the Compliance Committee’s review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.			and Prepaid Health Plans” Resource Handout - “Medicaid Managed Care: Compliance Program Requirements
11.5 (Formerly 2.8)	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies. b. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO’s equity. c. An MCO must have written policies and procedures ensuring that it does not have an individual	An MCO may not have a relationship with an individual or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. An MCO may not have an affiliation with an individual or entities who have been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation. Checks of all databases are required at the time of initial credentialing and recredentialing.	- Governance Policies & Procedures - Subcontracting and Employment Policies & Procedures - Evidence of database checks	42 CFR: \$438.610(a) \$438.610(b) \$438.610(c) \$455.436 COMAR: 10.67.03.03 10.67.07.03G Office of the Federal Register: Executive Orders

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	or entities debarred by Federal Agencies with an employment, consulting, or other arrangement with the MCO. d. An MCO must provide evidence of initial and monthly checks of the following databases as applicable: National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM. e. An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.	Monthly checks of the following databases are required: List of Excluded Individuals/Entities and Excluded Parties List Systems/SAM; <u>Social Security Death Master File post enrollment and at recredentialing.</u>		

Standard 12: Disenrollment Requirements and Limitations – The provisions for disenrollment apply to all managed care programs whether enrollment is mandatory or voluntary. This includes state contracts with MCO, PIHP, PAHP, PCCM, or PCCM entities. MCO policies and procedures must address the federal and state requirements for enrollee disenrollment when initiated by the Department, the MCO, and the enrollee. Policies and procedures must specify when disenrollment is for cause and without cause, methods for communicating requests for disenrollment, and the timeliness of disenrollment procedures.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
12.1	The MCO may request disenrollment for an enrollee from the <u>HealthChoice program in accordance with federal and state regulations.</u> a. <u>MCO policies and procedures specify the reasons for which the</u>	An MCO and the Department may request disenrollment of an enrollee who: <u>Becomes ineligible for continued enrollment due to any of the following reasons:</u>	<u>MCO Disenrollment Policies & procedures</u> <u>Member Handbook</u>	<u>§438.56 (a), (b) and (c).</u> COMAR: <u>10.09.69.REM</u> <u>10.67.02.05</u> <u>10.67.02.06(A)</u> <u>10.67.02.06(B)</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	MCO and the Department may request enrollee disenrollment. b. The MCO submits to the Department, within thirty (30) days of discovering a discrepancy, a list of Enrollees who are known to the MCO to have reasons to be disenrolled for any reason listed in the referenced COMAR regulations from the HealthChoice Program.	○ <u>Moves outside of the MCO's services area.</u> ○ <u>Becomes ineligible for continued enrollment due to medically necessary placement in a long-term care facility for more than 90 successive days.</u> ○ <u>Is admitted to an intermediate care facility (ICF) for individuals with intellectual disabilities (IID) or persons with related conditions.</u> ○ <u>Is eligible for rare and expensive case management (REM) pursuant to COMAR 10.09.69.</u> ○ <u>Loses Medicaid eligibility</u> ○ <u>Changes to an assistance category not eligible for MCO enrollment.</u> ○ <u>Dies.</u> ○ <u>Is not validly enrolled in the MCO.</u> ○ <u>Is 65 years of age or older.</u> ○ <u>Is eligible to receive Medicare benefits</u> ○ <u>Is an inmate of a public institution, including a State operated institution or facility.</u> <u>The Department must allow disenrollments, subject to the Department's approval, for other reasons including but not limited to:</u> • <u>Poor quality of care</u>		• <u>10.67.02.06(D)</u> • <u>10.67.04.15(C)(2)</u> MCO HealthChoice Agreement: • <u>Appendix Q B 4-5</u>

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• <u>Lack of access to services covered under the contract</u> • <u>Access to providers experienced in dealing with the enrollee's health care needs.</u> Note: MCOs must report any discrepancies to mdh.hcenrollment@maryland.gov for resolution.		
12.2	<u>MCO policies and procedures specify the reasons the MCO is prohibited from requesting enrollee disenrollment.</u>	Federal regulation prohibits an MCO from requesting enrollee disenrollment based on any of the following: • <u>An adverse change in the enrollee's health status.</u> • <u>The enrollee's utilization of medical services (overutilization and underutilization).</u> • <u>An enrollee's, diminished mental capacity</u> • <u>An enrollee's uncooperative or disruptive behavior resulting from his or her special needs. (An exception applies when the enrollee's continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees).</u>	• <u>MCO Disenrollment Policies & procedures</u> • <u>Enrollee Handbook</u>	42 CFR: • <u>\$438.56(b)(2)</u>
12.3	<u>The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for</u>	<u>An example of a method used to assure that the plan does not inappropriately disenroll a HealthChoice enrollee could be a checklist documenting acceptable and unacceptable reasons for</u>	• <u>Disenrollment Policy & procedures</u>	42 CFR: • <u>\$438.56(b)(3)</u> MCO HealthChoice Agreement:

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	<u>reasons other than those permitted under the contract.</u>	<u>disenrollment. These variables would be derived from Federal and State regulation, and the MCO/State contract language as identified in the references section for this element.</u>		<u>Appendix Q</u>
12.4	The MCO must have policies and procedures for notifying enrollees when, (1) the MCO terminates its contract with the state, and (2) when the MCO is acquired by another entity. In these instances, the MCO must: a. <u>Provide written notice to the enrollee at least 60 days before the date on which the MCO will exit the HealthChoice Program, or when the MCO is acquired by another entity.</u> b. <u>Include in the written notice to the enrollee, the name and provider number of the PCP assigned to the recipient and the telephone number of the enrollment broker.</u>	<u>The enrollee may have only one request to disenroll during the first 90 days of automatic assignment or initial enrollment into an MCO. The enrollee cannot be hospitalized at the time of the request. If the enrollee does not choose to make this request as per the above, the enrollee will be re-enrolled in the new or newly purchased MCO.</u> <u>If there is a change of MCO ownership, and the enrollee does not choose to disenroll in accordance with §A(1)(f)(ii) of this regulation, the enrollee will be reenrolled in the newly purchased MCO.</u>	<u>MCO Disenrollment Policies and procedures</u>	COMAR: <u>10.67.02.06(A)</u>

Crosswalks

Deeming Eligibility

Systems Performance Review Standards	Elements and Components Eligible for Deeming
Standard 1: Systematic Process of Quality Assessment and Improvement	1.3b, 1.3c, 1.3d, 1.3e, 1.3g, 1.3h, and 1.8
Standard 2: Accountability to the Governing Body	No elements/components are eligible for deeming.
Standard 3: Oversight of Delegated Entities and Subcontractors	No elements/components are eligible for deeming.
Standard 4: Credentialing and Recredentialing	4.1 and 4.7
Standard 5: Enrollee Rights	5.3a, 5.6a, and 5.8a
Standard 6: Availability and Accessibility	6.1b, 6.2a, 6.2b, 6.2c, and 6.2d
Standard 7: Utilization Review	7.1a, 7.1b, 7.1c, 7.2a, 7.2b, 7.2c, 7.2d, 7.2f, 7.4a, 7.7b, 7.7c, 7.7d, 7.7f, and 7.7g
Standard 8: Continuity of Care	8.4
Standard 9: Health Education Plan	No elements/components are eligible for deeming.
Standard 10: Outreach Plan	No elements/components are eligible for deeming.
Standard 11: Fraud and Abuse	No elements/components are eligible for deeming.
Standard 12: Disenrollment	No elements/components are eligible for deeming.

Standards are evaluated and compared to NCQA health plan accreditation standards and MCO performance to identify qualifications for deeming.

SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk

Standards	Availability of Services	Assurances of Adequate Capability and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Subcontractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Protect	Disenrollment
CFR Reference	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330	438.56
1: Systematic Process of Quality Assessment and Improvement	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
2: Accountability to the Governing Body	No	No	No	Yes	No	No	No	No	No	No	Yes	Yes
3: Oversight of Delegated Entities and Subcontractors	No	No	No	No	No	No	Yes	Yes	No	No	Yes	Yes
4: Credentialing and Recredentialing	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No	Yes	Yes
5: Enrollee Rights	Yes	No	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes
6: Availability and Accessibility	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	Yes	Yes
7: Utilization Review	Yes	No	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
8: Continuity of Care	Yes	No	Yes	No	No	No	No	No	No	Yes	Yes	Yes
9: Health Education Plan	Yes	No	Yes	No	No	No	No	No	No	No	Yes	Yes
10: Outreach Plan	Yes	No	Yes	No	No	No	No	No	No	No	Yes	Yes
11: Fraud and Abuse	No	No	Yes	Yes	Yes	No	Yes	No	No	No	Yes	Yes
12: Disenrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix C: Hilltop's MY 2024 Encounter Data Validation Report



The Hilltop Institute UMBC

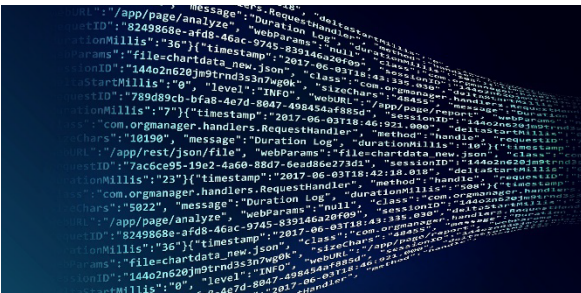


EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2022 to CY 2024

report



December 23, 2025



Suggested Citation: The Hilltop Institute. (2025, December 23). *EQR protocol 5, activity 3: Validation of encounter data, CY 2022 to CY 2024*. Baltimore, MD: UMBC.

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2022 to CY 2024

Table of Contents

Draft Executive Summary.....	i
Methods	i
Results	ii
Recommendations.....	iv
Introduction	1
Activity 3. Analysis of Electronic Encounter Data	2
Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements	4
Methodology.....	4
8ER Analysis	4
Claim Status “X” Methodology for HFMR.....	6
Results	6
Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity.....	15
Methodology.....	15
Results	15
Managed Care Regulations: Accurate and Complete Encounter Data.....	19
Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports.....	26
Methodology.....	26
Results	27
Time Dimension Analysis.....	27
Service Type Analysis.....	29
Outlier Data Analysis.....	30
Step 4. Compare Findings to State-Identified Benchmarks	31
Recommendations.....	32
Conclusion	33
References	35
Appendices	
A. Reporting Instructions for the Final CY 2024 HealthChoice Financial Monitoring Report (HFMR) and Supplemental Financial Data Reports	36
B. CY 2024 HFMR Denied Encounter and Zero Pay Encounter Files	38

C. Denial Codes, Errors, by Category with Provider-Related and Other Denial Codes, CY 2024	40
D. Percentage of Encounters Denied by MMIS Denial Category, by MCO, CY 2024.....	42
E. Top Three MMIS Denial Descriptions by Number of Denied Encounters by MCO, CY 2024	43
F. Number and Percentage of Accepted Encounters by Claim Type and MCO, CY 2024	44
G. Percentage of the Total Number of Accepted Encounters Submitted by Claim Type and Processing Time, CY 2022–CY 2024.....	45
H. Distribution of Accepted Encounters Submitted by MCO and Processing Time, CY 2024	46
I. Delivery Codes.....	47
J. Dementia Codes	48

List of Tables and Figures

Tables

1. Distribution of Denied Encounter Submissions by MMIS Denial Category, CY 2019–CY 2024	8
2. Distribution of Denied and Accepted Encounter Submissions by MCO, CY 2022–CY 2024	9
3. Percentage of Denied Encounters by MMIS Denial Category by MCO, CY 2024	10
4. Number and Percentage of Denied Encounters by MMIS Denial Category and MCO, CY 2022–CY 2024	12
5. Number of Denied Encounters for Provider Enrollment-Related and Other Denial Types by MCO, CY 2024	14
6. Distribution of Accepted Encounters by Claim Type and MCO, CY 2022–CY 2024	18
7. Percentage of HealthChoice Participants and Accepted Encounters by MCO, CY 2022–CY 2024	19
8. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2022–CY 2024	29
9. Number and Percentage of Inpatient Visits, ED Visits, and Observation Stays by MCO, CY 2022–CY 2024	30

Figures

E1. Total Number of Denied Encounters, CY 2019–CY 2024.....	ii
1. Number and Percentage of Accepted Encounters by Claim Type, CY 2022–CY 2024	17
2. Number of Accepted Institutional Encounters by MCO and Provider Reimbursement Category, CY 2022–CY 2024	21
3. Number of Accepted Medical Encounters by MCO and Provider Reimbursement Category, CY 2022–CY 2024	22
4. Accepted Medical Encounters with \$0 Provider Reimbursement Data by Reporting Indicator (05/09) and MCO, CY 2024	23
5. Accepted Institutional Encounters with \$0 Provider Reimbursement Data by Reporting Indicator (05/09) and MCO, CY 2024.....	24
6. Number of Accepted Encounters Submitted by Processing Time, CY 2022–CY 2024	28

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2022 to CY 2024

Executive Summary

HealthChoice is Maryland's mandatory managed care system for Medicaid and the Children's Health Insurance Program (CHIP), covering close to 90% of enrollees in calendar year (CY) 2024. Participants select or are assigned a managed care organization (MCO) and primary care provider, receiving benefits equivalent to fee-for-service (FFS) Medicaid.

Since 2018, The Hilltop Institute at UMBC has worked with Qlarant, Maryland's external quality review organization (EQRO), to evaluate MCO electronic encounter data for validation as required by the Centers for Medicare & Medicaid Services (CMS). The analysis performed by Hilltop, under contract with the Maryland Department of Health (the Department), is Activity 3—analyzing electronic encounter data of the CMS External Quality Review (EQR) Protocol 5. This process focuses on the completeness, accuracy, and quality of encounter data for program monitoring, policy decisions, and capitated rate setting. This report covers CY 2022 to CY 2024. Activity 3 requires the following four steps:

1. Develop a data quality test plan based on data element validity requirements
2. Encounter data macro-analysis—verification of data integrity
3. Encounter data micro-analysis—generate and review analytic reports
4. Compare findings to state-identified benchmarks

Methods

Hilltop evaluated electronic encounter data submitted by the MCOs for CY 2022 to CY 2024, focusing on two validation areas: 1) the Department's processing of submitted encounters before acceptance and 2) review of the accepted encounter data. Documentation covered the Department's electronic data interchange (EDI) and the Medicaid Management Information System (MMIS).

Hilltop developed a test plan for data quality validation, examining failed or denied encounters during the edit checks and analyzing the reasons for denials using the 8ER report, which contains all denied encounters, including those later reversed. The report details exception codes for denied encounters, categorized as duplicate, inconsistent, missing, not eligible, not valid, and provider enrollment-related errors.¹ The provider enrollment errors are primarily linked to the implementation of the National Provider Identifier (NPI) crosswalk and the Department's provider master file edits starting in 2020.

In response to the high volume of denied encounters, Hilltop developed a methodology to identify and de-duplicate denied encounters from MMIS data—a process not performed with

¹ Provider Enrollment codes: 122, 412, 951, 961, 962, 963, 964, 965, 971, 975, 976.

the 8ER report. In collaboration with the Department and MCOs, Hilltop implemented measures to reduce the denial rates linked to the limited-risk NPI uncollapsing.² Furthermore, Hilltop examined denied encounters for risk adjustment in capitated rates using data from CY 2023 and CY 2024, transmitted data to the state’s auditor for review and assessed the impact on HealthChoice Financial Monitoring Report (HFMR) results.

Hilltop verified that the state’s identifiers (IDs)³ are accurately incorporated into the MCO information system, key data fields are populated, and data quality is maintained. Hilltop reviewed provider reimbursement for \$0 pay encounters and reporting indicators of 05 (sub-capitated), 09 (denied), and no indicator. Hilltop also investigated the third-party liability (TPL) variable in MCO encounters.

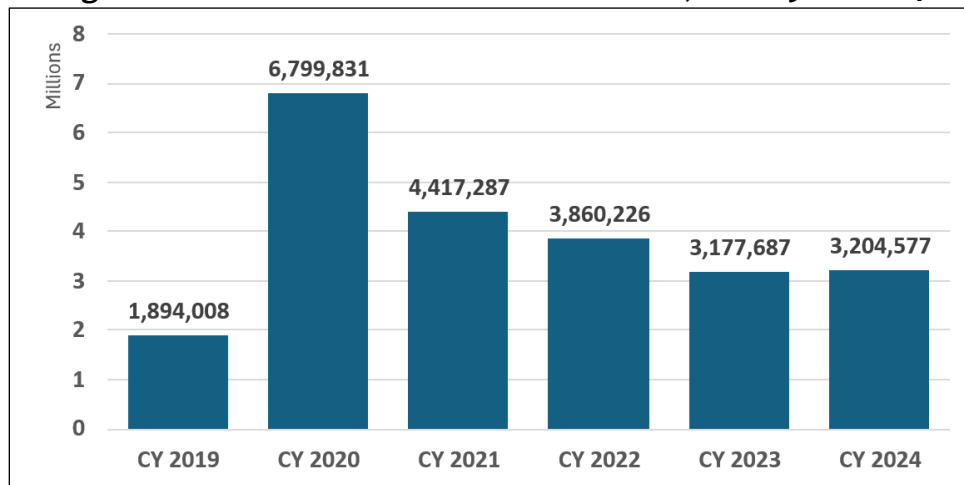
In addition, Hilltop reviewed accepted encounters and analyzed the volume and consistency of encounters submitted over time, utilization rates, data accuracy and completeness, and the timeliness of MCOs’ submissions to the Department.

Results

Denied Encounters: 8ER Report

Encounter data denials increased 259% from CY 2019 to CY 2020, then decreased by 35% in CY 2021 and by 17% from CY 2022 to CY 2024. As a percentage of all encounters submitted, however, the share of denials declined from CY 2022 to CY 2023 and remained stable in CY 2024. Figure E1 shows the total number of encounters denied from CY 2019 through CY 2024.

Figure E1. Total Number of Denied Encounters, CY 2019–CY 2024



² “NPI uncollapsing” refers to a health care data management initiative where each physical service location of a provider or organization is required to have its own unique NPI rather than share a single NPI across multiple locations. Historically, many health care organizations used one NPI for multiple locations (i.e., they “collapsed” all locations under one identifier). The uncollapsing process reverses this by assigning distinct NPIs to each location.

³ Recipient original ID (recipno), first date of service (begdos), last date of service (enddos), ICN, pay to provider number (prov), icd10 diagnosis codes, icd10 procedure codes, billdate.

Provider enrollment issues were the main reason for denials (previously included in not valid denials), accounting for between 42% and 74% of denials for each MCO in CY 2024. Other contributing factors included missing data and participant ineligibility.

Accepted Encounters: Claim Type and \$o Pay

In CY 2024, MCOs submitted 46.5 million accepted encounters, an increase from 45.8 million in CY 2023 and 45.6 million in CY 2022. Approximately 93.5% of encounters were accepted into MMIS in CY 2024, consistent with the rate during CY 2023 and slightly higher than the acceptance rate of 92.2% in CY 2022. The denied encounters are not deduplicated, so when these encounters are de-duplicated, the acceptance rate rises considerably. Claim type distribution remained consistent, with physician claims making up nearly two-thirds of all claims and pharmacy claims about one-quarter. Inpatient hospital stays, community-based services, and long-term care services accounted for less than 1% of services. The distribution of accepted encounters remained stable across MCOs and calendar years. Provider reimbursement data for institutional and medical encounters were variable in the completeness and accuracy of \$0 pay encounters and associated reporting indicators (sub-capitated or denied). Adherence to the requirement that encounters with \$0 provider reimbursement include a reporting indicator varied significantly among the MCOs during CY 2024. Finally, Hilltop found that reporting of TPL payments remains inconsistent and observed issues with mapping of TPL into the expected EDI format. There was a small set of encounter records that processed TPL amounts incorrectly, leading to incorrect reporting of \$0 pay amounts.

Accepted Encounters: Analytic Reporting

Hilltop analyzed encounter data by reviewing submitted fields, data volume, and consistency in three key areas: time, service type, and age-appropriate diagnosis and procedure codes. Providers are required to submit claims to MCOs within six months of the date of service, and the MCOs are required to submit encounters within 60 days of claim receipt. Together, these requirements establish a maximum processing time of eight months from date of service. Although MCOs have shown mixed performance in timely submissions, late submissions (>6 months) have decreased. In CY 2024, only ABH, MSFC, and UHC increased the percentage of encounters submitted within 1 to 2 days compared to CY 2022.

Rates of inpatient hospitalizations increased slightly, while both observation stays and emergency department (ED) visits remained stable over the evaluation period. Outlier data analysis identified few encounters that varied for participants over age 65 (ineligible for HealthChoice), participants with service dates before birth, and age-inappropriate delivery and dementia diagnoses. In addition, Hilltop examined behavioral health encounter duplicates submitted both as encounters and FFS claims.

Recommendations

While the MCOs have shown improvement in their encounter data submissions during the evaluation period, Hilltop recommends that the Department focus on these areas for continued improvement:

- Continue collaboration with MCOs to resolve provider enrollment and NPI crosswalk issues and reduce denials.
- Minimize denied encounters resulting from limited-risk NPI uncollapsing. MCOs should work with their provider networks to use correct NPIs in claim submissions and promptly update systems when new NPIs are assigned.
- Enforce adherence to \$0 reimbursement reporting indicator requirements. Consider additional reporting indicators to account for TPL or other reasons for \$0 reimbursement beyond provider denial and sub-capitation.
- Continue to develop and review the resolution to address the TPL variable in encounters not being captured consistently nor mapped into the expected EDI format.
- On a quarterly basis, share data regarding behavioral health claims paid both by the MCO and the behavioral health administrative services organization; require MCOs to prove that duplicate payments have been retracted.
- Flag MCOs with late encounter submissions beyond eight months for improvement.

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2022 to CY 2024

Introduction

HealthChoice—Maryland’s statewide mandatory Medicaid and Children’s Health Insurance Program (CHIP) managed care system—was implemented in 1997 under the Social Security Act’s §1115 waiver authority and provides participants with access to a wide range of health care services arranged or provided by managed care organizations (MCOs). In calendar year (CY) 2024, close to 90% of the state’s Medicaid and Maryland Children’s Health Program (MCHP) populations were enrolled in HealthChoice. HealthChoice participants are given the opportunity to select an MCO and primary care provider from their MCO’s network to oversee their medical care. If they do not select an MCO or primary care provider, one is automatically assigned. HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid (including MCHP) participants through the fee-for-service (FFS) system.

In addition to providing a wide range of services, the HealthChoice program aims to improve the accessibility and quality of health care services delivered to participants by the MCOs. The Maryland Department of Health (the Department) contracted with The Hilltop Institute at UMBC to analyze and evaluate the validity of encounter data submitted by the MCOs. Hilltop has supported the Department with monitoring and improving the quality and integrity of encounter data submissions since the inception of HealthChoice.

In 2012, the Centers for Medicare & Medicaid Services (CMS) issued external quality review (EQR) protocols to states receiving encounter data from MCOs, including eight protocols—three mandatory and five optional—focused on encounter data for quality, timeliness, and access to health care services (CMS, 2012). In April 2016, CMS released its final rule on managed care,⁴ which introduced a new regulation mandating that states require their MCOs to submit encounter data that complies with specified standards, formatting, and criteria for accuracy and completeness.⁵ This rule required substantive changes to the EQR protocols⁶ and provided an opportunity to revise the protocol design. Updated protocols were released in 2019 to assist states and external quality review organizations (EQROs) in improving the technical reports. Hilltop found that the new final rule released in November 2020 did not include substantive changes to the EQR regulations.⁷ In 2023, CMS released new EQR Protocol 5 requirements; however, there were no changes to activity for data validation (CMS, 2023). Hilltop reviewed the managed care final rule released in May 2024, which revealed that CMS is required to issue

⁴ Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

⁵ 42 CFR § 438.818.

⁶ 42 CFR § 438.350–438.370; 457.1250.

⁷ Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

protocols to ensure states' EQR technical reports incorporate outcomes data, quantitative assessments results, and validation information.⁸ States are required to begin implementation within one year of CMS publishing the protocols; Hilltop will continue to monitor CMS's release of the updated protocols.

In 2018, the Department asked Hilltop to collaborate with Qlarant, Maryland's EQRO, to annually evaluate all electronic encounter data submitted by the MCOs as part of the validation activity. Hilltop serves as the Department's data warehouse and evaluates all Maryland Medicaid encounter data, providing data-driven policy consultation, research, and analytics. Hilltop's analysis of Activity 3—analyzing electronic encounter data of the CMS EQR Protocol 5—is central to validating and ensuring the completeness, accuracy, and quality of data.

The following are the five required activities of CMS EQR Protocol 5:

- Activity 1: Review state requirements
- Activity 2: Review MCO's capability
- Activity 3: Analyze electronic encounter data
- Activity 4: Review of medical records
- Activity 5: Submission of findings

The Department required the MCOs to submit all CY 2024 encounters by June 20, 2025. In July 2025, Hilltop reviewed the 2023 CMS EQR Protocol 5 and found no changes. Hilltop also participated and presented at Encounter Data Workgroup meetings with the Department and MCOs regarding the quality and accuracy of encounter data. Hilltop then confirmed the proposed procedures for data validation with the Department and refined the methodology prior to and during this encounter data validation analysis. Next, Hilltop analyzed encounter data as of August 2025, including both denied and accepted encounters with 2024 dates of service. The review and audit processes for CY 2024 encounters concluded in November 2025.

Activity 3. Analysis of Electronic Encounter Data

Hilltop evaluated information from Activities 1 and 2 to support the analysis for Activity 3. Activity 1 is essential for developing the encounter analysis plan, as its purpose is to ensure the EQRO attains a comprehensive understanding of state requirements and standards for collecting and submitting encounter data (CMS, 2023). This activity covers types of encounters subject to validation, definitions of encounter data error types, required formatting for submitting encounters (837 standard transactions), and edit checks. Activity 2 involves evaluating MCOs' systems for collecting, reporting, and processing complete, accurate, and high-quality encounter

⁸ Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule. 89 Fed. Reg. 41,003 (May 10, 2024) (to be codified at 42 CFR Parts 430, 438 and 457).

data, as well as understanding the flow of data and their ability to resolve encounter data processing issues.

In accordance with Hilltop’s interagency governmental agreement with the Department to host a secure data warehouse for its encounters and provide data-driven policy consultation, research, and analytics, Hilltop completed Activity 3 of the encounter data validation that requires the following four steps:

1. Develop a data quality test plan based on data element validity requirements
2. Encounter data macro-analysis—verification of data integrity
3. Encounter data micro-analysis—generate and review analytic reports
4. Compare findings to state-identified benchmarks

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

Methodology

Hilltop incorporated information from Activities 1 and 2 to develop a data quality test plan. This plan accounts for both the state's Medicaid Management Information System (MMIS) (front-end), and adjudication edits built into MMIS targeting potential data problems the state may have inadvertently missed or allowed (CMS, 2023).

The denied encounter analysis used in this report, called the 8ER analysis, includes all denied encounters, even those later accepted or changed. This approach differs from the methods used to prepare an unduplicated data set of denied encounters for inclusion or exclusion from the MCO HealthChoice Financial Monitoring Report (HFMR) reports, where duplicative denied encounters are consolidated. The 8ER analysis looks at every time MMIS processed an encounter, whereas the HFMR considers the final disposition of the encounter. In July 2025, Hilltop provided both the Department and the MCOs with reporting instructions for the final CY 2024 HFMR and supplemental financial data reports (see Appendix A).

Hilltop met with the Department regularly to review encounter data analysis, discuss improvements, test new methodologies, and coordinate messaging with the MCOs. Hilltop also participated in the bimonthly MCO Encounter Data Workgroup and followed up with the Department on such topics as data quality and accuracy, denied encounter error rates, provider enrollment edits, provider reimbursement fields, and the use of sub-indicators in those fields.

Hilltop sought feedback from the MCOs to refine and test methodologies and shared results during the 2025 Workgroup meetings. Presentations included increases in 963 edit denials; limited-risk "National Provider Identifier (NPI) uncollapsing;"⁹ and analysis of denied encounters and \$0 pay cases. Hilltop also monitored and reported on the success of the MCOs' decrease in denied encounters with 437 exceptions and the decrease in the total error code 963-related denials.

8ER Analysis

Hilltop receives the electronic data interchange (EDI) error code (exception) report data (the 8ER report) daily and analyzes the volume, types, and reasons for failed/denied encounter submissions for each MCO. This report provides an analysis of the frequency of various error types and denial categories.

⁹ "NPI uncollapsing" refers to a health care data management initiative where each physical service location of a provider or organization is required to have its own unique NPI rather than share a single NPI across multiple locations. Historically, many health care organizations used one NPI for multiple locations (i.e., they "collapsed" all locations under one identifier). The uncollapsing process reverses this by assigning distinct NPIs to each location.

In August 2018, Hilltop met with the Department to obtain information about the processes and procedures for receiving, evaluating, and reporting on the validity of MCO encounter data and documenting how encounter data are accepted and validated for completeness and accuracy. The plan was to investigate the magnitude and types of missing encounter data and identify potential issues related to data quality and MCO submissions. Information provided included, but was not limited to, the following:

- MCOs submit encounter data using the X12 data standard (837)—through a secure EDI system—to the Department. The data are then transferred to MMIS (a mainframe computing environment) for processing and validation checks, generation of exception (error) reports/data set (8ER),¹⁰ and Remittance Advices (835).
 - The EDI 837 transaction set contains patient claim information, and the EDI 835 transaction set contains the claim payment and remittance advice and/or explanation of benefits data.
 - The Department’s EDI system receives encounter data from the MCOs in a format that is HIPAA EDI X12 837-compliant. Non-compliant data are returned (rejected) to the MCO for correction and resubmission, and MMIS never receives this type of rejection. After confirming the 837 compliance, MMIS translates the data for adjudication. Adjudication results are sent back to the EDI system, which generates exception (error) reports (8ER) and a HIPAA X12 835-compliant file. The summary of exceptions codes (denied encounters) is referred to as the “8ER” report by the Department and the MCOs.
- Encounter data fields validated through the MMIS process include recipient ID, sex, age, diagnosis codes, and procedure codes.
 - The MMIS does not validate the completeness or accuracy of provider reimbursement fields,¹¹ which are related to payment amounts from MCOs to providers for delivering the service.
- The Department processes incoming encounter data from the MCOs within one to two business days.
- Error code (exception) reports (835 and 8ER) are generated by the adjudication process and sent to the MCOs.

Hilltop used 1) data from the 8ER report denied encounters, 2) reasons for failure by the EDI, and 3) comparisons of denial results from CY 2022 through CY 2024 to conduct analyses. Hilltop performed checks on critical fields for missing, invalid (incorrect), and inconsistent data, including provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Eligibility issues arose for participants who were not eligible for MCO services at the time of the service. Examples of inconsistent data included discrepancies between dates, diagnosis conflict with age or sex, and inconsistencies between original and

¹⁰ The 8ER report is not de-duplicated and includes denied encounters that have a paid/accepted counterpart.

¹¹ For Institutional and Medical encounters, this is the “amt_pay_by_mco” field.

resubmitted encounters. Denied encounters were classified into five categories: missing data, participant not eligible for service, value not valid for the field, inconsistent data, and duplicates. Due to the high volume of invalid encounters for provider enrollment errors, Hilltop separated the “provider enrollment” invalid encounters from “other” invalid encounters and created a sixth denial category.¹² Hilltop also examined the distribution of denied and accepted encounters.

Claim Status “X” Methodology for HFMR

The CY 2023 MCO contract introduced potential penalties for MCOs with more than 5% of encounters denied, established to improve the data accuracy for risk adjustment of capitated rates and ensure compliance with federal regulations. Due to the concerns about the impact of the increase in denied encounters impacting rate setting and risk adjustment, the Department asked Hilltop to collect data on denied encounters from the MCOs. Because Hilltop’s data warehouse already contained these encounters (claim status type ‘X’),¹³ additional data from the MCOs was not required. The analysis provided details not available in the 8ER reports by using a new de-duping methodology that excludes denials if there is an accepted counterpart.

In the MCO CY 2024 contract, the Department removed penalties since MCOs improved submissions and stayed below the 5% threshold. The Department convened workgroups with the MCOs and Hilltop to help refine the criteria for determining the appropriate denials to develop a comprehensive data set of denied encounters. Certain encounters cannot be processed because of MMIS limitations; these are considered “inappropriate denials,” and the MCOs are not being held responsible for identified MMIS limitations.

Results

Hilltop’s analysis of the 8ER identified many denied encounters due to incorrectly submitted or invalid data, mainly linked to the MCO’s implementation of changes to the requirements for provider data on encounters. The Department asked Hilltop to analyze denied encounters for capitated rate risk adjustment using data for CY 2023 and CY 2024. To calculate the total denied encounters potentially missing from the base data used for risk adjustment, Hilltop developed a process to identify and de-duplicate denied encounters using data obtained from MMIS, which is not included in the generation of 8ER reports. The 8ER reports include numerous encounters that are resubmitted with new Invoice Control Numbers (ICNs) for a previously submitted denied encounter that had a different ICN. It is common for encounters to be submitted multiple times prior to acceptance; consequently, the 8ER analysis includes each submission. As a result, there are significant duplicates of the same encounter, causing the volume of denials in the 8ER to overstate the actual number of encounters denied. Most denied encounters were due to invalid provider data, primarily attributed to the implementation of provider enrollment encounter (NPI Crosswalk) edits that went live on January 1, 2020.

¹² Provider Enrollment codes: 122, 412, 951, 961, 962, 963, 964, 965, 971, 975, 976.

¹³ X is an internal MMIS code that is sent to Hilltop in monthly files.

Hilltop sent the data set of “appropriate denials” to the state’s auditor for review and testing, beginning with the CY 2023 HFMR review. As stated in the CY 2023 HFMR instructions, these denied encounters are to be excluded from MCO HFMR costs, which are used as the base to set future MCO capitation rates. Additionally, the auditor received a data set of accepted encounters with \$0 pay amounts for evaluation, built through the same iterative and collaborative process with the MCOs and the Department. In CY 2023, the auditor provided feedback to the MCOs about the volume of denied and \$0 pay encounters found to be reported in their HFMR costs. MCOs reviewed these audit results and, as appropriate, Hilltop adjusted the methodology to determine which should be considered “appropriate denials” and which \$0 pay encounters should be reviewed by the auditor. The auditor will continue testing denied and \$0 pay CY 2024 encounters using the refined methodology. The auditor will make HFMR adjustments for CY 2025. See Appendix B for the logic for denied encounters that use claim status X and \$0 pay encounters, including details on which denied encounters are included and excluded in the HFMR.

Hilltop generated quarterly reports indicating which CPT codes most often caused 437 exceptions for inclusion in the HFMR. Hilltop distributes 437 reports that provide aggregate counts by MCO and sent to the Department. The Department then shares that information in Encounter Data Workgroup meetings.

Analysis of the 8ER report revealed a significant number of invalid encounters due to provider enrollment errors. Therefore, Hilltop created six categories for denied encounters in this year’s report: duplicate, inconsistent, missing, not eligible, not valid, and provider enrollment. See Appendix C for the list of denial categories, denial codes (explanation of benefits (EOB) error codes matching the last 3 of the ICN), and error description. Hilltop also recategorized the error codes for CY 2019 through CY 2024 to demonstrate the high volume of provider enrollment errors beginning in CY 2020. Specifically, Hilltop identified that most invalid encounters were due to provider enrollment. For this reason, the following tables cannot be compared with similar tables in prior reports. See Appendix C for the list of denial codes, categorized into provider-related codes and all others, and then subdivided by denial category for CY 2024.

Table 1 presents the distribution of denied encounters submitted by all MCOs, by category, for CY 2019 to CY 2024.

Table 1. Distribution of Denied Encounter Submissions by MMIS Denial Category, CY 2019–CY 2024

Denial Category	CY 2019 (Baseline) # of Denied Encounters	CY 2019 (Baseline) % of Total	CY 2020 # of Denied Encounters	CY 2020 % of Total	CY 2021 # of Denied Encounters	CY 2021 % of Total	CY 2022 # of Denied Encounters	CY 2022 % of Total	CY 2023 # of Denied Encounters	CY 2023 % of Total	CY 2024 # of Denied Encounters	CY 2024 % of Total
Duplicate	103,108	5.4%	480,007	7.1%	77,347	1.8%	60,723	1.6%	49,319	1.6%	109,458	3.4%
Inconsistent	46,432*	2.5%	78,017	1.1%	40,841	0.9%	123,034	3.2%	51,590	1.6%	99,297	3.1%
Missing	344,257*	18.2%*	1,050,498*	15.4%*	753,586	17.1%	533,411	13.8%	456,532	14.4%	313,555	9.8%
Not Eligible	816,686*	43.1%	449,697*	6.6%	321,135	7.3%	529,468	13.7%	440,067	13.8%	526,032	16.4%
Not Valid**	170,935	9.0%	229,789	3.4%	194,885	4.4%	85,329	2.2%	146,262	4.6%	114,948	3.6%
Provider Enrollment**	412,590	21.8%	4,511,823	66.4%	3,029,493	68.6%	2,528,261	65.5%	2,033,917	64.0%	2,041,287	63.7%
Total	1,894,008	100%	6,799,831	100%	4,417,287	100%	3,860,226	100%	3,177,687	100%	3,204,577	100%

*The number and percentages of "Inconsistent," "Missing," and "Not Eligible" denied encounters in CY 2019 and CY 2020 were revised due to recategorizing denial codes in prior years' reports.

**The number of "Not Valid" denied encounters changed due to separating the "Provider Enrollment Not Valid" from "Other Not Valid."

Overall, the number of denied encounters decreased by 17.0% during the evaluation period (CY 2022 to CY 2024). While the denied encounters from the 8ER reports are not de-duplicated, the number of denied encounters in CY 2024 was still notably higher than in CY 2019. The number of provider enrollment-related encounters increased tenfold from CY 2019 to CY 2020, then decreased from CY 2020 to CY 2024 by 54.8%.

During the CY 2022 to CY 2024 evaluation period, provider enrollment-related denials decreased by 19.3%, while the share of all denied encounters attributed to provider enrollment data decreased by only 1.8 percentage points. The invalid denials increased by 34.7%, and the share of all denied encounters attributed to invalid data increased by only 1.4 percentage points between CY 2022 and CY 2024.

During the reporting period, "Provider Enrollment" denials were the most common, with "Missing" and "Not Eligible" denials rounding out the top three. The two categories of denials that increased in number were duplicate encounters and invalid encounters.

Table 2 presents the distribution of denied and accepted encounter submissions across MCOs for CY 2022 through CY 2024.

**Table 2. Distribution of Denied and Accepted Encounter Submissions by MCO,
CY 2022–CY 2024**

MCO	CY 2022 # of Denied Encounters	CY 2022 % of All Denied Encounters	CY 2023 # of Denied Encounters	CY 2023 % of All Denied Encounters	CY 2024 # of Denied Encounters	CY 2024 % of All Denied Encounters
ABH	105,659	2.7%	86,015	2.7%	39,437	1.2%
CFCHP	342,384	8.9%	92,812	2.9%	330,497	10.3%
JMS	252,155	6.5%	39,812	1.3%	16,350	0.5%
KPMAS	218,981	5.7%	163,828	5.2%	141,841	4.4%
MPC	585,477	15.2%	548,767	17.3%	590,449	18.4%
MSFC	70,142	1.8%	354,471	11.2%	286,506	8.9%
PPMCO	1,346,750	34.9%	1,102,763	34.7%	884,608	27.6%
UHC	558,659	14.5%	369,009	11.6%	379,282	11.8%
WPM	380,019	9.8%	420,210	13.2%	535,607	16.7%
Total	3,860,226	100%	3,177,687	100%	3,204,577	100%
MCO	CY 2022 # of Accepted Encounters	CY 2022 % of All Accepted Encounters	CY 2023 # of Accepted Encounters	CY 2023 % of All Accepted Encounters	CY 2024 # of Accepted Encounters	CY 2024 % of All Accepted Encounters
ABH	1,465,995	3.2%	1,493,493	3.3%	1,682,680	3.6%
CFCHP	2,393,506	5.3%	2,833,925	6.2%	3,160,226	6.8%
JMS	1,141,684	2.5%	1,056,101	2.3%	1,072,050	2.3%
KPMAS	3,059,397	6.7%	3,148,718	6.9%	3,244,493	7.0%
MPC	8,240,573	18.1%	8,080,070	17.6%	8,188,904	17.6%
MSFC	3,340,877	7.3%	3,389,419	7.4%	3,043,226	6.5%
PPMCO	12,115,262	26.6%	11,833,483	25.8%	11,762,772	25.3%
UHC	5,195,084	11.4%	5,030,139	11.0%	5,060,623	10.9%
WPM	8,614,423	18.9%	8,973,366	19.6%	9,246,814	19.9%
Total	45,566,801	100%	45,838,714	100%	46,461,788	100%

The volume of denied encounters decreased across many MCOs between CY 2022 and CY 2024, largely due to the implementation and usage of the Department's provider master file. While there was an overall increase in denied encounters for Maryland Physicians Care (MPC), MedStar Family Choice, Inc. (MSFC) and Wellpoint Maryland (WPM), there were decreases for Aetna Better Health (ABH), Jai Medical Systems (JMS), Kaiser Permanente of the Mid-Atlantic States (KPMAS), Priority Partners (PPMCO), and UnitedHealthcare (UHC), followed by a slight decrease for CareFirst Community Health Plan (CFCHP).

- PPMCO had the highest share (27.6%) of all denials in CY 2024, despite a decrease of 7.3 percentage points from CY 2022.

- CFCHP's share decreased by 6.0 percentage points between CY 2022 and CY 2023, then increased by 7.4 percentage points in CY 2024.
- MSFC had 8.9% of all denials in CY 2024, a decrease of 2.3 percentage points from CY 2023 and an increase of 7.1 percentage points from CY 2022.
- WPM had 16.7% of denials in CY 2024, an increase of 6.9 percentage points from CY 2022.
- ABH remained at 2.7% from CY 2022 to CY 2023, then decreased to 1.2% in CY 2024.
- JMS's share of all denials experienced a decrease of 6.0 percentage points from CY 2022 to 2024, and UHC's share decreased by 2.7 percentage points.

ABH, JMS, and KPMAS each had less than 5.0% of the denied encounters in CY 2024. All three MCOs decreased their share of denied encounters from CY 2022 to CY 2024. JMS had the most significant decrease, with a reduction of 6.0 percentage points.

Although there was some variation among MCOs in the distribution of the total denied encounters from CY 2022 to CY 2024, there was very little variation in the distribution of accepted encounters among MCOs, except for CFCHP and WPM, whose shares increased by 1.5 and 1.0 percentage points, respectively, and PPMCO, whose share decreased by 1.3 percentage points. All the other MCOs had less than a 1.0 percentage point change during the evaluation period.

Tables 3 and 4 show the rate of encounters denied by MMIS by category and MCO. Specifically, Table 3 presents the percentage of denied encounters by MMIS denial category and MCO for CY 2024. See Appendix D for a graphical representation of Table 3.

Table 3. Percentage of Denied Encounters by MMIS Denial Category by MCO, CY 2024

Denial Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Duplicate	3.0%	2.8%	2.6%	1.4%	2.3%	1.0%	0.8%	18.3%	0.6%
Inconsistent	2.5%	17.7%	0.4%	9.2%	1.0%	0.5%	0.1%	3.5%	1.0%
Missing	20.0%	11.8%	8.5%	16.9%	8.4%	3.3%	9.0%	9.1%	12.7%
Not Eligible	5.1%	13.9%	30.2%	14.8%	13.3%	21.8%	17.9%	15.4%	17.7%
Not Valid	13.1%	4.7%	16.0%	1.7%	1.3%	16.8%	2.7%	1.3%	0.9%
Provider Enrollment	56.3%	49.1%	42.3%	56.0%	73.8%	56.6%	69.5%	52.4%	67.2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

For all MCOs, the primary reason for encounter denial in CY 2024 was "Provider Enrollment" (making up between 42.3% and 73.8% of each MCO's denials). The second most common denial category was "Not Eligible"; JMS, MPC, MSFC, PPMCO and WPM all reported "Not Eligible" as their second-highest category. ABH and KPMAS reported "Missing" as their second-highest denial category. CFCHP reported "Inconsistent" as their second-highest denial category in CY 2024, while UHC had "Duplicate" as their second highest. For all MCOs except for UHC,

encounters denied for reasons grouped under the “Duplicate” category remained below 3.0%. UHC’s “Duplicates” represented 18.3% of their denied encounters. Encounters denied as “Inconsistent” remained below 4.0% for all MCOs except CFCHP and KPMAS, where “Inconsistent” represented 17.7% and 9.2% of denied encounters, respectively. Encounters denied as “Not Valid” remained below 5.0% for all MCOs except ABH, JMS and MSFC, where “Not Valid” represented 13.1%, 16.0% and 16.8% of denied claims, respectively.

Table 4 presents the distribution of denied encounters by denial category and how it changed for each MCO between CY 2022 and CY 2024.

Table 4. Number and Percentage of Denied Encounters by MMIS Denial Category and MCO, CY 2022–CY 2024

Denial Category	CY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Duplicate	2022	16	8,759	957	823	27,283	607	3,738	14,558	3,982	60,723
		0.0%	2.6%	0.4%	0.4%	4.7%	0.9%	0.3%	2.6%	1.0%	1.6%
	2023	186	843	594	1,430	3,309	7,729	5,892	25,473	3,863	49,319
		0.2%	0.9%	1.5%	0.9%	0.6%	2.2%	0.5%	6.9%	0.9%	1.6%
	2024	1,201	9,410	421	1,953	13,751	2,983	7,125	69,227	3,387	109,458
		3.0%	2.8%	2.6%	1.4%	2.3%	1.0%	0.8%	18.3%	0.6%	3.4%
Inconsistent	2022	5,162	62,819	75	3,523	1,501	741	1,253	42,262	5,698	123,034
		4.9%	18.3%	0.0%	1.6%	0.3%	1.1%	0.1%	7.6%	1.5%	3.2%
	2023	396	190	76	3,472	2,865	349	1,090	9,883	33,269	51,590
		0.5%	0.2%	0.2%	2.1%	0.5%	0.1%	0.1%	2.7%	7.9%	1.6%
	2024	974	58,604	67	13,014	5,779	1,292	1,148	13,260	5,159	99,297
		2.5%	17.7%	0.4%	9.2%	1.0%	0.5%	0.1%	3.5%	1.0%	3.1%
Missing	2022	14,259	28,442	73,168	43,191	55,069	9,998	193,751	62,825	52,708	533,411
		13.5%	8.3%	29.0%	19.7%	9.4%	14.3%	14.4%	11.2%	13.9%	13.8%
	2023	16,175	11,279	4,430	36,940	74,222	54,668	147,022	42,153	69,643	456,532
		18.8%	12.2%	11.1%	22.5%	13.5%	15.4%	13.3%	11.4%	16.6%	14.4%
	2024	7,870	38,933	1,391	24,032	49,461	9,526	79,844	34,689	67,809	313,555
		20.0%	11.8%	8.5%	16.9%	8.4%	3.3%	9.0%	9.1%	12.7%	9.8%
Not Eligible	2022	1,887	23,185	12,291	19,887	83,513	8,762	304,498	50,187	25,258	529,468
		1.8%	6.8%	4.9%	9.1%	14.3%	12.5%	22.6%	9.0%	6.6%	13.7%
	2023	2,393	12,665	11,331	13,768	51,771	86,358	146,334	47,036	68,411	440,067
		2.8%	13.6%	28.5%	8.4%	9.4%	24.4%	13.3%	12.7%	16.3%	13.8%
	2024	2,020	45,878	4,930	20,925	78,261	62,487	158,404	58,407	94,720	526,032
		5.1%	13.9%	30.2%	14.8%	13.3%	21.8%	17.9%	15.4%	17.7%	16.4%
Not Valid	2022	3,027	11,138	12,856	3,804	16,289	9,459	13,012	7,234	8,510	85,329
		2.9%	3.3%	5.1%	1.7%	2.8%	13.5%	1.0%	1.3%	2.2%	2.2%
	2023	2,535	5,383	10,901	3,247	5,772	78,741	26,353	5,360	7,970	146,262
		2.9%	5.8%	27.4%	2.0%	1.1%	22.2%	2.4%	1.5%	1.9%	4.6%
	2024	5,166	15,513	2,617	2,426	7,732	48,126	23,567	5,019	4,782	114,948
		13.1%	4.7%	16.0%	1.7%	1.3%	16.8%	2.7%	1.3%	0.9%	3.6%
Provider Enrollment	2022	81,308	208,041	152,808	147,753	401,822	40,575	830,498	381,593	283,863	2,528,261
		77.0%	60.8%	60.6%	67.5%	68.6%	57.8%	61.7%	68.3%	74.7%	65.5%
	2023	64,330	62,452	12,480	104,971	410,828	126,626	776,072	239,104	237,054	2,033,917
		74.8%	67.3%	31.3%	64.1%	74.9%	35.7%	70.4%	64.8%	56.4%	64.0%
	2024	22,206	162,159	6,924	79,491	435,465	162,092	614,520	198,680	359,750	2,041,287
		56.3%	49.1%	42.3%	56.0%	73.8%	56.6%	69.5%	52.4%	67.2%	63.7%
Total Denied Encounters	2022	105,659	342,384	252,155	218,981	585,477	70,142	1,346,750	558,659	380,019	3,860,226
	2023	86,015	92,812	39,812	163,828	548,767	354,471	1,102,763	369,009	420,210	3,177,687
	2024	39,437	330,497	16,350	141,841	590,449	286,506	884,608	379,282	535,607	3,204,577

The greatest number of denied encounters during the evaluation period were in the “Provider Enrollment” category. The total number of “Provider Enrollment” encounters decreased from 2,528,261 to 2,041,287 between CY 2022 and CY 2024, but the proportion of all denied encounters categorized as “Provider Enrollment” remained stable. The impact of provider enrollment denials was not distributed evenly across MCOs throughout the evaluation period.

In CY 2024, the rate of denials categorized as “Provider Enrollment” ranged from 42.3% of JMS’s denials on the low end to 73.8% of MPC’s denials at the high end.

In CY 2024, JMS had the largest percentage of encounters denied in the “Not Eligible” category (30.2%), and ABH had the lowest (5.1%). The percentage of denials in the “Not Eligible” category increased for all MCOs from CY 2022 to CY 2024—except for MPC and PPMCO, which had decreases of 1.0 and 4.7 percentage points, respectively.

Between CY 2022 and CY 2024, the share of encounters denied in the “Not Valid” category increased for five of the nine MCOs (ABH, CHCHP, JMS, MSFC, and PPMCO). JMS had the largest increase of 10.9 percentage points. MPC and WPM’s shares of denials in the “Not Valid” category decreased slightly (1.5 and 1.3 percentage points, respectively). The share of “Not Valid” denials for KPMAS and UHC remained steady over the evaluation period, though both experienced a slight increase in CY 2023.

In the “Missing” denial category, all MCOs except two experienced a decrease in the number of denials throughout the evaluation period. From CY 2022 to CY 2024, CFCHP had an increase of 10,491, and WPM had an increase of 15,101 “Missing” encounter denials.

While the number of encounter denials categorized as “Duplicate” increased for six of the nine MCOs (ABH, CFCHP, KPMAS, MSFC, PPMCO, and UHC), the remaining MCOs (JMS, MPC, and WPM) decreased in the number of these denials, with MPC having the greatest decline, from 27,283 in CY 2022 to 13,751 in CY 2024. UHC saw the largest increase in the number of denials categorized as “Duplicate,” from 14,558 in CY 2022 to 69,227 in CY 2024.

MCOs showed varied results in the numbers and percentages of denied encounters in the “Inconsistent” category. The total number of denials categorized as “Inconsistent” during the evaluation period decreased for all MCOs except KPMAS, MPC, and MSFC, which increased significantly (by 269.4%, 285.0%, and 74.3%, respectively). Expressed as a percentage of all denied encounters, JMS, MPC, MSFC, PPMCO, and UHC demonstrated stability in the rate of denials categorized as “Inconsistent,” with year-over-year changes of one percentage point or less. By contrast, the rate for ABH, CFCHP, KPMAS, and WPM varied widely, with CFCHP as an outlier with a 17.5 percentage point change between CY 2023 to CY 2024.

Overall, between CY 2022 and CY 2024, there was a decrease in denials marked “Inconsistent,” “Missing,” “Not Eligible,” and “Provider Enrollment,” while there was an increase in denials marked “Duplicate” and “Not Valid,” though “Not Valid” denials decreased since CY 2023. From CY 2022 to CY 2024, the greatest decrease in the share of denials was in the “Missing” category, which decreased by 4.0 percentage points.

Table 5 presents denied encounters by MCO, divided into provider enrollment-related and all other denials for CY 2022 to CY 2024. See Appendix E for more specific information about the

top three most common MCO-specific MMIS denial codes (errors) for CY 2024. The majority of the top three for each MCO are related to provider enrollment.¹⁴

Table 5. Number of Denied Encounters for Provider Enrollment-Related and Other Denial Types by MCO, CY 2024

Denial Type	MCO	CY 2022	CY 2023	CY 2024
Provider Enrollment-Related	ABH	81,308	64,330	22,206
	CFCHP	208,041	62,452	162,159
	JMS	152,808	12,480	6,924
	KPMAS	147,753	104,971	79,491
	MPC	401,822	410,828	435,465
	MSFC	40,575	126,626	162,092
	PPMCO	830,498	776,072	614,520
	UHC	381,593	239,104	198,680
	WPM	283,863	237,054	359,750
	Subtotal	2,528,261	2,033,917	2,041,287
Other	ABH	24,351	21,685	17,231
	CFCHP	134,343	30,360	168,338
	JMS	99,347	27,332	9,426
	KPMAS	71,228	58,857	62,350
	MPC	183,655	137,939	154,984
	MSFC	29,567	227,845	124,414
	PPMCO	516,252	326,691	270,088
	UHC	177,066	129,905	180,602
	WPM	96,156	183,156	175,857
	Subtotal	1,331,965	1,143,770	1,163,290
Total		3,860,226	3,177,687	3,204,577

Note: Previous reports used a slightly different list of provider enrollment-related codes, so the results for CY 2022 and CY 2023 were recategorized.

The number of provider enrollment-related denials varied across MCOs during the evaluation period. The number of encounters denied for this reason decreased for all MCOs except for MPC, MSFC, and WPM. Standouts include JMS, with a 95.5% decrease; ABH, with a 72.7% decrease; and MSFC, with a 299.5% increase in the occurrence of these errors. The HealthChoice program overall had 19.3% fewer provider enrollment-related errors in CY 2024 than in CY 2022.

¹⁴ Provider enrollment denial codes are 122, 412, 951, 961, 962, 963, 964, 965, 971, 975, and 976.

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

Methodology

Hilltop conducted integrity checks of the encounter data files and automated analyses. This process included verifying that the state’s identifiers (IDs)¹⁵ were correctly incorporated into the MCO information system; verifying that critical fields had complete data; and inspecting quality and general validity of the data. Hilltop evaluated the ratio of participants to total accepted encounters by MCO to check for similar distributions across MCOs. In addition, fields not verified in Step 1 were reviewed to determine how completely and accurately MCOs populated provider reimbursement fields when submitting encounter data to the Department after the mandate began on January 1, 2018.

Hilltop assessed the number of medical encounters with a \$0 provider reimbursement amount that were identified as sub-capitated or denied (MCO denied the provider claim) and compared the amount reported in the provider reimbursement field with the amount listed in the FFS fee schedule. In addition, Hilltop analyzed the completion of the institutional provider reimbursement data. Hilltop analyzed the \$0 reimbursement encounters by MCO, aggregated by the contract information segment, CN1,¹⁶ with indicators of 05 (sub-capitated), 09 (denied), and no indicator.¹⁷ Hilltop also investigated the third-party liability (TPL) variable in MCO encounters to determine whether MCOs are reporting this reimbursement amount appropriately.

Results

During CY 2024, the MCOs submitted 46.5 million accepted encounters (records), an increase from 45.8 million in CY 2023 and 45.6 million in CY 2022. Enrollment remained high through the end of CY 2023—despite the unwinding of the continuous eligibility requirements¹⁸—and began a slight decline in CY 2024. Utilization, as measured by the volume of accepted encounters, continued to rise from CY 2022 through CY 2024. To estimate the total number of encounters submitted, Hilltop added the number of accepted encounters with MMIS-denied encounters.¹⁹ This methodology resulted in an estimated 49.4 million encounters submitted in CY 2022, followed by a decrease to 49.0 million in CY 2023, and an increase to 49.7 million in CY 2024. In CY 2024, approximately 93.5% of encounters were accepted into MMIS, consistent with the rate during CY 2023 and slightly higher than the acceptance rate of 92.2% in CY 2022.

¹⁵ Recipient original ID (recipno), first date of service (begdos), last date of service (enddos), ICN, pay to provider number (prov), icd10 diagnosis codes, icd10 procedure codes, billdate.

¹⁶ <https://health.maryland.gov/iac/HIPAA/pdf/Companion%20Guide%20837%20Institutional%20Encounter.pdf>

¹⁷ \$0 Pay Encounters with 09-Denied reporting indicators and \$0 Pay Encounters with no indicator are to be excluded from the HFMR.

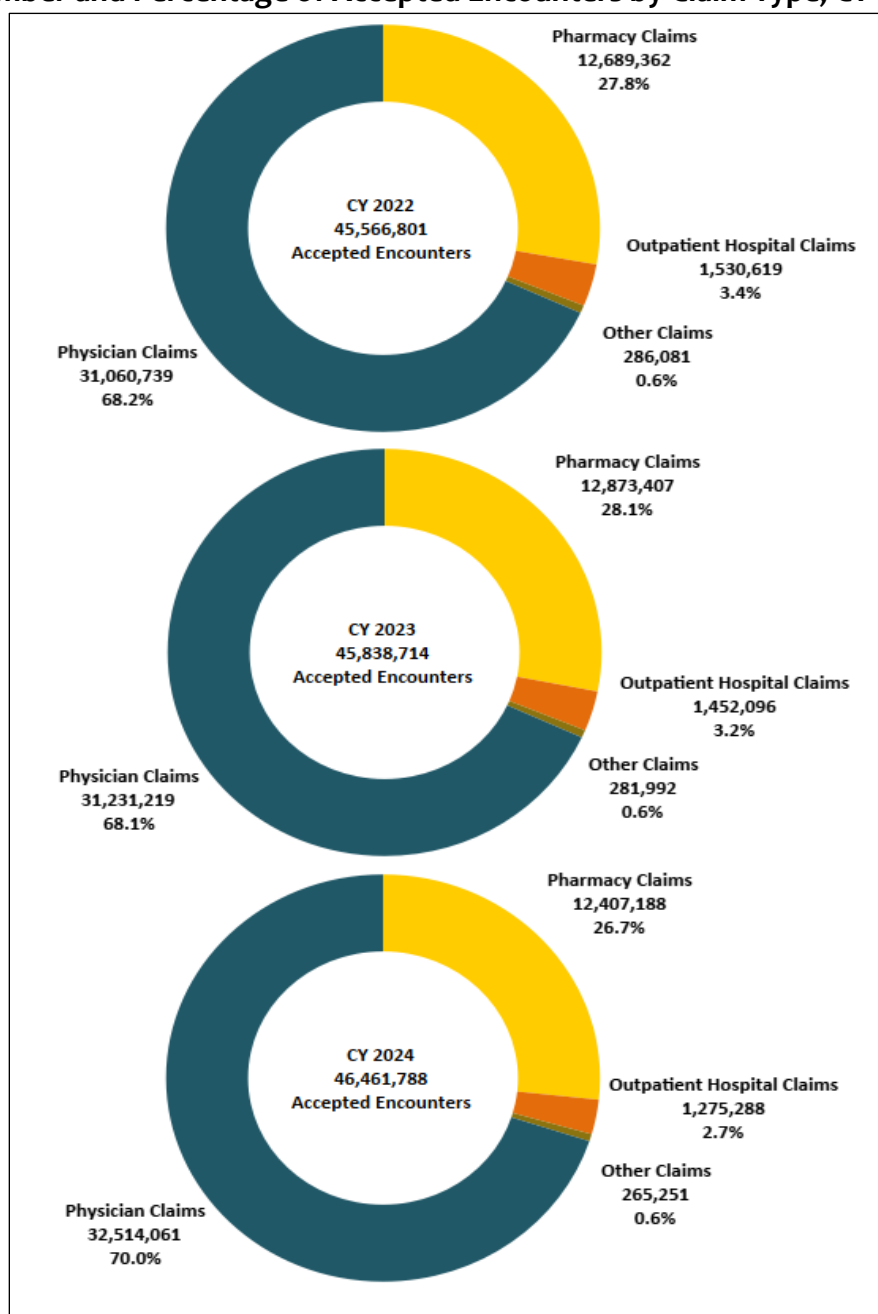
¹⁸ <https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-recognized-as-a-top-state-as-it-completes-yearlong-Medicaid-redeterminations-process.aspx>

¹⁹ These denials are not deduplicated, so this overstates the denied encounters.

Hilltop received a monthly copy of all encounters accepted and denied by MMIS. Upon receipt, Hilltop performed comprehensive validation assessments and integrity checks of the data fields to analyze and interpret their accuracy and completeness. These assessments included checking for records with an invalid end date of service or other errors. Data with these types of quality errors were excluded from import into Hilltop's data warehouse.

Figure 1 shows the distribution of accepted encounter submissions by claim type (physician claims, pharmacy claims, outpatient hospital claims, and other claims)²⁰ from CY 2022 to CY 2024.

²⁰ "Outpatient hospital claims" include emergency department (ED) visits. "Other" includes inpatient hospital stays, community-based services, and long-term care services.

Figure 1. Number and Percentage of Accepted Encounters by Claim Type, CY 2022–CY 2024

The distribution of accepted encounters by claim type remained largely unchanged during the study period. Physician claims represented most of the encounters during the evaluation period (just over two-thirds), followed by pharmacy claims (just over one-quarter). Across the evaluation period, other encounters—including inpatient hospital stays, community-based services, and long-term care services—accounted for less than 1% of services.

Table 6 displays the percentage and number of accepted encounters by claim type for each MCO from CY 2022 to CY 2024.

Table 6. Distribution of Accepted Encounters by Claim Type and MCO, CY 2022–CY 2024

Claim Type	CY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Physician	2022	69.1%	68.7%	59.8%	74.5%	66.3%	66.5%	67.6%	72.1%	67.5%
		1,013,129	1,644,307	682,602	2,280,214	5,463,440	2,222,432	8,191,130	3,745,792	5,817,693
	2023	67.4%	69.1%	58.0%	73.7%	67.3%	68.9%	65.6%	71.6%	69.0%
		1,006,943	1,958,456	612,772	2,321,226	5,439,299	2,335,553	7,765,292	3,603,109	6,188,569
	2024	69.1%	70.9%	61.3%	76.1%	69.8%	67.8%	67.7%	73.3%	70.6%
		1,162,055	2,239,127	657,563	2,467,780	5,715,944	2,064,607	7,968,599	3,707,875	6,530,511
Pharmacy	2022	26.4%	27.5%	36.2%	23.7%	29.2%	29.2%	28.5%	23.9%	28.3%
		386,874	657,020	413,751	726,213	2,406,846	973,973	3,447,617	1,241,078	2,435,990
	2023	29.0%	26.9%	37.3%	24.5%	29.1%	27.6%	29.4%	24.9%	27.8%
		433,636	763,158	394,177	772,994	2,350,299	935,295	3,478,092	1,253,464	2,492,292
	2024	27.7%	26.0%	34.4%	22.3%	26.7%	28.4%	28.6%	23.5%	26.2%
		465,957	821,942	369,035	722,759	2,186,653	865,415	3,363,711	1,188,770	2,422,946
Outpatient Hospital	2022	3.7%	3.1%	3.6%	1.1%	3.7%	3.5%	3.5%	3.3%	3.6%
		54,446	74,166	40,800	34,086	306,000	115,292	425,008	171,977	308,844
	2023	2.9%	3.2%	3.7%	1.1%	3.0%	2.8%	4.4%	2.9%	2.8%
		43,665	91,048	38,968	35,585	238,727	94,068	515,552	145,480	249,003
	2024	2.6%	2.5%	3.2%	1.0%	2.9%	2.9%	3.2%	2.7%	2.7%
		43,743	79,698	34,461	33,863	234,177	89,722	376,822	136,026	246,776
Other	2022	0.8%	0.8%	0.4%	0.6%	0.8%	0.9%	0.4%	0.7%	0.6%
		11,546	18,013	4,531	18,884	64,287	29,180	51,507	36,237	51,896
	2023	0.6%	0.8%	1.0%	0.6%	0.6%	0.7%	0.6%	0.6%	0.5%
		9,249	21,263	10,184	18,913	51,745	24,503	74,547	28,086	43,502
	2024	0.6%	0.6%	1.0%	0.6%	0.6%	0.8%	0.5%	0.6%	0.5%
		10,925	19,459	10,991	20,091	52,130	23,482	53,640	27,952	46,581
Total (100%)	2022	1,465,995	2,393,506	1,141,684	3,059,397	8,240,573	3,340,877	12,115,262	5,195,084	8,614,423
	2023	1,493,493	2,833,925	1,056,101	3,148,718	8,080,070	3,389,419	11,833,483	5,030,139	8,973,366
	2024	1,682,680	3,160,226	1,072,050	3,244,493	8,188,904	3,043,226	11,762,772	5,060,623	9,246,814

The distribution of accepted encounters remained relatively consistent across MCOs and calendar years. In CY 2024, physician encounters ranged from 61.3% of encounters (JMS) to 76.1% of encounters (KPMAS). JMS had the largest percentage of CY 2024 pharmacy encounters (34.4%), while KPMAS had the lowest percentage (22.3%). Outpatient hospital encounters in CY 2024 ranged from a low of 1.0% for KPMAS to a high of 3.2% for JMS and PPMCO. See Appendix F for a visual display of the number and percentage of accepted encounters by claim type and MCO in CY 2024.

Table 7 illustrates the distribution of HealthChoice participants and the volume of accepted encounters for each MCO during CY 2022 through CY 2024.

Table 7. Percentage of HealthChoice Participants and Accepted Encounters by MCO, CY 2022–CY 2024

MCO	CY 2022 Percentage of Total Participants	CY 2022 Percentage of All Accepted Encounters	CY 2023 Percentage of Total Participants	CY 2023 Percentage of All Accepted Encounters	CY 2024 Percentage of Total Participants	CY 2024 Percentage of All Accepted Encounters
ABH	4.1%	3.2%	4.5%	3.3%	5.0%	3.6%
CFCHP	5.8%	5.3%	6.7%	6.2%	7.6%	6.8%
JMS	2.1%	2.5%	2.1%	2.3%	2.1%	2.3%
KPMAS	8.1%	6.7%	8.4%	6.9%	8.0%	7.0%
MPC	16.8%	18.1%	16.5%	17.6%	16.2%	17.6%
MSFC	7.4%	7.3%	7.2%	7.4%	7.1%	6.5%
PPMCO	23.7%	26.6%	23.5%	25.8%	23.3%	25.3%
UHC	11.7%	11.4%	11.6%	11.0%	11.5%	10.9%
WPM	21.9%	18.9%	21.5%	19.6%	21.3%	19.9%
Total	100%	100%	100%	100%	100%	100%

PPMCO and WPM were the largest MCOs in CY 2024, followed by MPC, UHC, KPMAS, CFCHP, MSFC, ABH, and JMS. The distribution of accepted encounters among MCOs in CY 2022 through CY 2024 was nearly proportional to the participant distribution. For example, in CY 2024, MPC had 16.2% of all HealthChoice participants and 17.6% of all MMIS encounters.

Managed Care Regulations: Accurate and Complete Encounter Data

In 2016, CMS issued its final rule updating Medicaid managed care regulations²¹ to require MCOs to submit encounter data that are accurate and complete by January 2018.²² The Department notified Maryland MCOs in September 2017 that all encounter data submitted to the Department on or after January 1, 2018, must include allowed amounts and provider reimbursement amounts on each encounter (Maryland Department of Health, 2017).

²¹ Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

²² 42 CFR § 438.818(a)(2).

In November 2020, CMS released a new final rule²³ that included technical modifications; however, it did not include changes to the EQR or encounter data reporting regulations.

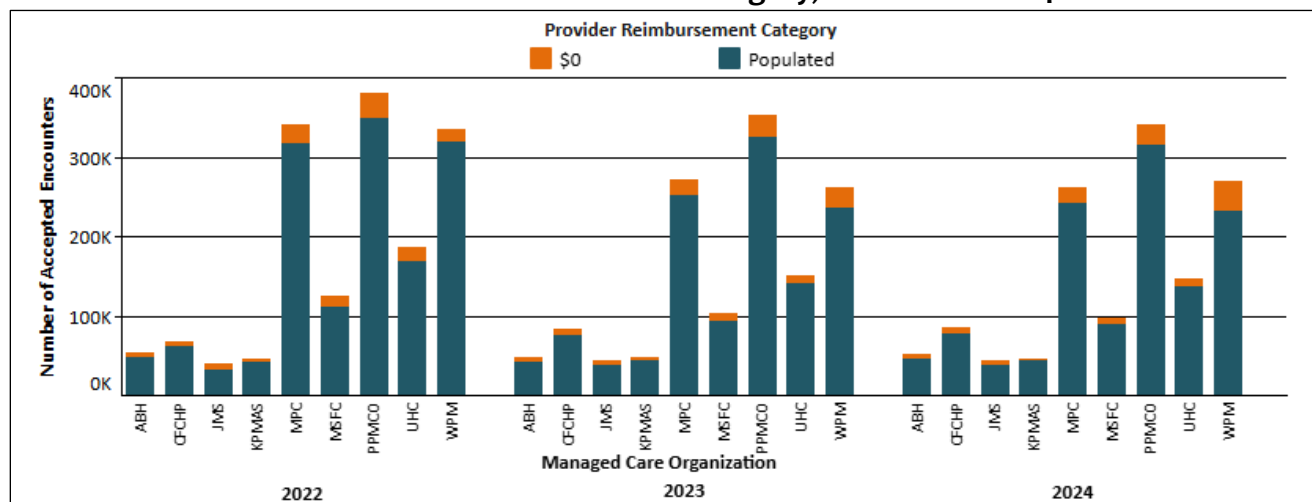
Since the Department and the MCOs worked together in 2010 to ensure the complete and accurate submission of data showing the amount paid on behalf of MCO members for their pharmacy encounters, pharmacy encounters have been reliable for over a decade. Pharmacy encounter data flow through a point-of-sale system, which ensures data accuracy at the time of submission. In October 2017, the Department established the pharmacy paid encounter process as a framework for receiving provider reimbursement data for all encounters.

The Department staff prepared MMIS to accept provider reimbursement data for all encounters in the fall of 2017, convened technical MCO workgroups, and updated the 837 Companion Guides for professional (medical) and institutional encounters. After MCOs began submitting provider reimbursement data for all encounters in January 2018, the Department found errors in processing the reimbursement amount for medical and institutional encounters. In February 2018, the Department reviewed submissions to assess the number of encounters with missing provider reimbursement data. This analysis included categorization of instances with a reimbursement amount of \$0, separated by denied ('09' on the CN1 segment) and sub-capitated ('05' on the CN1 segment), as well as the frequency with which reimbursement fields were or were not populated. The Department shared its findings and held meetings with MCOs individually to improve their submission processes. By August 2018, MMIS had received populated provider reimbursement data for all medical encounters.

In the fall of 2018, the Department found that only the provider reimbursement amount for the first service line of each institutional encounter was being recorded, which underreported the total amount paid. This issue was corrected in mid-2020; MMIS now stores the correct sum for all the total paid institutional service lines. The Department continues working with the MCOs to ensure the validity of institutional and medical encounter data.

Figure 2 displays the distribution of provider reimbursement category for accepted institutional encounter data by MCO from CY 2022 to CY 2024.

²³ Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

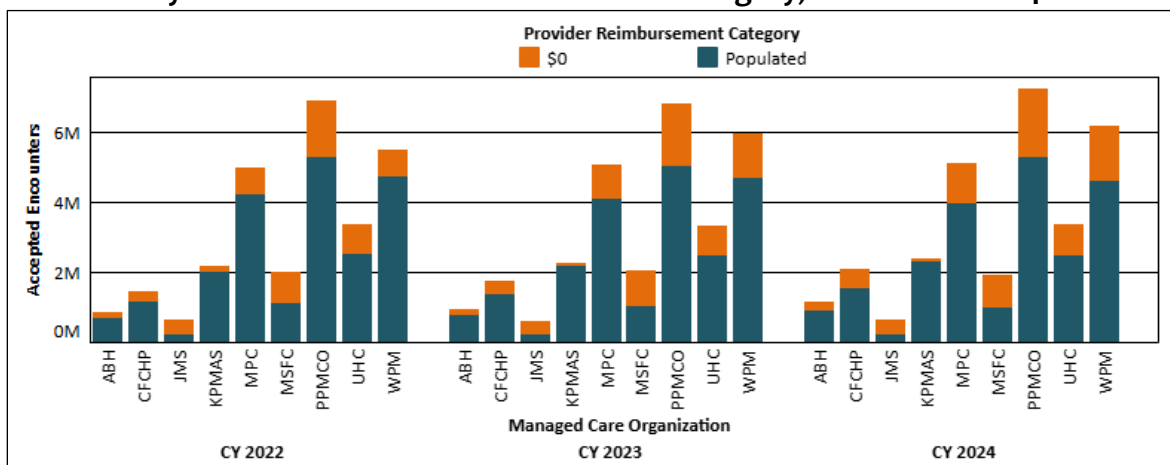
Figure 2. Number of Accepted Institutional Encounters by MCO and Provider Reimbursement Category, CY 2022–CY 2024

CY	Provider Reimbursement Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
2022	Populated	90.0%	91.6%	83.1%	94.0%	92.8%	88.9%	91.4%	90.7%	95.1%
		48,316	62,241	32,292	42,532	316,808	110,643	348,593	168,690	319,452
	\$0	10.0%	8.4%	16.9%	6.0%	7.2%	11.1%	8.6%	9.3%	4.9%
		5,367	5,695	6,562	2,691	24,422	13,816	32,885	17,318	16,372
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
2023	Populated	87.6%	92.2%	86.5%	93.5%	92.4%	91.6%	92.0%	92.9%	90.6%
		40,833	76,305	37,767	43,644	251,297	93,735	324,549	140,516	236,450
	\$0	12.4%	7.8%	13.5%	6.5%	7.6%	8.4%	8.0%	7.1%	9.4%
		5,775	6,487	5,875	3,016	20,679	8,631	28,090	10,736	24,536
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
2024	Populated	91.4%	92.1%	87.8%	95.3%	92.3%	92.0%	92.8%	93.5%	86.4%
		46,327	77,937	38,433	44,354	241,719	89,573	315,962	136,827	232,903
	\$0	8.6%	7.9%	12.2%	4.7%	7.7%	8.0%	7.2%	6.5%	13.6%
		4,344	6,640	5,347	2,205	20,304	7,747	24,565	9,550	36,730
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

The MCOs showed mixed results on the percentages of \$0 pay over the evaluation period. Those showing decreases in \$0 pay from CY 2022 to CY 2024 include JMS, MSFC, PPMCO, and UHC. Four MCOs demonstrated variable performance or remained stable—ABH, CFCHP, KPMAS, MPC—while WPM showed an increase in \$0 pay each year.

Figure 3 displays the number and percentage of accepted medical encounters by MCO and provider reimbursement category for CY 2022 through CY 2024.

Figure 3. Number of Accepted Medical Encounters by MCO and Provider Reimbursement Category, CY 2022–CY 2024



CY	Provider Reimbursement Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
2022	Populated	80.8%	79.8%	34.2%	93.7%	84.7%	55.2%	76.3%	74.8%	86.2%
		697,565	1,151,967	222,651	2,021,446	4,230,981	1,117,555	5,284,443	2,511,339	4,729,467
	\$0	19.2%	20.2%	65.8%	6.3%	15.3%	44.8%	23.7%	25.2%	13.8%
		165,635	290,813	428,663	136,943	766,411	907,070	1,641,938	845,955	757,248
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
2023	Populated	79.6%	79.2%	35.9%	96.3%	80.4%	50.3%	73.9%	74.4%	78.9%
		757,319	1,384,037	212,726	2,155,695	4,089,597	1,037,694	5,050,314	2,475,091	4,693,008
	\$0	20.4%	20.8%	64.1%	3.7%	19.6%	49.7%	26.1%	25.6%	21.1%
		194,248	364,427	379,478	83,740	994,630	1,027,232	1,785,564	849,931	1,257,830
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
2024	Populated	80.3%	75.0%	34.9%	96.0%	77.8%	51.8%	73.2%	73.7%	74.3%
		913,631	1,551,215	224,153	2,296,897	3,986,853	985,158	5,292,152	2,494,543	4,589,539
	\$0	19.7%	25.0%	65.1%	4.0%	22.2%	48.2%	26.8%	26.3%	25.7%
		223,887	518,017	418,360	95,958	1,136,629	918,506	1,938,185	890,466	1,583,476
	Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

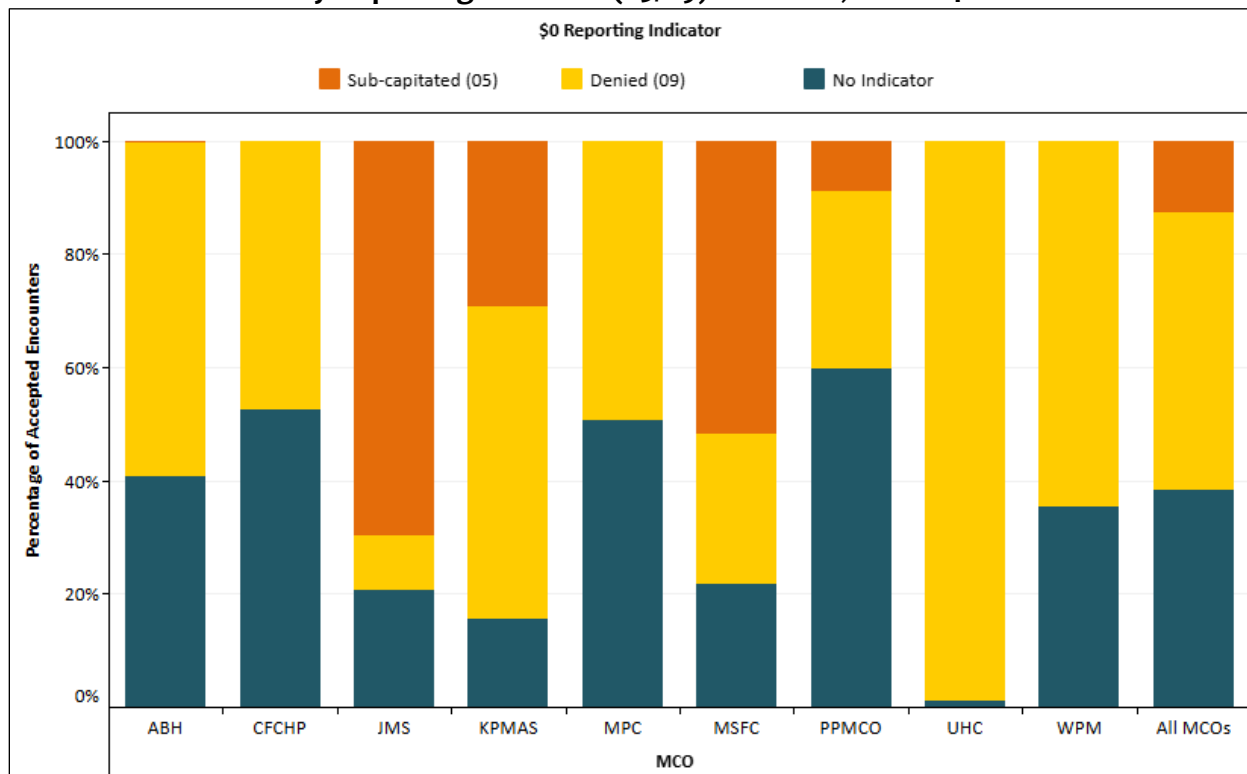
During the evaluation period, JMS²⁴ and KPMAS demonstrated improvement in the rate of medical encounters submitted with provider reimbursement amounts included, albeit JMS had a

²⁴ The majority of JMS' \$0 provider reimbursement is sub-capitated ('05' on the CN1 segment).

much lower baseline (34.2% in CY 2022 to 34.9% in CY 2024) while KPMAS was 93.7% in CY 2022 and 96.0% CY 2024. All other MCOs showed a decline in that rate between CY 2022 and CY 2024, especially notable with MPC (84.7% to 77.8%) and WPM (86.2% to 74.3%).

Figure 4 displays the percentage of accepted medical encounters with a \$0 provider reimbursement amount with the sub-capitated reporting indicator (05) on the CN1 segment, the denied reporting indicator (09) on the CN1 segment, and no indicator by MCO.

Figure 4. Accepted Medical Encounters with \$0 Provider Reimbursement Data by Reporting Indicator (05/09) and MCO, CY 2024



\$0 Reporting Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Sub-capitated (05)	108	0	291,998	27,985	0	476,502	173,720	0	0	970,313
	0.0%	0.0%	69.8%	29.2%	0.0%	51.9%	9.0%	0.0%	0.0%	12.6%
Denied (09)	132,406	245,603	39,768	53,016	560,976	243,711	604,887	880,403	1,024,445	3,785,215
	59.1%	47.4%	9.5%	55.2%	49.4%	26.5%	31.2%	98.9%	64.7%	49.0%
No Indicator	91,373	272,414	86,594	14,957	575,653	198,293	1,159,578	10,063	559,031	2,967,956
	40.8%	52.6%	20.7%	15.6%	50.6%	21.6%	59.8%	1.1%	35.3%	38.4%
Total	223,887	518,017	418,360	95,958	1,136,629	918,506	1,938,185	890,466	1,583,476	7,723,484
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Adherence to the requirement that encounters with \$0 provider reimbursement include a reporting indicator varied significantly among the MCOs during CY 2024. UHC was the only MCO that submitted nearly all its \$0 medical encounters with an indicator. By contrast, CFCHP, MPC,

and PPMCO submitted more than one-half of their \$0 provider reimbursement medical encounters without an indicator. The Department surveyed the MCOs regarding these results and found inconsistencies with some MCOs regarding their 05 sub-capitation reporting indicator usage compared to their reported existence of sub-capitation arrangements with medical providers during CY 2024.

Figure 5 applies the same analysis to institutional encounters, showing the percentage with \$0 provider reimbursement submitted with each indicator (05 sub-capitated or 09 denied) and without an indicator.

Figure 5. Accepted Institutional Encounters with \$0 Provider Reimbursement Data by Reporting Indicator (05/09) and MCO, CY 2024



\$0 Reporting Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Sub-capitated (05)	0	0	0	121	0	0	0	0	0	121
	0.0%	0.0%	0.0%	5.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Denied (09)	3,575	6,453	0	892	19,862	6,961	24,559	9,406	34,724	106,432
	82.3%	97.2%	0.0%	40.5%	97.8%	89.9%	100.0%	98.5%	94.5%	90.6%
No Indicator	769	187	5,347	1,192	442	786	6	144	2,006	10,879
	17.7%	2.8%	100.0%	54.1%	2.2%	10.1%	0.0%	1.5%	5.5%	9.3%
Total	4,344	6,640	5,347	2,205	20,304	7,747	24,565	9,550	36,730	117,432
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Most MCOs demonstrated a low rate of \$0 institutional encounters submitted without an indicator. Notable exceptions include JMS, which had 100% of its submissions without an

indicator, and KPMAS, which submitted more than half of their \$0 institutional encounters without an indicator and was the only MCO to use the sub-capitation indicator (05). PPMCO had 100% \$0 pay submitted encounters denied (09).

In August 2025, on behalf of the Department, Hilltop distributed files to each MCO detailing their CY 2024 \$0 reimbursement encounters submitted with a 09 indicator (“Denied by MCO”) on the CN1 segment and without an indicator. These data will help the MCOs estimate the impact of failing to comply with the requirement to include a reporting indicator on \$0 medical encounters and to improve the quality of their encounter data. These files also underwent an additional processing step whereby Hilltop removed records that had a counterpart with greater-than-\$0 provider reimbursement and the same provider, date of service, and Medicaid participant. These additional processing steps were performed to prepare files for the HFMR audit and are not analyzed for this report. This report includes encounter data that MMIS processes, regardless of whether they are included in the HFMR files.

Hilltop also analyzed the accepted medical encounters during CY 2024 by comparing the price paid against the price listed for the same service on the FFS fee schedule. Of the over 30 million medical encounters in this analysis, almost 26% of the encounters were reported with a \$0 pay amount. Approximately 40% of these were laboratory procedures. Of the encounters matched to the fee schedule with a non-zero payment amount, nearly 55% of encounters had some degree of difference between the amount paid by MCOs and the amount specified in the fee schedule. Of those encounters matched to the FFS fee schedule with a non-zero payment amount where there was some degree of difference, 70% were greater than the fee schedule payment amount and 30% were less; more than a third of these encounters were more than 20% greater than the FFS payment amount. The range by MCO of the percentage of encounters matched to the FFS fee schedule with a non-zero payment that was greater than the FFS fee schedule was from 12.4% to 28.0%.

In CY 2019, Hilltop determined that TPL was reported inconsistently in MMIS across MCOs. Some MCOs had up to 95% of their encounters with a positive TPL amount in a sample of trauma encounters from CY 2019, whereas others had no encounters with a positive TPL amount during the same period. For reference, FFS claims generally had positive TPL amounts in 1% to 3% of cases. Further analysis of a sample of trauma encounters from CY 2021 showed that the inconsistencies remained; three MCOs had no TPL for any encounters, and six MCOs had positive TPL in 85% to 99% of the encounters.

The Department reported that TPL for professional encounters was corrected in MMIS as of May 1, 2022. Analysis of trauma encounters from CY 2022 pulled from the professional file found that inconsistencies remained in TPL reporting, suggesting that only two MCOs have TPL properly recorded in professional files in CY 2022. The 2023 analysis of trauma encounters found more consistency, with four MCOs reporting TPL payments in 1% to 6% of their encounters. This decreased in CY 2024, with only three of the nine MCOs reporting TPL payments between 1% and 6%. In CY 2024, the other six MCOs did not report any TPL on their encounters, suggesting that TPL may be routinely missing from MMIS reporting for some MCOs. Hilltop will continue to

investigate TPL on all encounters and will review the results with the Department. In working with the Department, Hilltop has observed possible issues with mapping of TPL into the expected EDI format. Efforts are underway to resolve these issues.²⁵

Hilltop has not used the MCO-reported TPL amount in any analyses since CY 2018.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Methodology

Hilltop analyzed and interpreted data based on the submitted fields, volume and consistency of the encounter data, and utilization rates. The analyses included volume/consistency dimensions in three primary areas: time, service type, and appropriateness of diagnosis and procedure codes based on patient age. The Department helped identify several specific analyses for each primary area related to policy interests; the results can inform the development of long-term strategies for monitoring and assessing the quality of encounter data.

Hilltop conducted an analysis of encounter data by time dimensions (i.e., service date and processing date) to identify trends and evaluate data consistency. After determining the length of time between service dates and processing dates, Hilltop compared these dimensions to state standards or benchmarks for data submission and processing. Hilltop also compared time dimension data across MCOs to determine whether data are processed within similar time frames.

The service type analysis focused on three main service areas: inpatient hospitalizations, ED visits, and observation stays. The CY 2022 analysis provides baseline data and allows the Department to identify any inconsistencies in utilization patterns for these types of services in CY 2023 and CY 2024.

Finally, Hilltop analyzed whether diagnosis and procedure codes were age-appropriate. Participants older than 65 are ineligible for HealthChoice; therefore, any encounters for this population were noted, which could indicate an error in a participant's date of birth. Hilltop identified individuals with a service date before their date of birth and deliveries to participants below the age of 11 or above the age of 51. Since dementia is a disease generally associated with older age, Hilltop identified the number of participants under the age of 30 with a dementia diagnosis.²⁶ Hilltop also conducted an analysis of dental encounters for enrollees whose dental services potentially should have been covered through the FFS system. As in prior years, Hilltop provides participant-level, MCO-specific outlier reports for the Department to share with the MCOs.

²⁵ Specifically, some of the Service Line Adjudication (SVD) “loops” in the EDI transmission occurred more frequently than expected, requiring an update to MMIS mapping to be able to import.

²⁶ The ICD-10 Dementia diagnosis code G31.84 was removed.

Results

Time Dimension Analysis

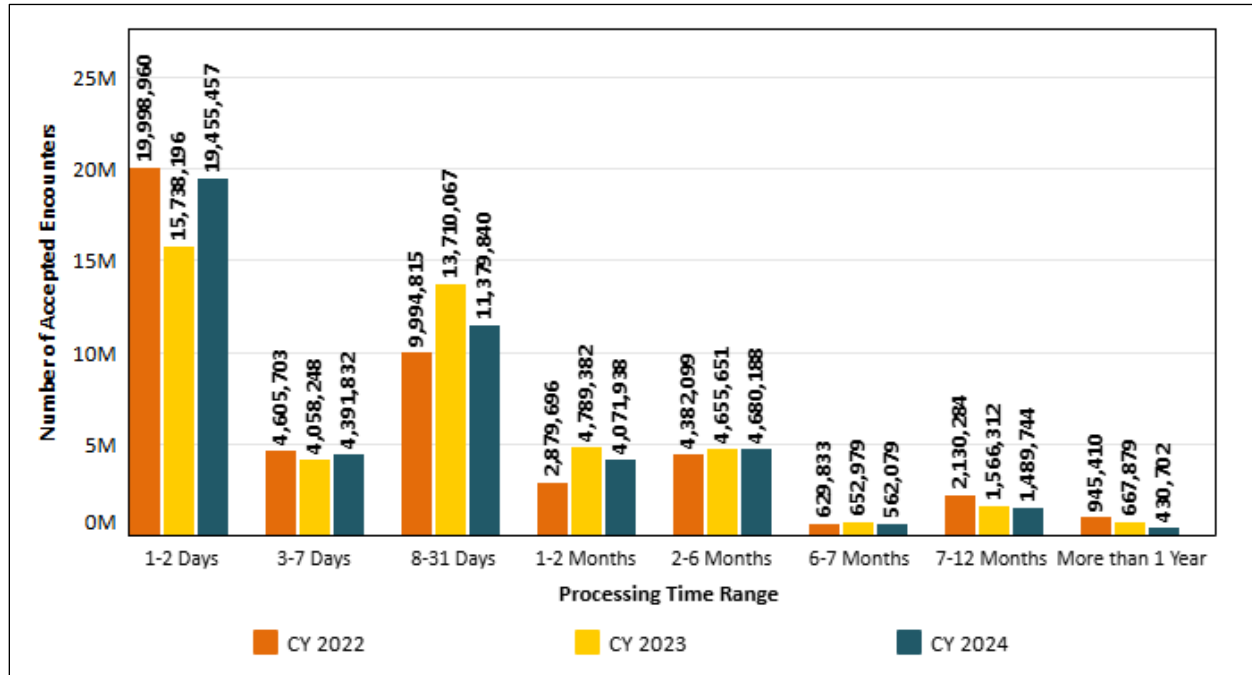
Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data. Encounter processing time spans the interval between the end date of service and the date on which the encounter is submitted to the Department. After providers render a service, they are required to invoice the MCO within six months. The MCO must then adjudicate the encounter within 30 days of invoice submission.²⁷ Maryland regulations require MCOs to submit encounter data to the Department “within 60 calendar days after receipt of the claim from the provider.”²⁸ Therefore, the maximum acceptable processing time allotted for an encounter between the end date of service and the date of submission to the Department is eight months.

The Medicaid program requires MCOs to submit encounters in a timely fashion; however, delays in submission occur, and some variation from month to month is expected. Noticeable changes related to timeliness may indicate irregular submission of encounter data. Figure 6 shows the timeliness of processing accepted encounter submissions from the end date of service for CY 2022 through CY 2024.

²⁷ Md. Code Ann., Health-Gen. § 15-102.3; § 15-1005.

²⁸ COMAR 10.09.65.15(B)(4).

Figure 6. Number of Accepted Encounters Submitted by Processing Time, CY 2022–CY 2024



Note for Figure 6 and Table 8: An encounter is labeled as “1-2 months” if the encounter was submitted between 32 and 60 days after the date of service; “2-6 months” if the encounter was submitted between 61 and 182 days after the date of service; “6-7 months” if the encounter was submitted between 183 and 212 days after the date of service; and “7-12 months” if the encounter was submitted between 213 and 364 days after the date of service.

Overall, there was mixed performance on the number of encounters submitted within six months. However, there was a decrease in encounters submitted after six or more months. Table 8 displays processing times for accepted encounters submitted to the Department by MCO from CY 2022 to CY 2024.

**Table 8. Percentage of Accepted Encounters Submitted
by MCO and Processing Time, CY 2022–CY 2024**

MCO	1-2 Days			3-7 Days			8-31 Days			1-2 Months		
	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024
ABH	33.3%	29.2%	39.8%	7.3%	7.9%	9.2%	17.1%	28.2%	22.9%	5.1%	10.3%	8.2%
CFCHP	54.0%	39.2%	47.7%	10.7%	8.6%	8.9%	16.6%	21.8%	18.3%	5.8%	7.5%	9.8%
JMS	30.6%	23.5%	26.4%	4.0%	3.9%	3.4%	16.7%	21.2%	21.0%	14.8%	15.2%	20.7%
KPMAS	57.5%	45.3%	45.3%	13.4%	11.0%	10.2%	21.2%	30.7%	21.3%	2.1%	8.0%	5.2%
MPC	47.1%	36.3%	42.4%	9.9%	8.8%	8.9%	17.5%	29.0%	21.2%	4.7%	8.5%	6.4%
MSFC	25.3%	26.4%	35.0%	5.7%	7.7%	7.4%	23.4%	33.9%	28.5%	17.4%	14.2%	13.4%
PPMCO	46.2%	33.5%	42.4%	10.7%	8.9%	10.2%	22.4%	30.1%	26.7%	5.8%	11.2%	7.9%
UHC	32.7%	24.1%	33.4%	10.5%	8.3%	9.4%	34.6%	36.4%	31.1%	7.4%	13.9%	12.0%
WPM	47.5%	39.1%	46.6%	10.9%	9.6%	10.4%	20.5%	29.0%	23.7%	4.4%	9.1%	8.2%
MCO	2-6 Months			6-7 Months			7-12 Months			More than 1 Year		
	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024	CY 2022	CY 2023	CY 2024
ABH	16.5%	11.4%	15.1%	3.9%	1.8%	2.1%	10.3%	6.5%	2.3%	6.5%	4.7%	0.3%
CFCHP	9.5%	7.4%	11.4%	0.6%	1.0%	0.9%	2.3%	5.0%	2.4%	0.6%	9.5%	0.6%
JMS	14.6%	27.6%	26.1%	2.4%	4.6%	1.0%	13.1%	3.8%	0.9%	3.8%	0.3%	0.4%
KPMAS	3.2%	2.9%	8.4%	0.5%	0.3%	1.8%	1.7%	1.0%	5.8%	0.5%	0.7%	2.1%
MPC	10.2%	8.3%	11.7%	1.6%	2.8%	1.8%	5.8%	5.7%	5.9%	3.2%	0.7%	1.7%
MSFC	17.3%	10.6%	10.6%	1.9%	0.9%	1.0%	6.9%	5.5%	3.1%	1.9%	1.0%	1.0%
PPMCO	8.6%	10.9%	8.1%	1.4%	1.0%	1.1%	3.6%	3.0%	2.8%	1.3%	1.4%	1.0%
UHC	10.3%	13.6%	10.9%	1.1%	1.3%	1.0%	2.4%	2.1%	1.9%	0.9%	0.3%	0.2%
WPM	7.6%	9.9%	7.9%	1.0%	1.2%	0.8%	5.2%	1.6%	1.9%	2.8%	0.4%	0.4%

ABH, MSFC, and UHC submitted a larger percentage of their encounters within 1 to 2 days in CY 2024 than in CY 2022. Only KPMAS had worse performance in all three of the longest time delay categories (6-7 months, 7-12 months, and more than 1 year) over the evaluation period.

See Appendix G for a stacked bar chart displaying the number and percentage of encounters within each claim type from CY 2022 to CY 2024 by processing time. Appendix H provides a table outlining the number and percentage of encounters submitted by MCOs by processing time in CY 2024.

Service Type Analysis

Table 9 shows the number and percentage of encounter visits for inpatient hospitalizations, ED visits, and observation stays by MCO for CY 2022 to CY 2024.

**Table 9. Number and Percentage of Inpatient Visits, ED Visits, and Observation Stays
by MCO, CY 2022–CY 2024**

Visits	CY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Number of Inpatient Visits	2022	4,176	6,923	3,086	7,679	20,100	9,272	28,102	12,816	22,277	114,431
	2023	4,850	8,579	3,237	8,050	21,226	8,333	29,778	12,871	22,688	119,612
	2024	5,669	9,222	3,344	8,948	21,144	8,081	31,984	13,742	25,631	127,765
Percentage of Inpatient Visits	2022	0.6%	0.6%	0.7%	0.7%	0.5%	0.6%	0.5%	0.5%	0.5%	0.5%
	2023	0.7%	0.7%	0.7%	0.7%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%
	2024	0.7%	0.6%	0.7%	0.8%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
Number of ED Visits	2022	23,569	33,155	18,701	25,341	127,470	54,528	170,435	75,401	135,907	664,507
	2023	25,879	39,534	18,633	26,038	128,584	47,049	172,795	77,602	135,116	671,230
	2024	26,259	39,596	18,569	25,270	121,320	45,401	166,906	73,867	129,703	646,891
Percentage of ED Visits	2022	3.5%	3.0%	4.0%	2.2%	3.1%	3.3%	3.1%	3.1%	3.1%	3.1%
	2023	3.6%	3.1%	4.1%	2.3%	3.2%	3.0%	3.2%	3.3%	3.1%	3.1%
	2024	3.3%	2.8%	4.1%	2.3%	3.2%	3.1%	3.1%	3.3%	3.1%	3.1%
Number of Observation Stays	2022	1,430	1,811	979	1,623	8,416	2,738	9,413	7,951	6,928	41,289
	2023	1,723	2,282	949	1,741	8,052	2,273	9,513	7,601	6,925	41,059
	2024	1,850	2,149	1,036	1,648	7,561	2,130	8,435	7,256	7,026	39,091
Percentage of Observation Stays	2022	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%
	2023	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.3%	0.2%	0.2%
	2024	0.2%	0.2%	0.2%	0.1%	0.2%	0.1%	0.2%	0.3%	0.2%	0.2%
Total Visits of Any Type	2022	672,857	1,093,093	469,075	1,143,675	4,048,013	1,666,516	5,512,901	2,393,716	4,316,397	21,316,243
	2023	725,534	1,286,938	455,712	1,155,967	4,023,229	1,590,177	5,456,680	2,345,972	4,320,909	21,361,118
	2024	784,067	1,426,091	458,049	1,121,687	3,802,732	1,443,911	5,325,429	2,268,447	4,230,510	20,860,923
Percentage of All Visits	2022	3.2%	5.1%	2.2%	5.4%	19.0%	7.8%	25.9%	11.2%	20.2%	100%
	2023	3.4%	6.0%	2.1%	5.4%	18.8%	7.4%	25.5%	11.0%	20.2%	100%
	CY 2024	3.8%	6.8%	2.2%	5.4%	18.2%	6.9%	25.5%	10.9%	20.3%	100%

Note: Visits were duplicated between inpatient visits, ED visits, and observation stays.

For this analysis, a visit was defined as one encounter per person per provider per day. MCOs reported a consistent distribution of visits by service type for all years of the evaluation period. Total inpatient hospitalizations and observation stays combined made up less than 1.0% of all visits each year. ED visits, which were 3.1% of all visits in each year of the evaluation period for the entire HealthChoice program, ranged from 2.3% of all visits (KPMAS) to 4.1% of all visits (JMS) in CY 2024. Overall, during the evaluation period, the percentage of inpatient visits increased slightly from 0.5% in CY 2022 to 0.6% in CY 2023 and 2024. The percentage of observation stays remained stable at 0.2%. As shown in the annual HealthChoice evaluation, the overall percentage of HealthChoice participants with an outpatient ED visit, ED visit with inpatient admission, and inpatient admission decreased between CY 2019 and CY 2023 (The Hilltop Institute, 2025).

Outlier Data Analysis

Hilltop conducted an analysis of encounter data submitted by MCOs to determine the effectiveness of encounter data edit checks between CY 2022 and CY 2024. The following areas were analyzed: 1) individuals over age 65 with encounters, 2) individuals with a service date before their date of birth, 3) age-appropriate diagnoses for delivery (births), 4) age-appropriate

dementia diagnoses, 5) MCO-reimbursed dental encounters, and 6) duplicate behavioral health services submitted both as encounters and as claims through the FFS system.

Because participants older than 65 are ineligible for HealthChoice, Hilltop searched for any encounters for those aged 66 or older. The number of MCO participants aged 66 or older who had encounters during the evaluation period fell between CYs 2022 and 2023 but rose again to peak in 2024.²⁹ The number of individuals with a service date before their date of birth increased between CY 2022 and CY 2023 but fell again in CY 2024.

Hilltop analyzed the volume of participants who had a diagnosis for delivery by age group between CY 2022 and CY 2024. Participants aged 0 to 11 and 51 or older are typically considered to be outside of the expected age range for delivery. Across all MCOs, the number of participants identified as delivering outside of the expected age ranges was 103 in CY 2022, 94 in CY 2023, and 101 in CY 2024. The data substantiate that, overall, the encounters submitted are age-appropriate for delivery. See Appendix I for delivery codes.

Another analysis focused on age-appropriate diagnoses of dementia (see Appendix J for dementia codes) from CY 2022 to CY 2024.³⁰ Although dementia is a disease generally associated with older age, onset can occur as early as 30 years of age. Thus, the prevalence of dementia diagnoses should increase with age after 30. Hilltop identified the number of participants under the age of 30 with an encounter with a dementia diagnosis. Only one MCO—JMS—had no dementia encounters with a participant aged 30 or younger in CY 2024. All other MCOs had a small number of such encounters, involving a total of 158 participants in CY 2024.³¹

The analysis of MCO-reimbursed dental encounters found no results in CY 2024, indicating that providers, MCOs, and the Department are aligned.

In May 2025, Hilltop completed an analysis of behavioral health encounters that were duplicates of claims submitted through the FFS system. Among professional claims, the most common type to have a duplicate encounter was presumptive and definitive drug testing, albeit many of those claims were denied by the MCO as indicated by \$0 payment and the 09 indicator. The Department continues to analyze the results.

Step 4. Compare Findings to State-Identified Benchmarks

In Steps 2 and 3, Hilltop compared the encounter data submitted by each MCO with benchmarks identified by the Department. Hilltop benchmarked each MCO against its own performance over time, as well as against other MCOs. Hilltop also identified and compared outlier data with overall trends noted among the MCOs.

²⁹ Data not shown due to small cell sizes.

³⁰ The ICD-10 dementia diagnosis code G31.84 was removed so the data cannot be compared to previous reports.

³¹ Data not shown by MCO due to small cell sizes.

Recommendations

The denied encounter analysis identified specific areas reduce denials. Hilltop's review of the 8ER reports shows that, out of approximately 49.7 million overall encounters, more than 3.2 million encounters (approximately 6.5%) were denied in CY 2024. This is a decrease from 4.4 million denied encounters in CY 2023 and 3.9 million in CY 2022. However, in CY 2019—before the use of the provider NPI crosswalk, validation, and provider enrollment edits was implemented—the number of denied encounters was 1.9 million, which increased by 259% in CY 2020. While denied encounters from the 8ER reports are not de-duplicated, their volume has continued to decline but is still higher than in CY 2019. The Department should keep monitoring and collaborating with the MCOs to resolve the usage of the Department's provider master file and NPI Crosswalk process. The Department should also continue to encourage MCOs to work with their providers to ensure that they are enrolled on the date of service and that they know how to check their current status. In addition, the Department should work with the MCOs to minimize denied encounters resulting from limited-risk NPI uncollapsing. MCOs should coordinate with network providers to use correct NPIs in claims and update systems quickly when new NPIs are assigned.

Hilltop analyzed and interpreted the encounter data and found that, during CY 2024, the MCOs submitted a total of 46.5 million accepted encounters (records), an increase from 45.8 million in CY 2022 and 44.3 million in CY 2023. Hilltop reviewed encounters by claim type and found similar distributions among MCOs. Each MCO's distribution of encounters across claim types remained stable throughout the calendar years. Additionally, Hilltop compared the proportion of HealthChoice participants by MCO with the proportion of accepted encounters by MCO, observing similar trends. The Department should continue to monitor the improvement in submissions of the number of accepted encounters by claim type across MCOs.

Hilltop conducted an analysis of accepted medical encounters with \$0 provider reimbursement and found that MCOs varied in their encounters submitted with populated data, with rates between 34.9% and 96.0% in CY 2024. MCOs with unusually high numbers of \$0 encounters or inconsistent use of reporting indicators should explain these figures to the Department and improve accuracy in future submissions.

Hilltop further analyzed the MCOs' use of the 05/09 indicator on the CN1 segment on accepted medical encounters with \$0 in the provider reimbursement field. Adherence to this requirement is uneven across MCOs: denied encounters (09) were the most common among submissions (49.0%), followed by encounters with no indicator (38.4%) and those with the sub-capitated (05) indicator (12.6%). The Department should consider implementing reporting to monitor adherence to this requirement.

Hilltop found inconsistent TPL payments in MMIS, with some MCOs not reporting any TPL on encounters, suggesting frequent omission of TPL data from MMIS submissions. After one MCO raised concerns, a departmental review found a problem in a limited subset of encounter records related to a mapping issue, where a \$0 TPL loop was selected instead of the valid TPL

amount, causing certain encounters to incorrectly appear as \$0-pay. This only impacts encounter-level reporting and analytics—not claims adjudication, capitation payments, or financial settlements. A prospective mapping correction is underway to prevent recurrence, and this issue should be resolved for CY 2026. The Department is reviewing TPL encounters to ensure the appropriate resolution to this issue.

Many behavioral health encounters—also submitted through the FFS system—are denied by the MCO, as indicated by \$0 payment and the 09 indicator. Some accepted encounters have a corresponding claim from the behavioral health administrative services organization, indicating duplicate payments for the same service. The Department is providing quarterly analysis of these duplicate payments to the MCOs and requiring proof of retracted payments made in error.

The auditor will continue to test CY 2024 denied and \$0 pay encounters and will apply adjustments for CY 2025. This testing will ensure that MCOs improve data quality, as the 2025 adjustments will modify base data by removing “appropriate” denials and \$0 pay from the HFMR costs.

Hilltop compared dates of service with MCO encounter submission dates and found that timeliness of encounter submissions demonstrated mixed performance during the evaluation period on the number of encounters submitted within six months. However, most encounters were submitted within 1 to 2 days, and there was a decrease in encounters submitted after six or more months. MCOs that submit encounters more than eight months after the date of service—the maximum time allotted for submission to the Department—should be flagged for improvement. Timely encounter data submission allows the Department to more closely monitor trends in expenditures and quality. The MCOs have shown a commitment to working with the Department and Hilltop to address issues with encounter data, whether through the Encounter Data Workgroup or through other means of stakeholder engagement.

Conclusion

HealthChoice is a managed care program designed to improve the access and quality of health care services for Maryland Medicaid participants. The analysis of the CY 2024 electronic encounter data shows a decrease in provider enrollment-related denied encounters. Although the changes in provider encounter edits still present challenges, the Department and the MCOs have continued to build on recent improvements.

The CY 2024 encounter data validation demonstrates progress in reducing denied encounters. The most concerning issue in CY 2024 encounter data is the ongoing volume of encounter denials from provider enrollment errors. The Department should continue to work with the MCOs to resolve their NPI Crosswalk and provider exceptions and enrollment issues, which will allow for more accurate rate setting in the future. Workgroup meetings with MCOs are ongoing for the CY 2025 contract, aiming to further refine which encounters should be excluded from the HFMR. In addition, “inappropriate denials” due to MMIS limitations are included in the HFMR. The Department will work with the MCOs to ensure that appropriately denied encounters will not be reported on the HFMR. In addition, some MCOs had unusually high volumes of \$0

encounters, which should also be excluded from the HFMR. In August 2025, the Department distributed files to each MCO detailing their CY 2024 \$0 reimbursement encounters submitted with and without a 09 indicator to help MCOs improve the quality of their encounter data. The Department will continue to work with the MCOs to provide an explanation and ensure the accuracy of the provider reimbursement field with future submissions.

Generally, the MCOs have similar distributions of denials, types of encounters, types of visits, and outliers, except where specifically noted in the results. This analysis identified minor outliers that merit further monitoring and investigation, though the MCOs have improved. Hilltop prepared recipient-level reports for Department staff to discuss with the MCOs. The Department should review the content standards and criteria for accuracy and completeness with the MCOs. Continued work with each MCO to address identified discrepancies will improve the quality and integrity of encounter submissions and enhance the Department's ability to assess the efficiency and effectiveness of the Medicaid program.

Hilltop found that the volume of accepted encounters was generally consistent with MCO enrollment. Although the time dimension analysis showed variation among MCOs regarding the timeliness of encounter submissions, most encounters were submitted within the eight-month maximum time frame allotted by the Department. While the MCOs demonstrated mixed performance on the number of encounters submitted within six months, there was a decrease in encounters submitted after six months during the evaluation period. The Department should continue to work with MCOs to ensure the timeliness of encounter submissions, especially for MCOs with high rates of submissions occurring more than eight months after the end date of service.

References

- Centers for Medicare & Medicaid Services. (2012, September). *EQR protocol 4 validation of encounter data reported by the MCO*. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf>
- Centers for Medicare & Medicaid Services. (2019, October). *CMS external quality review (EQR) protocols*. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>
- Centers for Medicare & Medicaid Services. (2023, February). *CMS external quality review (EQR) protocols*. <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>
- The Hilltop Institute. (2025, August 15). *Evaluation of the Maryland Medicaid HealthChoice program: CY 2019 to CY 2023*. Baltimore, MD: UMBC. <https://health.maryland.gov/mmcp/healthchoice/Documents/HC-Monitoring-Evaluation/Post-Award-Forum/2025/EvaluationOfTheHealthChoiceProgram-August2025.pdf>
- Maryland Department of Health. (2017, September 20). *Maryland Medical Assistance program: MCO transmittal No. 120*. https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_04-18.pdf
- Maryland Department of Health. (2018, September). *HealthChoice managed care organization agreement*. <https://mmcp.health.maryland.gov/healthchoice/Documents/MCO%20Agreement%202019%20for%20CY%202019%20MCO%20file.pdf>

Appendix A. Reporting Instructions for the Final CY 2024 HealthChoice Financial Monitoring Report (HFMR) and Supplemental Financial Data Reports

Ineligible, Improper Costs Removal

An “Office of Legislative Audits” (OLA) report dated June 21, 2023, relayed three findings. One of those findings stated that ineligible, improper costs reported by the MCOs were included in HFMRs and therefore in capitation rate calculations. These ineligible costs included 1) denied claims (e.g., duplicates) and claims which were not the responsibility of the MCO, such as, 2) claims for carved out services (e.g., behavioral health) or for 3) incarcerated individuals.

Regarding denied claims the items below should be included in the HFMR.

1. Error/Exception Codes 437 (Procedure Not Covered For Date of Service), 430 (Procedure or Revenue Code Not on File) when paired with revenue code 810 or 948, and 986 (Duplicate NDC Code), 435 (Recipient Sex Not Valid for Procedure) when associated with gender-neutral CPTs 81479 (Unlisted Molecular Pathology) or 81400-81408 (Molecular Pathology Levels 1-9).
2. \$0 Pay Encounters, 05-Sub-capitated reporting indicators.
3. Claim amounts for encounters denied for ePREP-related reasons (i.e., related to provider enrollment defined as falling under error/exception codes 122, 412, 951, 961, 962, 963, 964, 965, 971, 975, 976).
4. A logic change is being made is to \$0 files. Hilltop will remove records from the \$0 Pay file we send to the MCOs and M&S, if they had a paid counterpart with payment > \$0 and the same recipient ID, provider ID, and dates of service.

Also, the instances below should not be considered duplicates and therefore should not be excluded as duplicates (i.e., they should be included in the HFMR).

1. Anesthesia codes billed for the same date of service by different providers with different modifiers (QZ nurse anesthetist without medical direction by physician, QY medical direction of nurse anesthetist by anesthesiologist, QX non-physician anesthetist with medical direction by physician, QK medical direction of concurrent anesthesia procedures).
2. Modifiers 76 (repeat procedure by same physician) and 77 (repeat procedure by another physician).
3. Modifier 59 is not meant to identify a repeat procedure, rather procedures not normally reported together but appropriate under the circumstances (per the MCS CPT Manual). This modifier is frequently billed by providers WITHOUT the provider billing a separate line that does NOT include the modifier; rejection of such encounters based on the use of modifier 59 is not appropriate.

The items below should be excluded from the HFMR.

1. All denied encounters, except for error codes listed above.
2. \$0 Pay Encounters, 09-Denied reporting indicators.
3. \$0 Pay Encounters with no indicator.

CY 2024 HFMRs will be audited to ensure that denied encounters and \$0 pay encounters are appropriately excluded from reporting as described above.

The accompanying HFMR certification form should be taken to apply to all of these ineligible costs as a verification that they have been excluded.

Encounter Submissions-Home Health (HH) & Skilled Nursing Facility (SNF) & Genetic Testing

If the error code is 435, “Sex Recip N/Vald F/Rept Proc,” or 437, or 420, these claims should be submitted with all service lines even if it is known that they will fail. Getting a 420, 435, or 437 will demonstrate that they should be included in the HFMR. After failing, the MCO should resubmit just the service lines that will go through (i.e., strip out the offending lines).

Appendix B. CY 2024 HFMR Denied Encounter and Zero Pay Encounter Files

To: Aimee Dietsch
CC: Bryan O'Mara and Monchel Pridget
From: Jim Clavin, Todd Switzer, and Alice Middleton
Date: July 11, 2025
Re: CY 2024 HFMR Denied Encounter and Zero Pay Encounter Files

As part of the HFMR process for CY 2024, Hilltop will again be providing zero pay files and denied encounter files to the MCOs for review and feedback. The zero pay files and denied encounter data will be sent to Myers and Stauffer after a time period allowing for confirmation from the MCOs that the data are valid. Please review the information below and let us know if you have any questions.

- Hilltop will send zero pay files and—separately—denied encounter files to the MCOS by August 15, 2025
 - MCOs confirm receipt of files by August 22
 - MCOs provide any feedback by October 15
- Regarding the logic of the two sets of files:
 - The denied encounter files will use the same logic as developed by Hilltop in collaboration with the MCOs and the Department
 - The zero pay file logic will have one change based on MCO feedback:
 - Hilltop will remove records from the zero pay file if they had a paid counterpart with payment >\$0 and the same recipient ID, provider ID, and dates of service

The logic for the Denied Encounter File and Zero Pay File as of July 2025 is shown on the following page.

Denied Encounters Data File

- Includes claim status = X (Denied)
- Does not include denied encounters that have a paid/accepted counterpart with the same RECIPNO, BEGDOS, REVCODE/PROCODE, PROV.
**PROV is used only if there is no provider-related error codes on the denied encounter.
- The data set does not include denied encounters:
 - That have an error code from the HFMR Exclusion list: 122, 412, 437, 951, 961, 962, 963, 964, 965, 971, 975, 976, 986
 - When exception code is 430 and revenue code is 810 or 948
 - When exception code is 435 and CPT 81479 or between 81400 to 81408

Zero Dollar Pay Encounters

- Hilltop AMT_PAY_BY_MCO = \$0
- MMIS field P3815534-AMT-PAID-BY-MCARE
- Claim Status = P (Paid)
- Begin dates of service 1/1/2024 – 12/31/2024
- PAID dates through 6/30/2025
- CN101 Segment (OVERRIDE_CODE)
 - Included:
 - 9 = Denied by MCO
 - Missing
 - Not included:
 - 5 = Sub-capitated
- If the \$0 pay record had a paid counterpart with non-\$0 with the same RECIPNO, BEGDOS, ENDOS, PROV in the calendar year, then the zero dollar pay record is not included in the data set.
- If the \$0 pay record has a denied counterpart (claim status = X) with the same RECIPNO, BEGDOS, ENDOS, PROV and different modifiers, then the zero dollar pay record is not included in the data set.

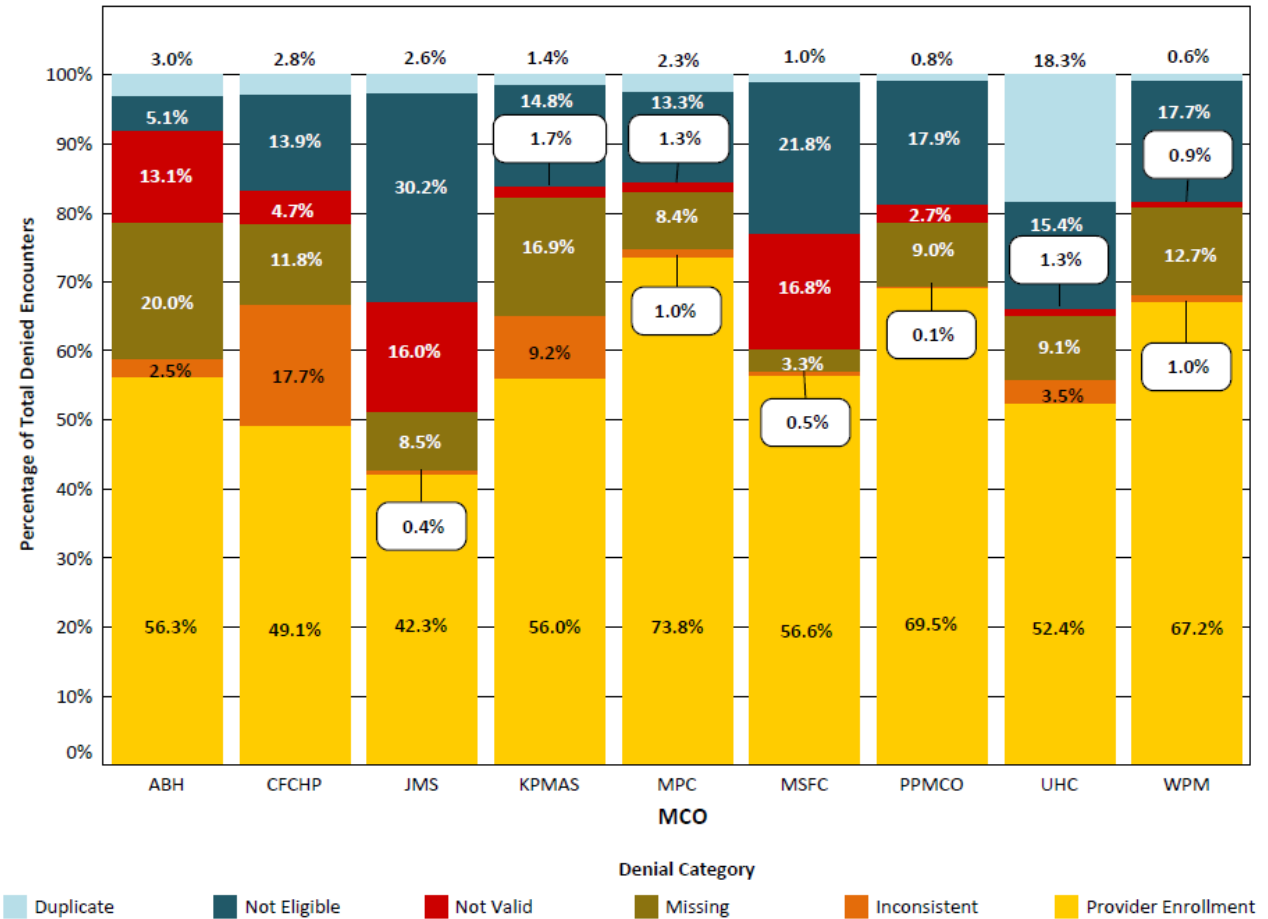
Appendix C. Denial Codes, Errors, by Category with Provider-Related and Other Denial Codes, CY 2024

Denial Type	Denial Category	Denial Code*	Error Description
Provider-Related	Provider Enrollment	122	INVALID RENDERING PROV NUMBER
		412	REND PROV NOT ON FILE
		951	PROVIDER NUMBER NOT VALID
		961	PAY-TO/FAC PROVIDER SUSPENDED
		962	RENDERING PROVIDER SUSPENDED
		963	PAY-TO/FAC PROV NOT ACT DOS
		964	REND PROV NOT ACT ON DOS
		965	BILL/PAY2 PROV NPI <> MA ID
		971	NPI NUMBER INVLD FR PYTOPROV
		975	NPI#NFDONPROVFLFRENREFFACTLY
		976	REND PROV NPI NO MATCH FFS ID
	Not Valid	531	SVC/REND PROV# N/9 NUM DIGITS
		950	SUB PROV NOT ON MASTER FILE
Other	Duplicate	902	ORIG ICN FD ON HIST ALRD VOID
		986	NDC CODE IS DUPLICATE
	Inconsistent	113	ADMIT DATE AFTER 1ST DATE SER
		126	THRU DOS PRIOR TO BEGIN DOS
		182	PAT STAT CD DISCHRG DTE CNFLT
		190	FIRST SURG DOS W/IN SVC PERIOD
		290	ORIG ENC TP A/RES DN AGREE
		435	SEX RECIP N/VALD F/REPT PROC
		454	FIRST DIAGNOSIS AGE CONFLICT
		455	FIRST DIAGNOSIS SEX CONFLICT
		465	2ND DIAG SEX CONFLICT
		474	3RD DIAGNOSIS AGE CONFLICT
		485	4TH DIAGNOSIS SEX CONFLICT
		589	FRM DOS PRIOR TO RECIP DOB
		901	ORIG ICN N/FOUND ON HISTORY
		912	VD/RESB MCO# NOT EQL HISTORY
		913	VOID RESUBMIT RECPT NOT = HIST
	Missing	135	BILLING PROV NUM MISSING
		170	INV/MISS PLACE OF SERVICE
		172	INVLD OR MISS REV/HCPSCS CODE
		249	UNITS OF SERVICE EQUAL ZERO
		361	TOOTH # REQD FOR PROC IS MISS
		362	TOOTH SURF REQ F/PROC IS MISS
		970	NPI NUMBER IS MISSING
		982	NDC MISSING OR NOT VALID
		985	NDC QUANTITY MISSING

Denial Type	Denial Category	Denial Code*	Error Description
	Not Eligible	250	RECPT NOT ON ELIGIBILITY FILE
		271	RECIP NOT ENRLD W/RPT MCO DOS
		437	PROC/REV CODE NOT COVD DOS
	Not Valid	124	FIRST DOS NOT STRUCTURED PROP
		129	RECPT NUMBER NOT 11 NUM DIGITS
		138	UB92 TYPE OF BILL INVALID
		144	LAST DOS AFTER BATCH PROC DATE
		167	ADMIT DATE NOT STRUCTURED PROP
		197	1ST SURG PROC DATE INVALID
		207	PATIENT DISCHARGE STATUS INVAL
		217	FACILITY NUMBER NOT VALID
		430	PROC/REV CODE NOT ON FILE
		450	FIRST DIAGNOSIS NOT ON FILE
		460	2ND DIAG NOT ON FILE
		470	3RD DIAG NOT ON FILE
		480	4TH DIAG NOT ON FILE
		550	FIRST PROC NOT ON FILE
		560	SECOND PROC NOT ON FILE
		600	CLAIM EXCEEDS 50 SERVICE LINES
		896	RELATED HISTORY REC MAX EXCEED
		900	VD/RESB RECD WOUT/ORIG ICN.
		973	NPI/MA# NOT MATCHED IN MMIS

* Explanation of benefits (EOB) error codes matching the last 3 of the ICN

Appendix D. Percentage of Encounters Denied by MMIS Denial Category, by MCO, CY 2024



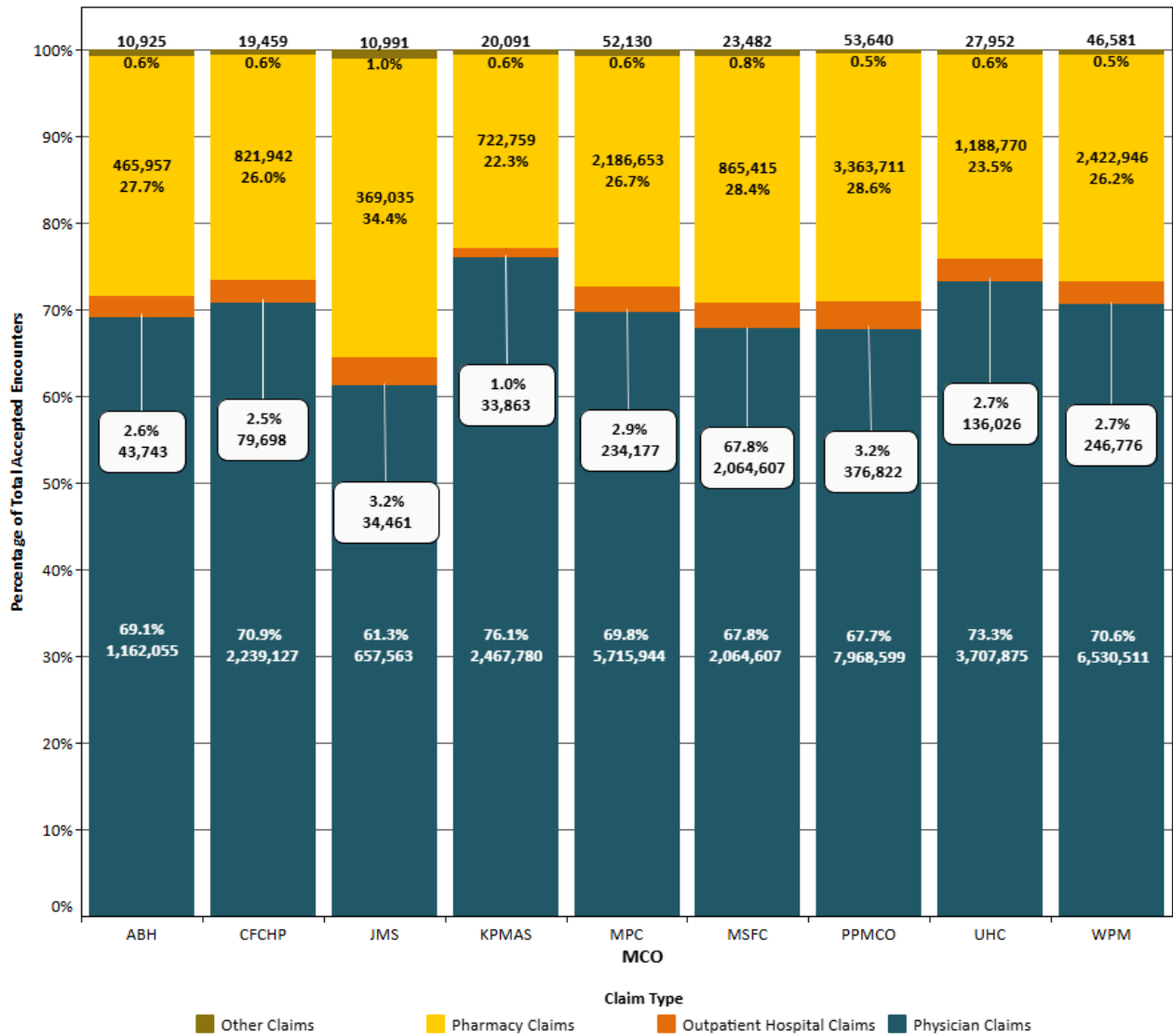
Appendix E. Top Three MMIS Denial Descriptions by Number of Denied Encounters by MCO, CY 2024

MCO	CY 2022			CY 2023			CY 2024		
	Denial Code**	Error Description	Denials	Denial Code**	Error Description	Denials	Denial Code**	Error Description	Denials
ABH	951*	PROVIDER NUMBER NOT VALID	20,227	951*	PROVIDER NUMBER NOT VALID	17,185	971*	NPI NUMBER INVLD FR PYTOPROV	6,221
	122*	INVALID RENDERING PROV NUMBER	14,422	971*	NPI NUMBER INVLD FR PYTOPROV	15,981	951*	PROVIDER NUMBER NOT VALID	5,831
	135	BILLING PROV NUM MISSING	13,144	135	BILLING PROV NUM MISSING	15,339	135	BILLING PROV NUM MISSING	5,340
CFCHP	122*	INVALID RENDERING PROV NUMBER	70,336	963*	PAY-TO/FAC PROV NOT ACT DOS	15,483	901	ORIG ICN N/FOUND ON HISTORY	57,818
	901	ORIG ICN N/FOUND ON HISTORY	62,413	951*	PROVIDER NUMBER NOT VALID	14,852	963*	PAY-TO/FAC PROV NOT ACT DOS	43,768
	951*	PROVIDER NUMBER NOT VALID	40,799	135	BILLING PROV NUM MISSING	10,297	951*	PROVIDER NUMBER NOT VALID	43,430
JMS	951*	PROVIDER NUMBER NOT VALID	73,311	271	RECIP NOT ENRLD W/RPT MCO DOS	7,315	271	RECIP NOT ENRLD W/RPT MCO DOS	4,560
	135	BILLING PROV NUM MISSING	72,728	951*	PROVIDER NUMBER NOT VALID	4,398	951*	PROVIDER NUMBER NOT VALID	2,069
	971*	NPI NUMBER INVLD FR PYTOPROV	72,713	437	PROC/REV CODE NOT COVD DOS	3,777	975*	NPI#NFDONPROVFLFRENREFFACTLY	1,556
KPMAS	951*	PROVIDER NUMBER NOT VALID	45,888	971*	NPI NUMBER INVLD FR PYTOPROV	35,222	951*	PROVIDER NUMBER NOT VALID	24,541
	971*	NPI NUMBER INVLD FR PYTOPROV	43,197	951*	PROVIDER NUMBER NOT VALID	34,596	135	BILLING PROV NUM MISSING	21,486
	135	BILLING PROV NUM MISSING	41,877	135	BILLING PROV NUM MISSING	33,992	971*	NPI NUMBER INVLD FR PYTOPROV	21,050
MPC	963*	PAY-TO/FAC PROV NOT ACT DOS	119,963	963*	PAY-TO/FAC PROV NOT ACT DOS	113,794	963*	PAY-TO/FAC PROV NOT ACT DOS	160,802
	951*	PROVIDER NUMBER NOT VALID	85,691	951*	PROVIDER NUMBER NOT VALID	78,369	271	RECIP NOT ENRLD W/RPT MCO DOS	71,572
	271	RECIP NOT ENRLD W/RPT MCO DOS	67,711	135	BILLING PROV NUM MISSING	66,895	961*	PAY-TO/FAC PROVIDER SUSPENDED	56,004
MSFC	963*	PAY-TO/FAC PROV NOT ACT DOS	20,532	129	RECPT NUMBER NOT 11 NUM DIGITS	72,328	122*	INVALID RENDERING PROV NUMBER	58,668
	951*	PROVIDER NUMBER NOT VALID	11,300	271	RECIP NOT ENRLD W/RPT MCO DOS	64,967	951*	PROVIDER NUMBER NOT VALID	54,277
	135	BILLING PROV NUM MISSING	6,398	951*	PROVIDER NUMBER NOT VALID	64,192	271	RECIP NOT ENRLD W/RPT MCO DOS	50,760
PPMCO	271	RECIP NOT ENRLD W/RPT MCO DOS	227,772	963*	PAY-TO/FAC PROV NOT ACT DOS	192,012	963*	PAY-TO/FAC PROV NOT ACT DOS	260,622
	951*	PROVIDER NUMBER NOT VALID	225,291	951*	PROVIDER NUMBER NOT VALID	183,527	271	RECIP NOT ENRLD W/RPT MCO DOS	128,391
	135	BILLING PROV NUM MISSING	159,157	135	BILLING PROV NUM MISSING	135,870	951*	PROVIDER NUMBER NOT VALID	109,528
UHC	951*	PROVIDER NUMBER NOT VALID	131,176	951*	PROVIDER NUMBER NOT VALID	59,159	902	ORIG ICN FD ON HIST ALRD VOID	67,109
	975*	NPI#NFDONPROVFLFRENREFFACTLY	86,177	963*	PAY-TO/FAC PROV NOT ACT DOS	38,732	271	RECIP NOT ENRLD W/RPT MCO DOS	53,060
	963*	PAY-TO/FAC PROV NOT ACT DOS	55,829	962*	RENDERING PROVIDER SUSPENDED	37,611	963*	PAY-TO/FAC PROV NOT ACT DOS	45,237
WPM	963*	PAY-TO/FAC PROV NOT ACT DOS	96,012	951*	PROVIDER NUMBER NOT VALID	66,543	271	RECIP NOT ENRLD W/RPT MCO DOS	86,098
	951*	PROVIDER NUMBER NOT VALID	62,768	971*	NPI NUMBER INVLD FR PYTOPROV	64,340	951*	PROVIDER NUMBER NOT VALID	73,866
	971*	NPI NUMBER INVLD FR PYTOPROV	48,722	135	BILLING PROV NUM MISSING	60,597	963*	PAY-TO/FAC PROV NOT ACT DOS	69,807

* Indicates a provider enrollment-related error code.

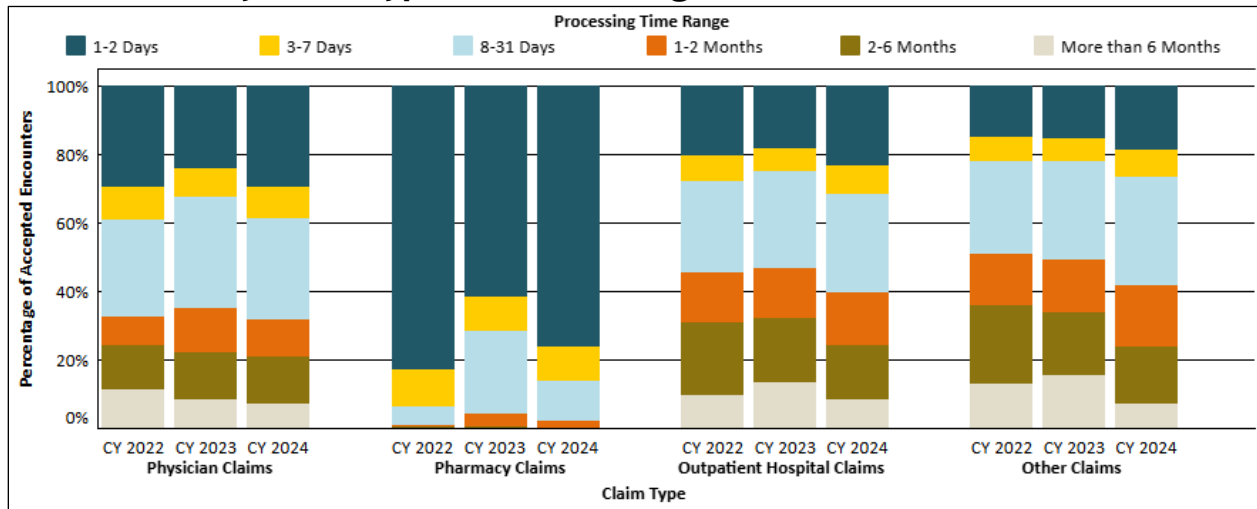
** Explanation of benefits (EOB) error codes matching the last 3 of the ICN

Appendix F. Number and Percentage of Accepted Encounters by Claim Type and MCO, CY 2024



Note: "Other Claims" is a combination of inpatient hospital claims, community-based services claims, and long-term care claims.

Appendix G. Percentage of the Total Number of Accepted Encounters Submitted by Claim Type and Processing Time, CY 2022–CY 2024



Processing Time Range	CY 2022 Physician Claims	CY 2023 Physician Claims	CY 2024 Physician Claims	CY 2022 Pharmacy Claims	CY 2023 Pharmacy Claims	CY 2024 Pharmacy Claims	CY 2022 Outpatient Hospital Claims	CY 2023 Outpatient Hospital Claims	CY 2024 Outpatient Hospital Claims	CY 2022 Other Claims	CY 2023 Other Claims	CY 2024 Other Claims
1-2 Days	29.4%	24.0%	29.6%	82.8%	61.6%	76.4%	20.3%	18.1%	23.2%	15.2%	15.5%	18.9%
3-7 Days	9.9%	8.4%	9.3%	11.1%	10.2%	9.9%	7.7%	7.0%	8.5%	6.7%	6.7%	7.8%
8-31 Days	28.4%	32.4%	29.2%	5.4%	24.1%	11.6%	26.7%	28.1%	28.8%	27.4%	28.5%	31.8%
1-2 Months	8.3%	13.0%	11.0%	0.2%	3.7%	2.0%	14.6%	14.5%	15.4%	14.9%	15.5%	17.6%
2-6 Months	12.7%	13.8%	13.6%	0.3%	0.2%	0.1%	21.1%	18.9%	16.0%	23.0%	18.5%	16.8%
More than 6 Months	11.3%	8.4%	7.3%	0.2%	0.2%	0.0%	9.6%	13.4%	8.1%	12.7%	15.3%	7.0%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	31,060,738	31,231,219	32,514,054	12,689,362	12,873,407	12,407,188	1,530,619	1,452,096	1,275,287	286,081	281,992	265,251

Appendix H. Distribution of Accepted Encounters Submitted by MCO and Processing Time, CY 2024

Processing Time Range	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
1-2 Days	39.8%	47.7%	26.4%	45.3%	42.4%	35.0%	42.4%	33.4%	46.6%	41.9%
	669,916	1,507,796	283,256	1,468,148	3,472,877	1,066,478	4,982,419	1,692,763	4,311,804	19,455,457
3-7 Days	9.2%	8.9%	3.4%	10.2%	8.9%	7.4%	10.2%	9.4%	10.4%	9.5%
	155,500	281,046	36,856	331,345	725,964	226,443	1,196,590	477,293	960,795	4,391,832
8-31 Days	22.9%	18.3%	21.0%	21.3%	21.2%	28.5%	26.7%	31.1%	23.7%	24.5%
	384,530	578,139	225,132	691,119	1,733,966	866,887	3,139,011	1,571,837	2,189,219	11,379,840
1-2 Months	8.2%	9.8%	20.7%	5.2%	6.4%	13.4%	7.9%	12.0%	8.2%	8.8%
	138,034	308,657	222,417	168,795	527,448	408,945	933,499	605,841	758,302	4,071,938
2-6 Months	15.1%	11.4%	26.1%	8.4%	11.7%	10.6%	8.1%	10.9%	7.9%	10.1%
	254,837	361,154	280,152	272,565	955,430	321,522	949,495	550,629	734,404	4,680,188
6-7 Months	2.1%	0.9%	1.0%	1.8%	1.8%	1.0%	1.1%	1.0%	0.8%	1.2%
	34,925	28,021	10,599	57,969	148,308	30,140	124,191	52,443	75,483	562,079
7-12 Months	2.3%	2.4%	0.9%	5.8%	5.9%	3.1%	2.8%	1.9%	1.9%	3.2%
	39,350	75,231	9,634	187,557	485,551	93,467	325,301	98,346	175,307	1,489,744
More than 1 Year	0.3%	0.6%	0.4%	2.1%	1.7%	1.0%	1.0%	0.2%	0.4%	0.9%
	5,588	20,182	4,004	66,995	139,355	29,344	112,264	11,471	41,499	430,702
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	1,682,680	3,160,226	1,072,050	3,244,493	8,188,899	3,043,226	11,762,770	5,060,623	9,246,813	46,461,780

Appendix I. Delivery Codes

Delivery services were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below during CY 2022 through CY 2024.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes	O60.1x, O60.2x, O61.x, O64.x, O65.x, O66.x, O67.x, O68*, O69.x, O70.x, O71.x, O72.x, O73.x, O74.x, O75.x, O76*, O77.x, O80*, O82*, Z37.x

*Only the three-character code listed in the table (e.g., O68, O76, and O80) was included as a valid diagnosis. For all other diagnosis codes, the analysis included all other codes that began with the diagnosis code listed in the table (e.g., O61.x), where x equals any number of digits after the decimal. For example, O61.x, the “x” can represent any number of digits after the decimal (e.g., O61.1 or O61.14) or no digits after the decimal (e.g., O61).

Appendix J. Dementia Codes

Dementia-related services in CY 2024 were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below. These codes indicate services for Alzheimer's disease and other types of dementia.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes*	F01, F02, F03, G30, G31**

* The three-character codes can include any number of alphanumeric characters after the decimal, such as F03.A.

** The ICD-10 Diagnosis code G31.84 has been removed.



The Hilltop Institute

UMBC

Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854

www.hilltopinstitute.org

Appendix D: 2024 Maryland HealthChoice Consumer Report Card

Information Reporting Strategy and Analytic Methodology

Introduction

As part of its external quality review (EQR) contract with the Maryland Department of Health (MDH), Qlarant is responsible for developing a Medicaid Consumer Report Card (CRC) on an annual basis.

Visual comparisons of performance demonstrated in a CRC help Medicaid enrollees compare and select a HealthChoice managed care organization (MCO). Ratings for each MCO are derived from performance measure scores selected 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 to develop the 2025 CRC, which is based on HEDIS MY 2023 data made available in 2024. This report is organized as follows:

- Information Reporting Strategy
 - The Information Reporting Strategy explains the criteria used to determine the most appropriate and effective methods of reporting quality information to the intended target audience – Medicaid enrollees.
- Analytic Method
 - The Analytic Method provides a statistical basis for the analysis used for reporting comparative MCO performance.
- Measures
 - Reporting Categories and Measures
 - Questions Comparing CAHPS Measures for the Medicaid Product Line

Information Reporting Strategy

The most formidable challenge facing all consumer information projects is communicating a large amount of complex information in a clear and meaningful manner while fairly and accurately representing the data. The reporting strategy presented incorporates methods and recommendations based on experience and research regarding how to best present quality information to consumers. Based on a review of available HEDIS and CAHPS measures, Qlarant recommends the following reporting categories, outlined with associated measures in the tables that follow:

- Access to Care
- Care for Kids with Chronic Illness
- Doctor Communication and Service
- Keeping Adults Healthy
- Keeping Kids Healthy
- Pregnancy and Infant Care⁶

The recommended categories are based on measures reported by HealthChoice MCOs during MY 2023 and are designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in areas most important to them and their families. Two categories (Access to Care and Doctor Communication and Service) are relevant to all enrollees; the remaining categories are relevant to specific Maryland HealthChoice enrollees, including children, children with chronic illness, pregnant enrollees and their infants, and adults. 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

The measures considered for inclusion in the CRC are derived from those required by MDH for MCOs to report. These include HEDIS measures, the CAHPS results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures.⁷

The measures that were previously within the Taking Care of Women category have been redistributed across the categories Keeping Adults Healthy and Pregnancy and Infant Care. In addition, the lead screening measure was reallocated from the Keeping Kids Healthy category to Pregnancy and Infant Care. Due to challenges with the Maryland Department of Environment Childhood Lead Registry (CLR) MY 2023 data, the encounter-based lead measure will not be used for the 2025 CRC. Instead, the HEDIS measure Lead Screening in Children (LSC) will replace the encounter-based lead measure.

HEDIS Measures

The following table identifies Measure Specifications and HEDIS General Updates, initially released in March 2023, for each performance measure. For all reportable measures, the National Committee for Quality Assurance (NCQA) revised the "Other" criteria in the Nonclinical Components table and revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*. For detailed changes, refer to *HEDIS Measurement Year 2023 Summary Table of Measures, Product Lines, and Changes*.

⁶ The category Pregnancy and Infant Care is new to the 2025 CRC and replaces the category Taking Care of Women.

⁷ See the "Reporting Categories and Measures" section for a complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

Table 133. Measure Specific Updates

Reporting Category	Performance Measures	Changes for MY 2023 reflected in 2025 Report Card Calculations
Access to Care	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Added a required exclusion for enrollees who died during the measurement year.
Care for Kids with Chronic Illness; Keeping Adults Healthy	Asthma Medication Ratio (AMR)	- Added instructions to report rates stratified by race and ethnicity for each product line. - Clarified in the “Event/diagnosis” criteria that required exclusions are not a step. - Added a required exclusion for enrollees who died during the measurement year. - Removed “Dyphylline Guaifenesin Medications Lists” from the Asthma Controller Medications table. - Added new data elements tables for race and ethnicity stratification reporting. - Removed the <i>Note</i> from the “Event/diagnosis” criteria in the Clinical Component table under <i>Rules for Allowable Adjustments of HEDIS</i>.
Keeping Adults Healthy	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Added a required exclusion for enrollees who died during the measurement year.
Keeping Adults Healthy	Breast Cancer Screening (BCS) **	Retired measure
Keeping Adults Healthy	Breast Cancer Screening (BCS-E) **	- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes. - Added new data elements tables for race and ethnicity stratification reporting.
Keeping Adults Healthy	Blood Pressure Control for Patients with Diabetes (BPD)	- Added a required exclusion for enrollees who died during the measurement year. - Added a direct reference code for palliative care. - Updated the number of occurrences required for the frailty cross-cutting exclusion.
Keeping Adults Healthy	Cervical Cancer Screening (CCS) **	- Revised the optional exclusions for hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix to be required exclusions. - Added a required exclusion for enrollees who died during the measurement year. - Added a direct reference code for palliative care.
Keeping Adults Healthy	Chlamydia Screening in Women (CHL) **	- Revised the optional exclusions for pregnancy test to be step 3 of the event/diagnosis criteria. - Added a required exclusion for enrollees who died during the measurement year.

Reporting Category	Performance Measures	Changes for MY 2023 reflected in 2025 Report Card Calculations
Keeping Adults Healthy	Controlling High Blood Pressure (CBP)	- Added a required exclusion for enrollees who died during the measurement year. - Replaced the reference of “female members” to “members” in the required exclusions. - Added a direct reference code for palliative care. - Revised the optional exclusions to be required exclusions. - Updated the number of occurrences required for the frailty cross-cutting exclusion.
Keeping Adults Healthy	Eye Exam for Patients with Diabetes (EED)	- Added a required exclusion for enrollees who died during the measurement year. - Added a direct reference code for palliative care. - Updated the number of occurrences required for the frailty cross-cutting exclusion. - Added a <i>Note</i> to clarify that an eye exam result documented as “unknown” does not meet criteria.
Keeping Adults Healthy	Hemoglobin A1c Control for Patients with Diabetes (HBD)	- Added a required exclusion for enrollees who died during the measurement year. - Added a direct reference code for palliative care. - Updated the number of occurrences required for the frailty cross-cutting exclusion.
Keeping Kids Healthy	Appropriate Testing for Pharyngitis (CWP)	- Added a required exclusion for enrollees who died during the measurement year. - Removed the <i>Note</i> from the “Event/diagnosis” criteria in the Clinical Components table under <i>Rules for Allowable Adjustments of HEDIS</i>.
Keeping Kids Healthy	Appropriate Treatment Upper Respiratory Infection (URI)	Added a required exclusion for enrollees who died during the measurement year.
Keeping Kids Healthy	Child and Adolescent Well-Care Visits (WCV)	Added a required exclusion for enrollees who died during the measurement year.
Keeping Kids Healthy	Immunization for Adolescents (IMA)	- Added instructions to report rates stratified by race and ethnicity for each product line. - Added a required exclusion for enrollees who died during the measurement year. - Added new data elements tables for race and ethnicity stratification reporting.
Keeping Kids Healthy	Immunizations for Adolescents (IMA-E)	- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes. - Added new data elements tables for race and ethnicity stratification reporting.
Pregnancy and Infant Care*	Childhood Immunization Status (CIS) ¹	- Added anaphylaxis to a vaccine to select numerators. - Added a required exclusion for enrollees who died during the measurement year.

Reporting Category	Performance Measures	Changes for MY 2023 reflected in 2025 Report Card Calculations
		Removed seropositive test results from the numerator criteria in the hybrid specification.
Pregnancy and Infant Care*	Child Immunization Status (CIS-E) ¹	Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
Pregnancy and Infant Care*	Lead Screening in Children (LSC)^ ¹	- Added a required exclusion for enrollees who died during the measurement year. - Revised the “Other” criteria in the Nonclinical Components table under <i>Rules for Allowable Adjustments of HEDIS</i>. - Revised the “Required exclusions” criteria in the Clinical Components table under <i>Rules for Allowable Adjustments of HEDIS</i>.
Pregnancy and Infant Care*	Prenatal and Postpartum Care (PPC)	- Replaced all references of “women” to “member” throughout the measure specification. - Added a required exclusion for enrollees who died during the measurement year. - Clarified continuous enrollment requirements for step 2 of the Timeliness of Prenatal Care numerator.
Pregnancy and Infant Care*	Well-Child Visits in the First 30 Months of Life (W30) ¹	- Added instructions to report rates stratified by race and ethnicity for each product line. - Added a required exclusion for enrollees who died during the measurement year. - Added new data elements tables for race and ethnicity stratification reporting.

*New Reporting Category for 2025 CRC.

** Performance Measures have been redistributed from the previous category Taking Care of Women.

^ HEDIS measure replaced encounter-based lead measure

¹ Performance Measures previously included in the category Keeping Kids Healthy

CAHPS Patient Experience Survey Measures

Consistent with the 2024 CRC, it is recommended that results of both the CAHPS Health Plan Survey 5.1H, Adult Version, and the CAHPS Health Plan Survey 5.1H, Child Version with the Children with Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.1H 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 conditions.

The “CAHPS 5.1H Measures for the Medicaid Product Line” section shows the questions comprising the CAHPS 5.1H measures recommended for the CRC and their score values.

Format

The following considerations are important when designing report cards:

Table 134. Formatting Elements

Format Element	Instructions
Space	Maximize the amount of space 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 enrollees choosing an MCO for the first time, enrollees receiving the Annual Right to Change Notice and prioritizing their current health care needs, current enrollees 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 star graphics to provide a visual representation of MCO performance ratings.

Recommendation. The following formatting recommendations have been made to increase the CRC's level of clarity and effectiveness for consumers:

- Measure explanations and performance results should be presented on a one-page document, helping readers match explanations to their respective data.
- The document should be 11 x 18 inches with English on one side and Spanish on the other.
- The document's contents should be written at a sixth-grade reading level with short, direct sentences intended to relate to the audience's particular concerns.
- The document will 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.
- The document contents should be translated into Spanish using an experienced translation vendor.

Rationale. Cognitive testing conducted for similar projects showed that Medicaid enrollees 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 onto a single page. Given

the number of MCOs whose information is being presented in Maryland’s HealthChoice CRC, a one-page document will allow easy access to all information.

Rating Scale

Rate MCOs on a tri-level rating scale.

Recommendation. The following recommendations have been made for the tri-level rating scale:

- Compare each MCO’s performance with the average performance of all MCOs potentially available to the target audience (i.e., the average of all HealthChoice MCOs aka “the Maryland HealthChoice MCO average”).
- Use stars or circles to represent performance as “above,” “the same as,” or “below” the Maryland HealthChoice MCO average.

Rationale. A tri-level rating scale matrix displaying performance across categories provides enrollees with an easy-to-read “picture” of quality across plans and presents data in a manner that emphasizes meaningful differences between available MCOs (refer to the “Analytic Method” section below). This methodology differs from similar methodologies comparing MCO performance with ideal targets or national percentiles. This approach is more useful in an environment where enrollees must choose from a group of MCOs. At this time, developing an overall performance 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 CRC compares each MCO’s actual score with the unweighted statewide MCO average for a particular reporting category. A symbol (i.e., a star) denotes whether an MCO performed “above,” “the same as,” or “below” the Maryland HealthChoice MCO average.⁸

This analysis aims to generate reliable and useful information Medicaid enrollees can use to compare the quality of health care provided by Maryland’s HealthChoice MCOs. A statistically reliable index of differences should compare MCO-to-MCO quality performance directly, allowing consumers to easily detect differences in MCO performance.

⁸ For state performance reports directed at enrollees, 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 an MCO’s performance relative to other MCOs, rather than presenting how well the state’s Medicaid MCOs serve enrollees *overall*. In a report card, each MCO represents an equally valid option to the reader, regardless of enrollment size.

Handling Missing Values

Missing values are addressed in the following ways:

1. Analysts need to first decide which pool of observed (non-missing) MCOs should be used to derive replacement values for missing data and then decide how imputed values will be chosen. Imputed values may be fixed values (i.e., “zero,” “25th percentile for all MCOs in the nation”), calculated values (i.e., means or regression estimates), or probable selected values (i.e., multiplying imputed values).
2. Analysts determine which method should be used to replace missing values. This method 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 non-missing cases, scores for MCOs that perform below the mean would be higher if they fail to report.
3. Commercial plan data is not an appropriate replacement for missing data 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 the performance of commercial managed care plans. Given 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.
4. Further, utilizing regional MCOs to derive missing values is also inappropriate because of the 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. One disadvantage of using only Maryland HealthChoice MCOs for missing data replacement is there are fewer than 20 MCOs available to derive replacement values; therefore, 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 enrollees 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, were assigned a result of NA.
- For CAHPS, health plans that do not meet the minimum denominator of at least 100 responses are assigned a 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:

1. If fewer than 50% of MCOs report a measure, the measure is dropped from the report card category.

2. If an MCO has reported at least 50% 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.
3. If an MCO is missing more than 50% of the measures composing a reporting category a designation of “Insufficient Data” is given 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 when values are missing. “NA” values will be replaced with the mean of non-missing observations, and “BR/NR” values will be replaced with the minimum value of non-missing 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 non-survey measures (HEDIS, Maryland encounter data).

Handling New MCOs

MCOs are eligible for inclusion in the report card when they are able to report more than half the required HEDIS and CAHPS measures used in the report card category.

Members Who Switch Products/Product Lines

Per HEDIS guidelines, members who are enrolled in different products or product lines during continuous enrollment for a measure are considered 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.

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

Qlarant's statistical methodology includes the following steps:

1. Create standardized versions (z-scores) 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. Standardized scores are determined by subtracting the overall mean for all MCOs from the mean value of individual MCOs and dividing by the standard deviation of all MCOs.
2. Combine the standardized measures into summary scores for each reporting category and 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 the individual MCO summary score values.
5. Use the standard errors to calculate 95% confidence intervals (CI) for the difference scores.
6. Categorize MCOs into three categories based on these CIs:
 - Above Average: 95% CI is in the positive range
 - Average: 95% CI includes zero
 - Below Average: 95% CI is in the negative range

This procedure generates classification categories, so differences from the group mean for individual MCOs in the “above average” and “below average” categories are based on statistically significant differences compared to the group mean, 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 to ensure all data in the report card are accurately presented and support public reporting of the report card. This process includes:

- the Qlarant team closely reviewing the project's agreed-upon requirements and specifications of each measure so that the impact(s) of any changes are assessed and clearly delineated,
- having two analysts independently review the specifications and code the report card,
- having two analysts independently checking all data results,
- having each analyst complete quality reviews of the data, and
- having analysts meet to discuss and resolve any discrepancies in the analysis.

Reporting Categories and Measures

Table 135. Access to Care Measures

Category: Access to Care	Data Source	Weight
Getting Needed Care (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Getting Care Quickly (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Customer Service (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years (AAP) Adults' Access to Preventive/Ambulatory Health Services - 45-64 years (AAP)	HEDIS	1/6
Access to Care – Supplemental Security Income (SSI) Adult - 21 years or older ¹	MDH Encounter Data	1/6
Access to Care - SSI Children - ages 0-20 ¹	MDH Encounter Data	1/6

¹ Maryland Population Health Incentive Program Measure

Table 136. Doctor Communication & Service Measures

Category: Doctor Communication & Service	Data Source	Weight
Rating of All Health Care (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Personal Doctor (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Specialist Seen Most Often (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
How Well Doctors Communicate (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Shared Decision Making (“Yes” Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Health Promotion and Education (“Yes” summary rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Coordination of Care (“Usually” & “Always” Question Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14

Table 137. Keeping Kids Healthy Measures

Category: Keeping Kids Healthy	Data Source	Weight
Appropriate Treatment for Upper Respiratory Infections - 3 months - 18 years (URI)	HEDIS	1/5
Appropriate Testing for Pharyngitis - 2-18 years (CWP)	HEDIS	1/5
Child and Adolescent Well-Care Visits- Ages 3-11 (WCV)	HEDIS	1/5
Child and Adolescent Well-Care Visits- Ages 12-17 and Ages 18-21 (WCV)	HEDIS	1/5
Immunization for Adolescents (Combo 1) (IMA) ³	HEDIS	1/5

³ For measures that NCQA allows both traditional and Electronic Clinical Data Systems (ECDS) reporting methods, a weighted average is used in the calculation of a plan score for that category.

Table 138. Care for Kids with Chronic Illness Measures

Category: Care for Kids with Chronic Illness	Data Source	Weight
Access to Prescription Medicines (Rating Mean)	CAHPS 5.1H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ("Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Getting Needed Information (Rating Mean)	CAHPS 5.1H MC	1/6
Coordination of Care for Children with Chronic Conditions ("Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Asthma Medication Ratio - 5-11 years (AMR) ¹	HEDIS	1/6
Asthma Medication Ratio - 12-18 years (AMR) ¹		

¹ Maryland Population Health Incentive Program Measure

Table 139. Pregnancy and Infant Care Measures

Category: Pregnancy and Infant Care	Data Source	Weight
Timeliness of Prenatal Care (PPC) ¹	HEDIS	1/5
Postpartum Care (PPC) ¹	HEDIS	1/5
Childhood Immunization Status (Combo 3) (CIS) ^{3**}	HEDIS	1/5
Lead Screening in Children (LSC) ^{4**}	HEDIS	1/5
Well-Child Visits in the First 30 Months of Life (W30) **	HEDIS	1/5

¹ Maryland Population Health Incentive Program Measure

³ For measures that NCQA allows both traditional and Electronic Clinical Data Systems (ECDS) reporting methods, a weighted average is used in the calculation of a plan score for that category.

⁴ HEDIS measure replaced encounter-based lead measure

* Previously included in category Taking Care of Women

**Previously included in category Keeping Kids Healthy

Table 140. Keeping Adults Healthy Measures

Category: Keeping Adults Healthy	Data Source	Weight
Glycemic Status Assessment - Poor Control (<8.0%) (GSD)	HEDIS	1/10
Glycemic Status Assessment - Poor Control (>9.0%) (GSD) ^{1,2}	HEDIS	1/10
Eye Exam for Patients with Diabetes (EED)	HEDIS	1/10
Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS	1/10
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis – 18-64 years (AAB) ²	HEDIS	1/10
Asthma Medication Ratio - 19-50 years (AMR) ¹ Asthma Medication Ratio - 51-64 years (AMR) ¹	HEDIS	1/10
Controlling High Blood Pressure (CBP)	HEDIS	1/10
Breast Cancer Screening (BCS-E) ^*	HEDIS	1/10
Cervical Cancer Screening (CCS)*	HEDIS	1/10
Chlamydia Screening - Total Rate: 16-24 years (CHL)*	HEDIS	1/10

¹ Maryland Population Health Incentive Program Measure² Note: MCO rate used in the analysis is the inverse score in order to provide consistency with other measures (i.e., a higher % is better).

^ Traditional measure (BSC) retired; weight is now based on Electronic Clinical Data Systems (ECDS) reporting methods.

* Previously included in category Taking Care of Women

CAHPS 5.1H Measures for the Medicaid Product Line

The tables below display the questions, response choices, and corresponding score values used to calculate results for the CAHPS 5.1H MY 2023 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.

CAHPS 5.1H Adult Questionnaire Measures

Table 141. Adult Questionnaire with Never, Sometimes, Usually, or Always Responses

Questions	Adult Questionnaire Category
MA and MC	Getting Needed Care
Q20=MA Q41=MC	In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?
Q9=MA Q10=MC	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

Questions	Adult Questionnaire Category
MA and MC	Getting Care Quickly
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?
Q6=MA Q6=MC	In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
MA and MC	How Well Doctors Communicate
Q12=MA Q27=MC	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
Q13=MA Q28=MC	In the last 6 months, how often did your personal doctor listen carefully to you?
Q14=MA Q29=MC	In the last 6 months, how often did your personal doctor show respect for what you had to say?
Q15=MA Q32=MC	In the last 6 months, how often did your personal doctor spend enough time with you?
MA and MC	Customer Service
Q24=MA Q45=MC	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
Q25=MA Q46=MC	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
MA and MC	Coordination of Care
Q17=MA Q35=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?

MA = CAHPS 5.1H MY 2023 Medicaid Adult Questionnaire; MC = CAHPS 5.1H MY 2023 Medicaid Child Questionnaire (With CCC Measure)

Table 142. Adult Questionnaire with Worst Through Best Responses

Questions	Adult Questionnaire Category
MA and MC	Rating of All Health Care
Q8=MA Q9=MC	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?
MA and MC	Rating of Personal Doctor
Q18=MA Q36=MC	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?

Questions	Adult Questionnaire Category
MA and MC	Rating of Specialist Seen Most Often
Q22=MA Q43=MC	We want to know your rating of the specialist you talked to 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?

MA = CAHPS 5.1H MY 2023 Medicaid Adult Questionnaire; MC = CAHPS 5.1H MY 2023 Medicaid Child Questionnaire (With CCC Measure)

Table 143. Adult Questionnaire with Yes or No Responses

Questions	Adult Questionnaire Category
MA and MC	Shared Decision Making
Q43=MA Q79=MC	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
Q44=MA Q80=MC	Did you and a doctor or other health provider talk about the reasons you might not want to take medication?
Q45=MA Q81=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?
MA and MC	Health Promotion and Education
Q41=MA Q77=MC	In the last 6 months, did you and a doctor, or other health provider, talk about specific things you could do to prevent illness?

MA = CAHPS 5.1H MY 2023 Medicaid Adult Questionnaire; MC = CAHPS 5.1H MY 2023 Medicaid Child Questionnaire (With CCC Measure)

CAHPS 5.1H Child Questionnaire Measures

The following questions from the CAHPS 5.1H MY2022 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 the basic components of care essential for the 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 (other than vitamins) 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.

Table 144. Child Questionnaire with Never, Sometimes, Usually, or Always Responses

Questions	Child Questionnaire Category
MC Only	Access to Prescription Medicines
Q51	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?
MC Only	Access to Specialized Services
Q15	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?
Q18	In the last 6 months, how often was it easy to get this therapy for your child?
Q21	In the last 6 months, how often was it easy to get this treatment or counseling for your child?
MC Only	Family-Centered Care: Getting Needed Information
Q8	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?

MC = CAHPS 5.1H MY 2023 Medicaid Child Questionnaire (With CCC Measure)

Table 145. Child Questionnaire with Yes or No Responses

Questions	Child Questionnaire Category
MC Only	Family-Centered Care: Personal Doctor Who Knows Child
Q33	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?
Q38	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?
Q39	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?
MC Only	Coordination of Care for Children with Chronic Conditions
Q13	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?
Q24	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?

MC = CAHPS 5.1H MY 2023 Medicaid Child Questionnaire (With CCC Measure)

Appendix E: Report Reference Page

Access the links below to find identified reports on MDH's Quality Assurance [website](#).

Performance Improvement Project Validation

[MY 2024 PIP Report](#)

Performance Measure Validation

Healthcare Effectiveness Data and Information Set:
[MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2024 Results](#)

Consumer Assessment of Healthcare Providers and Systems: [CSS' State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations' Adult and Child Populations 2025 CAHPS 5.1H Member Experience Survey](#)

Population Health Incentive Program: [MY 2024 PHIP Report](#)

Systems Performance Review

[MY 2024 SPR Statewide Executive Summary Report](#)

Network Adequacy Validation

[MY 2024 and MY 2025 NAV Comprehensive Report](#)

Encounter Data Validation

[MY 2024 EDV Report](#)

Early and Periodic Screening, Diagnosis, and Treatment

[MY 2024 EPSDT Statewide Executive Summary Report](#)

Consumer Report Card

2025 Consumer Report Card in [English](#) and [Spanish](#)

Grievances, Appeals, and Denials Focused Study

[MY 2024 GAD Annual Report](#)

Appendix F: Report Requirements

This section lists required and recommended elements for the detailed technical report, this ATR, for EQR activities specified in 42 CFR §438.364 and CMS feedback received by states. Page numbers identify locations for corresponding elements addressed in this ATR and from the 2023 CMS EQR protocols in the applicable columns. Qlarant does not disclose the identity or other protected health information of any enrollee.

Required or Recommended Element	CMS Protocol	ATR
Timely Submission. Qlarant submitted the ATR to MDH by April 30 th .	pg. 20	Cover Page
Easy Navigation. Qlarant supports easy navigation throughout the report with a clickable or hyperlinked table of contents and listing of figures and tables, and section jumps throughout the report to applicable appendices.	pg. 19	Entire report
Eligible Inclusion. Qlarant included all eligible Medicaid plans in this ATR. No Maryland HealthChoice MCOs are CHIP-specific. Qlarant identifies that no HealthChoice MCOs are exempt from EQR with a statement in the “Introduction” and “Background” subsections of the “Executive Summary” and “Introduction” of the main body of this ATR.	pg. 15	MY 2024 MCO profiles
Task Analysis and Summary. Each mandatory activity (PIP, PMV, SPR, and NAV) and Maryland’s chosen optional activities (EDV, EPSDT medical record review, CRC, and GAD) include objectives, technical methods of data collection and analysis, descriptions of data obtained, and conclusions drawn from the data.	pg. 17	Each task section
Performance Improvement Projects. Qlarant includes information on the validation of PIPs underway during the preceding 12 months for MY 2024, including a description of the interventions associated with each state-required PIP topic.	pg. 17	MY 2024 MDH-Selected Topics
Performance Measure Validation. Qlarant includes information on the validation of each HealthChoice MCO’s performance measures calculated by MDH during the preceding 12 months.	pg. 18	MY 2024 Summary of MetaStar’s HEDIS Measure Results
Compliance Review. Qlarant includes information on a review, conducted within the previous three-year period, to assess each HealthChoice MCO’s compliance with standards in CFR’s Subpart D and QAPI requirements.	pg. 18	SPR Standards Crosswalk
Comparison to Peers. Qlarant provides methodologically appropriate, comparative information about all HealthChoice MCOs.	pg. 16	Entire report
HealthChoice MCO Assessments. Qlarant assesses strengths and weaknesses and summarizes findings on quality, access, and timeliness of care for each MCO providing benefits to enrollees.	pg. 15	Appendix A: MCO-Specific Summaries

Required or Recommended Element	CMS Protocol	ATR
MCO Quality Improvement. Qlarant provides recommendations for improving the quality of healthcare services furnished by the MCOs for HealthChoice enrollees.	pg. 15	Appendix A: MCO-Specific Summaries
MDH Quality Improvement. Qlarant provides recommendations to MDH for how Maryland can target goals and objectives in the quality strategy, to better support improvement in the quality, access, and timeliness of services.	pg. 16	State Recommendations
Recommendation Progress Assessments. Qlarant assesses the degree to which each MCO effectively addressed recommendations for quality improvement made during the previous year's EQR.	pg. 16	Appendix A: MCO-Specific Summaries