HealthChoice Quality Strategy

MY 2025 - MY 2027

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HealthChoice Quality Strategy

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HealthChoice Quality Strategy

Introduction

Under 42 CFR 438.340(a) and 42 CFR 457.1240(e), the Centers for Medicare and Medicaid Services (CMS) require that state Medicaid and CHIP managed care programs develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of healthcare and services managed care plans provide.

The purpose of Maryland's HealthChoice Quality Strategy is to describe population health and quality improvement priorities, health reform efforts, and goals and objectives to move these areas forward in the HealthChoice program. The HealthChoice Quality Strategy covers measurement year (MY) 2025 through MY 2027, using the quality strategy evaluation data from MY 2022 through MY 2024. MY 2024 targets have been reassessed to determine if goals are on track to meet or exceed through the duration of this quality strategy and if revisions are needed to realign with agency objectives.

Maryland intends to update this quality strategy every three years, with the next update scheduled for 2028. This strategy will also be updated in the event of any significant changes, including but not limited to adding or removing goals or objectives; changes that trigger public comment, tribal consultation, and input from the Maryland Medicaid Advisory Committee; and substantive changes to managed care laws and regulations during the period this strategy is designed to cover.

HealthChoice is Maryland's statewide, mandatory, Medicaid managed care program. The Maryland General Assembly passed Senate Bill (SB) 750 on April 8, 1996, which authorized the Maryland Department of Health (MDH) to require Medicaid participants to enroll in MCOs. To implement SB 750, Maryland prepared an application for waiver of certain Medicaid requirements, under Section 1115(a) of the Social Security Act (1115 Waiver). The 1115 Waiver proposed the development and implementation of a Medicaid Managed Care Program. The application was submitted to CMS, formerly the Health Care Financing Administration (HCFA), on May 3, 1996, and was approved by HCFA on October 30, 1996.

HealthChoice enables the extension of coverage and/or targeted benefits to certain participants who would otherwise be without health insurance or access to benefits tailored to the participant's specific medical needs. HealthChoice combines Medicaid and the Maryland Children's Health Program (MCHP), and Maryland's Children's Health Insurance Program (CHIP) coverage. Maryland currently contracts with nine managed care organizations (MCOs) to provide HealthChoice services and benefits.

Table 1: HealthChoice Managed Care Organizations, Authorities, and Covered Populations

Contracted Managed Care Organizations	Populations Covered by HealthChoice MCOs
• Aetna Better Health of Maryland (ABH) • CareFirst BlueCross BlueShield Community Health Plan of Maryland (CFCHP) • Jai Medical Systems (JMS) • Kaiser Permanente of the Mid-Atlantic States (KPMAS) • Maryland Physicians Care (MPC) • MedStar Family Choice (MSFC) • Priority Partners (PPMCO) • UnitedHealthcare (UHC) • Wellpoint Maryland (WPM)	• Families with low income that have children • Families receiving Temporary Assistance for Needy Families • Children younger than 19 years eligible for MCHP • Children in foster care • Former foster care adults up to age 26 • Adults under the age of 65 with income up to 138% of the federal poverty level (FPL) • Pregnant individuals with income up to 264% of the FPL or individuals who are one year postpartum • Participants receiving Supplemental Security Income (SSI) who are under 65 and ineligible for Medicare

Currently, HealthChoice covers 84% of Marylanders on Medicaid and MCHP, which represents over 1.2 million participants. Eligible Medicaid participants may choose a contracted MCO along with primary care providers (PCP) in MCO networks to serve as their medical homes. HealthChoice benefits are equivalent to those provided through the Medicaid fee-for-service (FFS) program, except for certain carved-out services.

Table 2: HealthChoice Covered Services and Exclusions

HealthChoice Covered Services	Services "Carved Out" of HealthChoice
• Inpatient and outpatient hospital care • Physician care • Clinic services • Laboratory and x-ray services • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children • Prescription drugs (see carved out column for exceptions) • Durable medical equipment and disposable medical supplies • Home health care • Vision services • Dialysis • Skilled nursing facility or rehabilitation care up to 90 days • Primary mental health care	• Specialty behavioral health care • Substance use disorder treatment services • Specialty behavioral health drugs and substance use disorder drugs • Dental care for Medicaid participants • Health-related services and targeted case management services are provided to children through individualized Education Plans (IEPs) or individualized Family Service Plans (IFSPs) • Occupational therapy, physical therapy, and speech therapy for children • Personal care services • Long-term care services after the first 90 days • HIV/AIDS drug resistance testing, including but not limited to viral load testing, genotypic testing, phenotypic testing • Services covered under 1915(c) home and community-based services waivers

MDH is the state agency responsible for HealthChoice and the Maryland Medical Assistance Program generally. Coordination and oversight fall under the Maryland Medicaid Administration, which includes the Office of Medical Benefits Management. Within the Office of Medical Benefits Management, Managed Care ensures that the requirements established in 42 CFR 438, Subpart D, are adhered to, and that all MCOs apply these principles universally and appropriately. Quality monitoring, evaluation, and education through participant and provider feedback are integral components of the managed care program and help to ensure that health care is not compromised. The functions and infrastructure of the administration support efforts to identify and address quality issues efficiently and effectively.

Effectiveness of the Previous Quality Strategy

Maryland's previous HealthChoice Quality Strategy covered the period of MY 2022 through MY 2024 and included quantifiable targets and outcomes for the HealthChoice program overall. Quality assurance reports demonstrating the HealthChoice MCOs' continued commitment to improvement and compliance with federal managed care requirements are available on the HealthChoice Quality Assurance Annual Reports website.

To evaluate progress towards the goals and objectives outlined in the previous Quality Strategy, Maryland relied upon the quality assurance activity reports developed by its quality vendors, national benchmarks when available and applicable, and its own oversight of HealthChoice. Through the preparation of the strategy and ongoing compliance mapping, several points were revealed where Maryland could strengthen its oversight, such as isolating individual elements of the EPSDT review for improvement; further strengthening sanctions in HEDIS performance monitoring; setting timely submission thresholds for encounter data validation; and developing validation activities for primary care provider networks and provider directories.

The 2022-2024 Quality Strategy Evaluation can be reviewed on our website here and in Appendix B.

Quality Strategy Goals and Objectives

According to the Section 1115 waiver filing that establishes the Maryland HealthChoice Program, HealthChoice's broader program goals are:

- Improving access to health care for the Medicaid population
- Improving the quality of health services delivered
- Providing patient-focused, comprehensive, and coordinated care through the medical home
- Emphasizing health promotion and disease prevention
- Expanding coverage through resources generated through managed care efficiencies

To achieve these broader goals, Maryland has identified the following specific goals and measurable objectives for HealthChoice over the next three years:

Goal 1: Improve HealthChoice aggregate performance on Medicaid HEDIS measures by reaching or exceeding the MY 2024 HealthChoice aggregate by MY 2027.

Objective 1.1: Increase the number of HEDIS measures that meet or exceed the HealthChoice aggregate achieved in MY 2024, by MY 2027.

As reflected across the United States, the COVID-19 public health emergency (PHE) significantly impacted people's ability to seek preventive care and impaired many critical business functions and industries connected to health care. As the nation collectively attempts a return to normalcy, seeking and maintaining appropriate, quality health care has become a paramount priority. Maryland observed that the PHE affected both healthcare outcome

performance and measurement. Since the PHE ended, HealthChoice has been focusing on improving performance beyond pre-pandemic rates across health plans and providers. This post-pandemic Quality Strategy demonstrates Maryland's intention to keep Marylanders in Medicaid healthy. Our goals used the highest performance in MY 2018 and MY 2019 as a baseline to set realistic targets that the HealthChoice MCOs can accomplish over the strategy period. Through the use of the Quality Strategy Evaluation, MY 2024 targets were re-evaluated against MY 2023 data to determine reachability or reassessment. When targets met or exceeded the HealthChoice aggregate for the three-year period (2022-2024), a revised target was established for MY 2027.

Objective 1.2: Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Medicaid HMO Mean or next highest Quality Compass percentile by MY 2027.

Once the MCOs can return to their performance prior to the public health emergency, the focus will then shift to either maintaining and improving upon the baseline to ensure the HealthChoice aggregate meets or exceeds the Medicaid National HEDIS Mean over the next three measurement years, with progressive targeting to reach higher national percentiles over time.

Goal 2: 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.

Objective 2.1: Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures to achieve the HEDIS Medicaid 90th percentile no later than MY 2027.

Pregnant and postpartum individuals are identified as a special needs population by the HealthChoice program. In the 2022-2024, Maryland Medicaid successfully increased the HealthChoice HEDIS aggregate by three percentage points. HealthChoice regulations require MCOs to identify potential risks to the health of the birthing person by encouraging prenatal care providers to complete a prenatal risk assessment (PRA) at the individual's first visit. The prenatal risk assessment is then shared with local health departments to connect the enrollee to community resources and assistance, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (commonly known as WIC), Maryland Medicaid's behavioral health administrative services organization for substance use disorder treatment, and home visiting programs in their county. Prenatal care providers are also encouraged to complete an enhanced maternity services form at subsequent visits to determine the enrollee's eligibility for other support that address care needs that arise during pregnancy.

In addition to these administrative efforts, Maryland Medicaid, in partnership with the Health Services Cost Review Commission (HSCRC), has identified maternal and child health as a population health priority area, specifically targeting the reduction of severe maternal morbidity. Comprehensive prenatal and postpartum care has been a cornerstone for preventing poor birth outcomes. As part of the Statewide Integrated Health Improvement Strategy (SIHIS), Maryland Medicaid has instituted multiple programs focused on improving health outcomes for pregnant and postpartum individuals, including but not limited to:

- Statewide expansion of the home visiting services pilot

- Statewide expansion of MOM program (enhanced case management for pregnant and postpartum Medicaid participants with opioid use disorder)
- Medicaid coverage of doulas/birth workers
- Enhanced payment for the HealthySteps and CenteringPregnancy models

In 2021, the HSCRC committed $8 million dollars annually from FY 2022 to FY 2025 for these initiatives. In 2025, these funds were extended through December 31, 2027, under SB 213. As these efforts continue, it is anticipated that access to prenatal and postpartum care will increase, contributing by extension to the improvement of health outcomes for pregnant and postpartum individuals through early detection, prevention, intervention, and treatment of conditions that impact the birthing person and child.

Since 2023, Maryland conducted a perinatal performance improvement project that focused on prenatal care, postpartum care, well-child care through the first 30 months of the baby's life, and childhood immunizations to encourage MCOs to focus on maternal and child health improvement over time. This project encourages MCOs to optimize the utilization of the Maryland Prenatal Risk Assessment (M-PRA), doulas, home visiting services, CenteringPregnancy and other benefits that promote better engagement and outcomes. MCOs will continue to work though this topic until the end of 2026 when another improvement topic will be selected.

To align with these initiatives, the Population Health Incentive Program (PHIP), which began in MY 2022, includes the HEDIS Timeliness of Prenatal Care and Postpartum Care measures to promote better performance among the HealthChoice MCOs. Incentives are set based on performance relative to the HEDIS 50th, 75th, and 90th percentiles, with rewards for superlative performance and demonstrated MCO-specific performance improvement.

Additionally, Medicaid is working with the Maternal & Child Health Bureau in Maryland's Public Health Services Administration to support the Integrated Maternal Health Services (IMHS) grant. The goal of the IMHS grant is to, in part, implement a statewide digital version of the M-PRA.

Objective 2.2: Improve the HealthChoice aggregate for measures tracking chronic health outcomes to the HEDIS Medicaid 75th percentile by MY 2027.

Improving health outcomes for HealthChoice participants with chronic diseases is a key feature of Maryland's strategy. Chronic health problems, including asthma, diabetes, and substance use disorders (SUDs), impact the lives of participants in numerous ways. Maryland is committed to primary, secondary, and tertiary prevention wherever possible with the intent of limiting the impact of poor health outcomes associated with the development or lack of appropriate management of chronic disease states. Several programs have been put into place to address these issues, including but not limited to:

- Maryland Quality Innovation Program (M-QIP)
- HealthChoice Diabetes Prevention Program (DPP)
- MOM Program
- Doulas
- Home Visiting Services
- Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management
- Achieving Healthcare Efficiency through Accountable Design (AHEAD) and the Medicaid Advanced Primary Care Program
- Population Health Incentive Program (PHIP)

Maryland Quality Innovation Program (M-QIP) – *Calendar Year 2026 M-QIP State Directed Payment ("Pre-Print") is pending CMS approval as of January 1, 2026*

In partnership with the MCOs and the University of Maryland, M-QIP aims to improve health outcomes for persons with SUDs, diabetes, and asthma. Under this state directed payment authority, the University of Maryland works to reinvest in Baltimore City and Prince George's County to reduce avoidable ED utilization and preventable admissions for HealthChoice beneficiaries served by University of Maryland providers regarding SUD, diabetes, and asthma. Avoidable ED visits are measured using the New York University Center for Health and Public Service Research (NYU) ED algorithm, whereas Preventable Admissions are measured using the Agency for Healthcare Research and Quality (AHRQ) specifications. In addition to reducing preventable acute care utilization, additional metrics are employed to gauge the quality of programming and progress toward established goals, including diabetes control and average wait times for specialists. In CY 2026, these metrics are anticipated to shift to better align with statewide goals, pending CMS approval.

HealthChoice Diabetes Prevention Program

The HealthChoice Diabetes Prevention Program (DPP), which went into effect on September 1, 2019, allows MCOs to provide the National DPP Lifestyle Change Program to HealthChoice enrollees which is an evidence-based program established by the Centers for Disease Control and Prevention (CDC) to prevent or delay the onset of type 2 diabetes through healthy eating and physical activity. A healthcare professional or an MCO may refer HealthChoice participants to the program; however, enrollees may directly enroll in their MCO's in-network CDC-recognized type 2 diabetes prevention programs in certain situations.

MOM Program

The MOM Program provides enhanced case management services through member MCOs to pregnant individuals with opioid use disorder (OUD). Through a combination of case management and prenatal care, the model works to reduce the burden of neonatal abstinence syndrome (NAS) on the participants' children.

Doulas and Home Visiting Services

Effective February 21, 2022, Maryland Medicaid provides coverage for doula services to Medicaid beneficiaries. A doula, or birth worker, is a trained professional who provides continuous physical, emotional, and informational support to birthing parents before, during, and after birth. Maryland Medicaid is also offering Home Visiting Services (HVS) as a statewide benefit as of January 2022. Maryland reimburses for two evidence-based models for home HVS; they include Healthy Families America and Nurse Family Partnership.

Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management

Since the launch of the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management program in 2017, Maryland Medicaid and the Environmental Health Bureau (EHB) have collaborated to train personnel; develop program procedures and protocols; implement budget and invoicing pathways; utilize data for outreach and enrollment; create new methods of billing for environmental assessments, and refine quality assurance mechanisms with the goal of reducing exposures to lead and asthma triggers within the homes of Medicaid/MCHP enrolled or eligible children.

AHEAD and the Medicaid Advanced Primary Care Program

The Medicaid Advanced Primary Care Program (Medicaid Advanced PCP) is an alternative payment model constructed to serve as the foundation and driving force for catalyzing advanced primary care delivery for Medicaid participants. In partnership with CMS and the Center for Medicare and Medicaid Innovation (CMMI), Maryland is increasing investments in primary care practices that will allow practices to engage in care transformation activities to improve whole-person care and quality outcomes. A quality incentive program is a key component of this model. The quality measures emphasize chronic disease management and are aligned with PHIP.

PHIP

Beginning on January 1, 2022, PHIP was designed as an incentive program to improve quality by awarding financial incentives to MCOs for meeting or exceeding defined benchmarks or demonstrating significant improvement in a subset of HEDIS measures and state-developed encounter data measures. The program is designed with two rounds of incentives available.

Round 1 (Two Tiers)

- *Tier 1:* Comparison of HEDIS *performance* measures to national benchmarks and non-HEDIS measures to HealthChoice benchmarks
- *Tier 2:* Determining meaningful measure *improvement* compared to prior year performance

Round 2

- Rewards plans who earned more than 80% of Round 1 incentives *and* performed well on the HEDIS Performance Monitoring Policy requirements for the measurement year with a bonus payment

Goal 3: 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.

Objective 3.1: Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2027.

The Systems Performance Review evaluates if the MCOs have sufficient policies and procedures to comply with federal and state policies, regulations, and statutes. The minimum compliance score for this activity, therefore, is 100%, as the MCOs must meet all these requirements to operate. The 12 standards for the Systems Performance Review include:

- Systematic Process of Quality Assessment
- Accountability to the Governing Body
- Oversight of Delegated Entities
- Credentialing and Recredentialing
- Enrollee Rights
- Availability and Accessibility

- Utilization Review
- Continuity of Care
- Health Education
- Outreach
- Fraud and Abuse
- Disenrollment (New)

Objective 3.2: Improve the HealthChoice provider network ability to demonstrate compliance during onsite audits with scores at least 80% for each of the EPSDT/Healthy Kids Medical Record Review components of the Laboratory Tests/At-Risk Screenings (LAB) elements by MY 2027.

The EPSDT/Healthy Kids Medical Record Review measures MCO network provider compliance with the Healthy Kids periodicity schedules and requirements, which are sourced from the American Academy of Pediatrics Bright Futures program and other evidence-based practices. HealthChoice primary care providers are encouraged to receive EPSDT training through the Maryland Healthy Kids Program, which oversees compliance with the EPSDT benefit. The MCOs are expected to monitor their network providers' compliance with the EPSDT requirements. Through this objective, MDH and the MCOs will work together to improve seven elements within the Laboratory Tests/At-Risk Screening component that are negatively trending with three years ≤ the 80% minimum compliance threshold:

- 9-11 Year Dyslipidemia Lab Test
- 18-21 Year Dyslipidemia Lab Test
- 24 Month Blood Lead Test
- 3-5 Year (Baseline) Blood Lead Test
- 12 Month Anemia Test
- 24 Month Anemia Test
- 3-5 Year Anemia Test

Objective 3.3: Increase the HealthChoice aggregate scores to at least 85% for all network adequacy validation activities by MY 2027.

The Network Adequacy Validation activity applies a combination of secret shopper calls to a random sample of primary care providers, MCO provider directory validation, and direct testing of routine and urgent care appointment compliance. Failure to maintain accurate directory information or ensure appointment availability could lead to participants using urgent care and emergency department care to compensate for provider availability, which may drive up costs and increase health risks for the population. Examples of areas measured by this activity include:

- Accuracy of MCOs' online provider directories for primary care providers, including but not limited to name, address, phone number, whether the provider is accepting new patients, the ages the provider serves, the languages spoken in the practice, and accommodations for individuals with disabilities
- Availability of routine and urgent appointments at both pediatric and adult primary care provider practices.

Objective 3.4: Increase the percentage of accepted encounters that are submitted within 6 months to 95% and increase the percentage of accepted encounters submitted within 1-2 days to 50% by MY 2027.

Federal regulations require MDH to validate the accuracy and completeness of encounter data submitted by MCOs. Maryland regulations require MCOs to submit encounter data to the Department within 60 calendar days after receipt of the claim from the provider. Through the encounter data validation, encounters are reviewed in the aggregate to determine the timeliness of submission, number, and type of rejections, accuracy of the data when compared to medical record reviews, and resolution of any outliers identified. The validation and other monitoring efforts will ensure MCOs submit accurate and complete encounters in a timely fashion for purposes of data analysis, submission to CMS through the Transformed Medicaid Statistical Information System (T-MSIS), and assessment of participant utilization for capitation rate risk adjustment.

Objective 3.5: Increase the HealthChoice aggregate to minimum compliance for each element of review for grievances, appeals, and pre-service determinations by MY 2027.

MCO processing and handling of grievances, appeals, and pre-service determinations have a direct impact on how participants receive care and perceive their health plan. MDH requires MCOs to submit participant and provider data related to grievances, participant appeals, and pre-service determination information. Samples of each area are evaluated through this activity and the Systems Performance Review process. Areas of noncompliance are addressed through the Systems Performance Review and other focused interventions if trends across MCOs are identified. Areas monitored include:

- Timeliness of processing member appeals, member and provider grievances, and denial determinations
- Timeliness of sending notifications after appeals, grievances, and preauthorizations are completed
- Record reviews to determine if notices included required information and were prepared for member comprehension

When MCOs receive findings for these activities, MDH requires MCOs to submit corrective action plans addressing the areas identified as opportunities for improvement. Through this objective, MDH will work collaboratively with the MCOs to ensure that the corrective action plans are fully implemented to ensure full compliance with all requirements.

MDH has initiated a clinical preservice denial audit, which compares the MCOs' prior authorization determination to their medical necessity criteria. The results are stratified by service category (i.e., pharmacy, surgical procedures, or durable medical equipment). The audit process continues to be refined, and results of the audit may be included in the Quality Strategy in future years.

HealthChoice Quality Metrics and Performance Targets

Maryland works collaboratively with MCOs and stakeholders to identify opportunities for continuous quality improvement. Through our quality assurance program, Maryland currently oversees and monitors the following activities to evaluate the effectiveness of the health care delivered by the MCOs. Please note that the HealthChoice program targets for its quality metrics that follow this activity overview are not the equivalent of the HealthChoice MCO minimum compliance scores. The targets are intended to drive continuous quality improvement on the program level.

Table 3: HealthChoice Quality Assurance Activity Overview

Activity	Description	Frequency	Authorities	Link to Webpage
Healthcare Effectiveness Data and Information Set (HEDIS)	Developed by the National Committee for Quality Assurance, HEDIS is a widely used tool that measures performance on dimensions of care and service.	Annual	COMAR 10.67.04.03	Healthcare Effectiveness Data and Information Set (HEDIS) MY 2024 Report
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Developed by the federal Agency of Healthcare Research and Quality in collaboration with NCQA, CAHPS is a survey designed to capture accurate and reliable information from Medicaid participants about their experiences with managed care organizations and their contracted network providers.	Annual	COMAR 10.67.04.03	Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2024 Report
Primary Care Provider (PCP) Satisfaction Survey	The PCP Satisfaction Survey is a Maryland-developed survey tool for Medicaid PCPs to evaluate their interactions with HealthChoice MCOs in areas like claims processing, customer service, preauthorization, and more.	Annual	Md. Health-General Art. 15-103	Primary Care Provider (PCP) Satisfaction Survey 2024 Report
Performance Improvement Projects	Performance improvement projects focus on clinical and nonclinical areas, and they include measures of performance using objective quality indicators, implementation of system interventions to achieve quality improvement, evaluation of intervention	Three-year projects, with quarterly or annual reporting updates	COMAR 10.67.04.03	MY 2023 Medicaid Managed Care Organization Performance Improvement Project Validation Annual Report

Activity	Description	Frequency	Authorities	Link to Webpage
	effectiveness, and planning and initiation of activities to increase or sustain improvement.			
EPSDT/Healthy Kids Medical Record Review	The EPSDT/Healthy Kids Medical Record Review evaluates provider compliance with the EPSDT Healthy Kids periodicity schedule.	Annual	COMAR 10.67.04.03	2023 EPSDT Medical Record Review Executive Summary
Systems Performance Review	The Systems Performance Review provides an assessment of the structure, process, and outcome of each MCO's internal quality assurance programs, as well as evaluates compliance with state and federal laws and regulations.	Triennial comprehensive review, with an annual assessment of corrective action plan implementation and baseline standards	COMAR 10.67.04.03	MY 2024 Systems Performance Review Executive Summary Report
Consumer Report Card	The Consumer Report Card assists Medicaid participants with selecting one of the participating HealthChoice MCOs. The report card compares plan performance in six domains by using performance measures from HEDIS, CAHPS, and encounter data measures from PHIP to assign a star rating.	Annual	COMAR 10.67.04.03	2025 HealthChoice Consumer MCO Report Card (English) 2025 HealthChoice Consumer MCO Report Card (Spanish)
HealthChoice Population Health Incentive Program (PHIP)	The HealthChoice Population Health Incentive Program is an incentive program designed to improve quality by awarding financial incentives for meeting or exceeding defined benchmarks or demonstrating significant improvement in a subset of HEDIS measures and state-developed encounter data measures.	Annual	COMAR 10.67.04.03-2	2023 Population Health Incentive Program Report
NCQA Accreditation	Maryland requires all participating HealthChoice MCOs to maintain NCQA health plan accreditation. New plans joining	Triennial (dependent upon the plan's original accreditation date)	COMAR 10.67.04.03	Maryland HealthChoice MCOs Rating and Accreditation Status

Activity	Description	Frequency	Authorities	Link to Webpage
	HealthChoice must obtain accreditation within two years of the date they begin providing health care services.			
Encounter Data Validation	Maryland performs an annual encounter data validation to ensure encounter data submitted by the MCOs are accurate, complete, and valid. The review is performed collaboratively by the EQRO and Maryland Medicaid's data warehouse vendor, The Hilltop Institute of the University of Maryland Baltimore County.	Annual	42 CFR 438.242	**2023 Encounter Data Validation Report**
Grievance, Appeal, and Denial Review	Maryland engages the EQRO to review the MCO preservice determinations, enrollee grievances, and enrollee and provider appeals quarterly to analyze trends and identify anomalies.	Quarterly	COMAR 10.67.04.15	**MY 2024 Grievance Appeals Denials Annual Report**
Network Adequacy Validation	Maryland's EQRO performs a direct test of the MCO's primary care provider networks to confirm the information provided in the MCOs' provider directories is accurate and complete. In addition, the EQRO verifies the availability of standard and urgent appointments as defined in COMAR regulations.	Annual	COMAR 10.67.04.03	**2024 Network Adequacy Validation Report**
MCO Performance Monitoring	The HealthChoice MCO Performance Monitoring Policies are a form of intermediate sanctions designed to hold MCOs accountable when problems arise in four quality assurance areas: network adequacy, HEDIS, EPSDT/Healthy Kids Medical Record Review, and the Systems Performance Review. MCOs may be subject to sanctions for repeated findings of	Annual	COMAR 10.67.10.01	See the HealthChoice Performance Monitoring and Intermediate Sanctions section of the Quality Strategy.

Activity	Description	Frequency	Authorities	Link to Webpage
	noncompliance.			
Performance Improvement Project Evaluation	The Performance Improvement Project Evaluation conducted by Maryland is designed to ensure MCOs are submitting projects that are accurate, understandable, and designed to implement meaningful and sustainable interventions that improve the topic area of the PIP.	Annual	COMAR 10.67.04.03	See the HealthChoice Performance Improvement Projects and Interventions section of the Quality Strategy.

The following tables are a comprehensive compilation of the quality metrics and performance targets that Maryland evaluates for HealthChoice MCOs.

Healthcare Effectiveness Data and Information Set (HEDIS)

Original targets were established by evaluating the highest HealthChoice aggregate rate for MY 2018 and MY 2019. The MY 2024 targets were set in the 2022-2024 strategy for measures that demonstrated a decline in MY 2019 and MY 2020. Those 2024 targets were baselined with a goal to return to those higher rates where data collection and medical record review were not impacted by the coronavirus public health emergency (pre-pandemic). During the Quality Strategy evaluation for MY 2022 – MY 2024, it was determined that establishing targets based on pre-pandemic rates was not effective because of the pandemic's lasting changes to the health care landscape. New MY 2026 targets are established using the following method: If the NHM has been achieved for MY 2024, NCQA Benchmarks were evaluated to determine a target within the next highest percentile (i.e., 75th percentile or 90th percentile). If the NHM was not achieved in MY 2024, targets were set by increasing the achieved rate by 2% over the next three-year strategy cycle.

Table 4: HealthChoice Performance Metrics and Targets – HEDIS

HEDIS Measure	Maryland Average Reportable Rate (MARR)			NHM Performance A↑/B↓	HEDIS Percentile TARGET
	MY 2022	MY 2023	MY 2024	MY 2024	MY 2027
Cervical Cancer Screening (CCS)	59.43%	57.56%	61.15%	A↑	75th
Chlamydia Screening in Women (CHL), 16-20 years	62.66%	63.15%	63.53%	A↑	90th
Chlamydia Screening in Women (CHL), 21-24 years	69.69%	68.79%	69.19%	A↑	90th
Chlamydia Screening in Women (CHL), Total	66.23%	65.89%	66.15%	A↑	90th
Childhood Immunization Status (CIS), Combo 3	68.89%	68.85%	72.09%	A↑	90th

Childhood Immunization Status (CIS), Combo 7	59.45%	59.61%	62.39%	A↑	90th
Childhood Immunization Status (CIS), Combo 10	36.16%	33.49%	32.28%	A↑	75th
Appropriate Testing for Pharyngitis (CWP)	74.89%	79.44%	82.98%	A↑	75th
Immunizations for Adolescents (IMA), Combo 1 - Meningococcal, Tdap	84.59%	83.59%	84.80%	A↑	75th
Immunizations for Adolescents (IMA), Combo 2 - HPV, Meningococcal, Tdap	41.90%	39.87%	42.62%	A↑	90th
Lead Screening in Children (LSC)	72.68%	74.71%	77.68%	A↑	90th
Topical Fluoride for Children (TFC)	-	0.97%	1.22%	TBD	TBD
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile Documentation, Total	82.07%	81.80%	85.53%	A↑	75th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Nutrition, Total	77.21%	75.60%	77.46%	A↑	75th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Physical Activity, Total	74.91%	72.66%	74.20%	A↑	75th
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Total	61.20%	63.25%	61.52%	B↓	NHM
Risk of Continued Opioid Use (COU), 15 Days, Total*	4.79%	4.84%	5.16%	A↑	75th
Risk of Continued Opioid Use (COU), 31 Days, Total*	3.02%	3.10%	3.40%	A↑	75th
Use of Opioids at High Dosage (HDO)*	6.69%	6.28%	6.23%	A↑	50th
Use of Imaging Studies for Low Back Pain (LBP)	78.56%	76.56%	75.92%	A↑	90th
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers*	23.12%	22.93%	22.55%	B↓	NHM
Use of Opioids From Multiple Providers (UOP), Multiple Pharmacies*	3.20%	3.49%	2.52%	A↑	75th
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers and Multiple Pharmacies*	2.01%	2.42%	1.82%	A↑	75th
Appropriate Treatment for Upper Respiratory Infection (URI), Total	90.84%	89.33%	89.46%	A↑	75th

Asthma Medication Ratio (AMR), Total	69.60%	69.93%	70.61%	A↑	75th
Pharmacotherapy Management of COPD Exacerbation (PCE), Systemic Corticosteroid	70.98%	75.76%	72.68%	A↑	775th
Pharmacotherapy Management of COPD Exacerbation (PCE), Bronchodilator	87.36%	88.99%	86.45%	A↑	75th
Adults’ Access to Preventive/Ambulatory Health Services (AAP), 20-44 years	66.04%	65.22%	69.85%	B↓	NHM
Adults’ Access to Preventive/Ambulatory Health Services (AAP), 45-64 years	77.75%	77.20%	81.28%	A↑	75th
Controlling High Blood Pressure (CBP)	59.97%	63.12%	67.04%	A↑	75th
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	-	54.59%	51.75%	B↓	NHM
Statin Therapy for Patients with Cardiovascular Disease (SPC), Received Statin Therapy, Total	80.31%	83.06%	81.83%	A↑	75th
Statin Therapy for Patients with Cardiovascular Disease (SPC), Statin Adherence 80%, Total	63.08%	62.91%	65.47%	B↓	NHM
Cardiac Rehabilitation - Achievement (CRE)	1.11%	1.85%	1.62%	B↓	NHM
Cardiac Rehabilitation - Engagement1 (CRE)	1.83%	2.64%	2.97%	B↓	NHM
Cardiac Rehabilitation - Engagement2 (CRE)	2.05%	3.67%	2.62%	B↓	NHM
Cardiac Rehabilitation - Initiation (CRE)	0.67%	0.90%	0.80%	B↓	NHM
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	87.90%	87.94%	89.48%	A↑	90th
Prenatal and Postpartum Care (PPC), Postpartum Care	82.60%	84.18%	85.60%	A↑	90th
Glycemic Status Assessment for Patients with Diabetes (GSD), Poor Control (>9.0%)*	33.91%	31.90%	30.66%	A↑	75th
Glycemic Status Assessment for Patients with Diabetes (GSD), Control (<8.0%)	57.30%	59.01%	60.45%	A↑	75th
Eye Exam for Patients with Diabetes (EED)	53.09%	55.57%	58.54%	A↑	75th
Blood Pressure Control for Patients with Diabetes (BPD)	63.56%	66.70%	71.30%	A↑	75th
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	69.03%	72.38%	75.43%	A↑	75th

Statin Therapy for Patients with Diabetes (SPD), Received Statin Therapy	66.34%	66.36%	68.49%	A↑	90th
Statin Therapy for Patients with Diabetes (SPD), Statin Adherence 80%	58.50%	59.09%	58.97%	B↓	NHM
Kidney Health Evaluation for Patients with Diabetes (KED)	45.84%	46.09%	50.24%	A↑	95th
Plan All-Cause Readmissions (PCR) - Observed / Expected*	TB	TB	TB	TBD	TBD
Well-Child Visits in the First 30 Months of Life (W30), 15 months	57.46%	58.39%	62.38%	A↑	75th
Well-Child Visits in the First 30 Months of Life (W30), 15-30 months	70.07%	71.24%	75.28%	A↑	90th
Child and Adolescent Well-Care Visits (WCV), Total	54.62%	56.20%	60.08%	A↑	90th
Antibiotic Utilization for Respiratory Conditions (AXR)	15.50%	23.21%	25.07%	B↓	NHM
Antidepressant Medication Management (AMM), Acute Phase	44.05%	48.00%	45.46%	B↓	NHM
Antidepressant Medication Management (AMM), Continuation Phase	32.55%	33.07%	29.11%	B↓	NHM
Pharmacotherapy for Opioid Use Disorder (POD), Total	11.04%	19.96%	16.70%	B↓	NHM
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	45.87%	50.77%	50.39%	B↓	NHM
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	86.76%	90.32%	91.48%	A↑	95th
Diagnosed Mental Health Disorders (DMH), Total	18.64%	20.16%	22.13%	B↓	NHM
Diagnosed Substance Use Disorders (DSU), Total	5.47%	5.46%	5.60%	B↓	NHM
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Continuation Phase	38.23%	6.25%	35.41%	B↓	NHM
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Acute Phase	32.36%	8.62%	34.53%	B↓	NHM
Adult Immunization Status (AIS-E), Influenza	-	0.15%	16.07%	B↓	NHM
Adult Immunization Status (AIS-E), TdTdap	-	0.42%	45.91%	A↑	75th
Adult Immunization Status (AIS-E), Zoster	-	0.13%	17.07%	A↑	90th
Adult Immunization Status (AIS-E), Pneumococcal	-	0.00%	75.00%	A↑	95th

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Blood Glucose and Cholesterol Total	53.98%	0.00%	65.48%	A↑	95th
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Blood Glucose Total	84.86%	100.00%	75.52%	A↑	95th
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Cholesterol Total	54.53%	0.00%	66.22%	A↑	95th
Breast Cancer Screening (BCS-E)	59.64%	59.23%	60.92%	A↑	90th
Cervical Cancer Screening (CCS-E)		45.14%	57.42%	A↑	90th
Colorectal Cancer Screening (COL-E)	28.24%	24.29%	38.82%	A↑	75th
Prenatal Immunization Status (PRS-E)	21.40%	23.15%	25.24%	A↑	75th
Social Need Screening and Intervention, Food Screening (SNS-E)	-	-	2.32%	TBD	TBD
Social Need Screening and Intervention, Food Intervention (SNS-E)	-	-	39.56%	TBD	TBD
Social Need Screening and Intervention, Housing Screening (SNS-E)	-	-	3.04%	TBD	TBD
Social Need Screening and Intervention, Housing Intervention (SNS-E)	-	-	31.28%	TBD	TBD
Social Need Screening and Intervention, Transportation Screening (SNS-E)	-	-	2.81%	TBD	TBD
Social Need Screening and Intervention, Transportation Intervention (SNS-E)	-	-	23.49%	TBD	TBD

A↑ = At or Above the NHM; **B↓** = Below the NHM; **TBD** – To be determined/NCQA has not established performance thresholds; **TB** – Trend break
-No rates available/measure was not available for reporting/new
Lower rate indicates better performance

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Previous quality strategy targets were established by evaluating the highest HealthChoice aggregate rate for MY 2019 through MY 2021 and comparing those against the 2021 Quality Compass rates. New MY 2024 targets set for Satisfaction Survey scores were established by evaluating performance against MY 2024 rates and identifying the next possible NCQA National Percentile to achieve (i.e., 10th, 33rd, 67th, etc.). The Shared Decision-Making measure for both Adult and Child CAHPS surveys are set to improve by two percentage points since that measure is collected on behalf of MDH. MDH is working with the MCOs to explore ways to improve member experience.

Table 5: HealthChoice Performance Metrics and Targets – CAHPS Adult and Child

CAHPS - ADULT		2023 (MY 2022)	2024 (MY 2023)	2025 (MY 2024)	TARGET MY 2024	Performance against Target	Performance against MY 2023 NCQA Quality Compass National Avg	MY 2027 NCQA Quality Compass Percentile TARGET
Getting Needed Care	Patient Experience Domain (Combines two survey questions that address member access to care. Both questions use a Never, Sometimes, Usually, or Always response scale, with Always being the most favorable response. This measure is included in HPR under the sub-domain of Getting Care.	78.2%	79.7%	79.1%	86.6%	↓	↓	33rd
Getting Care Quickly	Patient Experience Domain (Combines responses to two survey questions that address the timely availability of both urgent and check-up/routine care. The questions use a Never, Sometimes, Usually, or Always scale, with Always being the most favorable response. This measure is reported in HPR under the sub-domain of Getting Care.).	78.3%	78.8%	76.8%	85.8%	↓	↓	33rd
Rating of Personal Doctor	Satisfaction with Plan Physicians (Patient Experience Domain)	64.89%	66.2%	64.7%	68.3%	↓	↓	33rd
Rating of Specialist Seen Most Often	Satisfaction with Plan Physicians (Patient Experience Domain)	61.8%	65.3%	64.6%	68.3%	↓	↓	33rd
Rating of All Health Care	Satisfaction with Plan Physicians (Patient Experience Domain)	55.2%	54.5%	54.1%	57.0%	↓	↓	33rd
Coordination of Care	Satisfaction with Plan Physicians (Patient Experience Domain)	82.5%	84.6%	81.5%	85.8%	↓	↓	33rd
Rating of Health Plan	Satisfaction with Plan Services (Patient Experience Domain)	55.9%	55.4%	56.9%	58.8%	↓	↓	33rd
How Well Doctors Communicate	Combines responses to four survey questions that address physician communication. Results are reported as the proportion of members responding Always or Usually.	91.8%	92.6%	92.3%	95.7%	↓	↓	67th

Shared Decision Making	Combines responses to three survey questions that focus on decisions related to prescription medicines. Results are reported as the proportion of members responding Yes.	78.2%	79.9%	80.7%	81.3%	↓	Measure not supported by NCQA	83.3%
Customer Service	Combines responses to two survey questions about member experience with the health plan's customer service. Results are reported as the proportion of members responding Always or Usually.	88.6%	88.7%	87.0%	93.3%	↓	↓	33rd
CAHPS - CHILD w/CCC		**2023 (MY 2022)**	**2024 (MY 2023)**	**2025 (MY 2024)**	**TARGET MY 2024**	**Performance against Target**	**Performance against NCQA Quality Compass National Avg (All LOBS)**	**MY 2027 Quality Compass Percentile TARGET**
Getting Needed Care	Patient Experience Domain (Combines two survey questions that address member access to care. Both questions use a Never, Sometimes, Usually, or Always response scale, with Always being the most favorable response. This measure is included in HPR under the sub-domain of Getting Care.).	78.0%	79.9%	79.8%	92.3%	↓	↓	33rd
Getting Care Quickly	Patient Experience Domain (Combines responses to two survey questions that address the timely availability of both urgent and check-up/routine care. The questions use a Never, Sometimes, Usually, or Always scale, with Always being the most favorable response. This measure is reported in HPR under the sub-domain of Getting Care.).	81.7%	82.5%	82.1%	93.6%	↓	↓	33rd
Rating of Personal Doctor	Satisfaction with Plan Physicians (Patient Experience Domain)	73.6%	75.4%	75.9%	79.7%	↓	↓	67th
Rating of Specialist Seen Most Often	Satisfaction with Plan Physicians (Patient Experience Domain)	67.4%	70.8%	67.8%	74.8%	↓	↓	33rd

Rating of All Health Care	Satisfaction with Plan Physicians (Patient Experience Domain)	67.8%	70.6%	70.8%	75.9%	↓	↓	67th
Coordination of Care	Satisfaction with Plan Physicians (Patient Experience Domain)	77.9%	80.4%	80.4%	87.2%	↓	↓	33rd
Rating of Health Plan	Satisfaction with Plan Services (Patient Experience Domain)	66.8%	69.7%	68.9%	72.2%	↓	↓	33rd
How Well Doctors Communicate	Combines responses to four survey questions that address physician communication. Results are reported as the proportion of members responding Always or Usually.	90.8%	91.5%	91.7%	97.9%	↓	↓	33rd
Shared Decision Making	Combines responses to three survey questions that focus on decisions related to prescription medicines. Results are reported as the proportion of members responding Yes.	75.9%	75.5%	74.5%	83.3%	↓	Measure not supported by NCQA	76.5%
Customer Service	Combines responses to two survey questions about member experience with the health plan's customer service. Results are reported as the proportion of members responding Always or Usually.	82.7%	86.9%	85.7%	91.3%	↓	↓	33rd
Access to Prescription Medicines	Results are reported as the proportion of members responding Always or Usually.	88.3%	88.5%	89.3%	93.3%	↓	↑	67th
Access to Specialized Services	Combines responses to three survey questions addressing the child's access to special equipment or devices, therapies, treatments, or counseling. Results are reported as the proportion of members responding Always or Usually.	66.3%	68.8%	69.0%	80.4%	↓	↓	67th
Getting Needed Information	Results are reported as the proportion of members responding Always or Usually.	88.02%	87.8%	89.6%	95.95%	↓	↓	33rd

Personal Doctor Who Knows Child	Combines responses to three survey questions addressing the doctor's understanding of the child's health issues. Results are reported as the proportion of members responding Yes.	90.2%	89.1%	90.5%	92.4%	↓	↓	33rd
Coordination of Care for Children with Chronic Conditions	Combines responses to two survey items addressing care coordination needs related to the child's chronic condition. Results are reported as the proportion of members responding Yes.	70.1%	73.6%	72.8%	74.8%	↓	↓	33rd

↑ = At or Above performance; ↓ = Below performance

Note: NCQA retired the *Shared Decision Making* measure in 2020. The Maryland Department of Health received permission from NCQA to continue using the three Shared Decision-Making questions for tracking purposes.

Systems Performance Review

The Systems Performance Review (SPR) is an annual independent review performed by MDH's EQRO to determine whether the MCOs are delivering care in accordance with the federal and state laws, regulations, and policies governing Medicaid managed care. A comprehensive review of eleven standards is conducted every three years. During the interim years, MCOs are evaluated on any newly introduced elements or components, areas where MCOs received unmet findings that required corrective action, and areas meeting standards with additional opportunities for improvement. The minimum compliance score for all plans and all standards is 100%. Standard 12 was introduced as a Baseline standard for MY 2024 with a MY 2027 target of 100%.

Table 6: HealthChoice Performance Metrics and Targets - Systems Performance Review

SPR Standards	MY 2018	MY 2021	MY 2024	TARGET MY 2024	Performance Against Target	TARGET MY 2027
Standard 1: Systematic Process of Quality Assessment	100%	100%	100%	100%	⇆	100%
Standard 2: Accountability to the Governing Body*	93%	-	97%	100%	↓	100%
Standard 3: Oversight of Delegated Entities	88%	95%	100%	100%	⇆	100%
Standard 4: Credentialing and Recredentialing	99%	99%	100%	100%	⇆	100%
Standard 5: Enrollee Rights	91%	96%	98%	100%	↓	100%
Standard 6: Availability and Access	86%	99%	100%	100%	⇆	100%
Standard 7: Utilization Review	93%	94%	95%	100%	↓	100%

Standard 8: Continuity of Care	100%	100%	100%	100%	⇆	100%
Standard 9: Health Plan Education*	100%	-	97%	100%	↓	100%
Standard 10: Outreach	100%	99%	100%	100%	⇆	100%
Standard 11: Fraud and Abuse	94%	98%	99%	100%	↓	100%
Standard 12: Disenrollment	-	-	Baseline			100%
COMPOSITE SCORE	**97%**	**98%**	**99%**	**100%**	↓	**100%**

*These standards were exempt from review for MCOs that achieved 100% in comprehensive reviews prior to MY 2021 (except for new elements and/or components).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Medical Record Review

The EPSDT/Healthy Kids Medical Record Review is conducted annually. This review evaluates PCP adherence to the EPSDT Healthy Kids Periodicity Schedule maintained by the Maryland Healthy Kids Program. The Maryland Healthy Kids Program's primary focus is compliance with EPSDT standards, and a team of nurse consultants work with MCO PCPs to certify whether they understand the principles of EPSDT care. To conduct this activity, the EQRO receives from Hilltop a sample of children aged 0-21 who received services during the calendar year being assessed. The EQRO then reaches out to each provider's office to request a copy of the child's full medical record to determine if they received the appropriate EPSDT services for their age group. There are five principal components reviewed, and their primary metrics are listed in Table 9. Since all five elements met the minimum compliance threshold for MY 2023 (≥80%) but not the HealthChoice Aggregate Target (≥94%), MDH is placing additional focus on achieving a minimum target of ≥80% for individual components in the Laboratory Tests/At-Risk Screen component, while also striving to achieve the previously established HealthChoice Aggregate Target for all elements by MY 2027.

Table 7: HealthChoice Performance Metrics and Targets - EPSDT/Healthy Kids Medical Record Review

EPSDT Minimum Compliance Score: ≥ 80% HealthChoice Aggregate Target ≥ 94%		**MY 2021**	**MY 2022**	**MY 2023**	**TARGET MY 2024**	**MY 2023 Performance Against MY 2024 Target**	**MY 2027 TARGET**
Health & Developmental History	A comprehensive medical and family history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance.	95%	96%	93%	94%	↓	94%
Comprehensive Physical Examination	The comprehensive physical exam uses a systems review method that requires documentation of a minimum of five systems (–e.g., heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) to meet EPSDT standards.	96%	98%	97%	97%	⇆	98%

Laboratory Tests/At-Risk Screenings	The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis, lead exposure, anemia, and STI/HIV.	83%	85%	80%	87%	↓	87%
Immunizations	Children receiving Medical Assistance must be immunized according to the current MDH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee of Immunization Practices and the American Academy of Pediatrics. PCPs who see Medicaid enrollees through 18 years of age must participate in the MDH's Vaccines for Children (VFC) Program.	91%	95%	92%	93%	↓	93%
Health Education/Anticipatory Guidance	Health education enables the patient and family to make informed healthcare decisions. Anticipatory guidance provides the family with information on what to expect in terms of the child's current and next developmental stage. Information should be provided about the benefits of healthy lifestyles and practices, as well as injury and disease prevention.	94%	97%	96%	94%	↓	96%
HealthChoice Aggregate Totals		**93%**	**95%**	**93%**	**≥ 94%**	↓	**≥ 94%**

⇆=Target achieved; ↑=Improvement over rate; ↓=Decline over rate

Table 8: HealthChoice Performance Metrics and Targets - Laboratory Test/At-Risk Screenings Element Scores

Laboratory Test/At-Risk Screening Elements Minimum Compliance Target: > 80%	HealthChoice Aggregate MY 2021	HealthChoice Aggregate MY 2022	HealthChoice Aggregate MY 2023
9-11 Year Dyslipidemia Lab Test	67%	72%	59%
18-21 Year Dyslipidemia Lab Test	83%	80%	75%
24 Month Blood Lead Test	80%	84%	75%
3-5 Year (Baseline) Blood Lead Test	97%	95%	78%
12 Month Anemia Test	80%	85%	78%

Laboratory Test/At-Risk Screening Elements Minimum Compliance Target: > 80%	HealthChoice Aggregate MY 2021	HealthChoice Aggregate MY 2022	HealthChoice Aggregate MY 2023
24 Month Anemia Test	79%	82%	73%
3-5 Year Anemia Test	96%	90%	76%

Network Adequacy Validation

The HealthChoice Network Adequacy Validation is a direct test of each MCO's primary care network. The EQRO uses a sample of primary care providers (PCPs) drawn from each plan's listing and contacts PCPs via telephone to verify demographic details, panel information, ages served, appointment availability, and more for accuracy. The EQRO then compares the information collected telephonically to the MCO's online provider network directory to determine if the information is consistent with the information from the telephonic contact and easy for HealthChoice consumers to navigate and understand. The primary metrics for the activity are identified below. Since the HealthChoice composite target was achieved for MY 2024, individual NAV targets for MY 2027 were re-established using MY 2024 targets when not achieved. If the MY 2024 target was achieved, a new target was set at two percentage points higher, when possible.

Table 9: HealthChoice Performance Metrics and Targets - Network Adequacy Validation

Network Adequacy Validation Minimum Compliance Score: ≥ 80% HealthChoice Composite Target ≥ 85%	MY 2022	MY 2023	MY 2024	TARGET MY 2024	Performance Against Target	TARGET MY 2027
Routine Care Appointment Compliance	87.6%	90.5%	89.4%	100%	↓	100%
Urgent Care Appointment Compliance	85.2%	89.7%	91.0%	93%	↓	93%
Accuracy of Provider Directory: PCP Listed in Online Directory	96.9%	97.3%	96.7%	97%	↓	97%
Accuracy of Provider Directory: PCP's Practice Location Matched Survey Response	93.0%	90.5%	93.1%	98%	↓	98%
Accuracy of Provider Directory: PCP's Practice Telephone Number Matched Survey	91.0%	92.6%	92.1%	96%	↓	96%
Accuracy of Provider Directory: Specifies that PCP Accepts New Medicaid Patients for the Listed MCO and Matches Survey Response	78.3%	77.8%	80.7%	80%	↑	83%

Accuracy of Provider Directory: Specifies Age Specification of Patients Seen	96.6%	97.4%	97.1%	100%	↓	100%
Accuracy of Provider Directory: Specifies Languages Spoken by PCP	96.6%	96.9%	97.1%	100%	↓	100%
Accuracy of Provider Directory: Specifies Practice Accommodations for Patients with Disabilities (with specific details)	92.4%	94.7%	94.8%	100%	↓	100%
HealthChoice Composite	**90.84%**	**91.93%**	**92.44%**	**≥ 85%**	↑	**≥ 90%**

Table 10: HealthChoice Performance Metrics and Targets - Network Adequacy Time and Distance Standards

	Urban[1]		**Suburban[2]**		**Rural[3]**	
Provider Type	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)
Primary Care	15	10	30	20	40	30
Primary Care - Pediatric	15	10	30	20	40	30
Pharmacy	15	10	30	20	40	30
Diagnostic Laboratory/X-Ray	15	10	30	20	40	30
Gynecology	15	10	30	20	40	30
Prenatal Care[4]	15	10	30	20	90	75

[1] Urban Counties: Baltimore City

[2] Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's

[3] Rural Counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester

[4] Prenatal Care providers include obstetricians and certified nurse midwives. Family practitioners who provide prenatal care and deliveries may be considered in areas where there is a shortage of obstetricians.

Acute Inpatient Hospitals	20	10	45	30	75	60
Core Specialties (Cardiology, ENT, Gastroenterology, Neurology, Oncology, Ophthalmology, Orthopedics, Surgery, Urology)	30	15	60	45	90	75
Major Specialties (Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, Pulmonology)	30	15	80	60	110	90
Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

HealthChoice Encounter Data Validation

The Encounter Data Validation (EDV) is an annual assessment of the completeness and accuracy of the encounter data submitted by the HealthChoice MCOs to MDH. This activity is conducted jointly by the EQRO and MDH's Medicaid data warehouse vendor, The Hilltop Institute, University of Maryland Baltimore County (Hilltop). Hilltop conducts an overall assessment of the encounter data collected to ensure that edit checks work properly, data is submitted timely, and there are few anomalies that could impact the validity of the information provided. The primary metrics and targets for accepted encounters processing times are presented below.

Table 11: Percentage of Total Accepted Encounters and Processing Time

Processing Time Range	Accepted Encounters Submitted			TARGET MY 2027
	CY 2021	CY 2022	CY 2023	
1-2 Days	45.9%	43.9%	34.3%	50%
3-7 Days	11.0%	10.1%	8.9%	20%
8-31 Days	22.3%	21.9%	29.9%	15%
1-2 Months	6.2%	6.3%	10.4%	5%
2-6 Months	8.5%	9.6%	10.2%	5%

HC Total	93.9%	91.8%	93.7%	≥95%

HealthChoice Performance Improvement Projects and Interventions

Maryland calls for HealthChoice MCOs to develop a variety of interventions that address member, provider, and MCO based barriers to achieving the two measures. The MCOs should conduct a root cause analysis with stakeholders and frontline feedback to better promote the completion of the appropriate lead screening. Upstream, equitable, and sustainable solutions are encouraged in addition to community partnerships to help implement the quality improvement process and deliver strategies that improve not only the quality measures but also contribute to the health of the communities the MCOs serve.

MCOs are required to use data-driven interventions with strategies that have a measurable impact. In addition, the state encourages MCOs to explore evidence-based approaches using quality improvement tools such as Plan-Do-Study-Act (PDSA) cycles and SMART goals to evaluate their test of change.

PIPs will continue using the Rapid Cycle PIP Process, launched in MY 2018 with previous Lead Screening topic, to provide MCOs with a quality improvement method that identifies, implements, and measures changes over short periods. This process aligns with the CMS EQR PIP Validation Protocol. To break the process down into manageable steps, the Rapid Cycle PIP approach is continuous and allows the MCOs to monitor their improvement efforts over short time periods (monthly or quarterly) and in real time. Frequent monitoring allows for quick modifications when necessary. The goal is for MCOs to improve performance in a short amount of time and sustain improvement resulting in a positive impact on enrollee health outcomes.

During the annual 2021 reporting period, MDH implemented an evaluation process to provide in-depth feedback to the MCOs on the quality of their improvement interventions. This evaluation is in addition to the validation performed by the EQRO to further assist the HealthChoice MCOs develop impactful and sustainable improvements and best practices. MDH assesses the MCOs' annual PIP reports for evidence that each has met the required elements for their interventions. MDH then provides insights into the strengths of the MCO's PIP and areas that might be improved. The MDH review panel includes the HealthChoice Medical Director and Quality Assurance Health Policy Analyst to assess the annual PIP reports across three major categories: ***Report Quality***, ***Intervention Planning & Design,*** and ***Intervention Evaluation.*** Each category is scored annually based on the categorical elements and an Evaluation Grade is assigned based on the Total Evaluation Score.

In addition to providing ongoing feedback on the current PIP approaches, MDH implemented a new process to conduct a survey of all HealthChoice MCOs to learn more about the actions taken to maintain improvement on the previous PIP topics. The team will continue to monitor the previous study performance indicators for three calendar years after the conclusion of the PIP. The inaugural survey was conducted on June 27, 2023, to

describe the MCOs' survey responses about the ongoing activities and compare outcomes of the previous cycle's PIP Topics: Childhood Lead Screening (Lead) (MY 2017 - MY 2021) and Asthma Medication Ratio (AMR) (MY 2016 - MY2021).

Beginning in 2023, MDH rolled out two new PIP topics and created additional layers to the PIP process. In addition to the Annual

MDH PIP Intervention Evaluations and the Rapid Cycle PIPs as described above, the PIPs will be structured around a menu of evidence-based strategies. MDH and the EQRO have researched and considered approaches that will align the MCOs' PIP interventions with other statewide public health and Medicaid innovation initiatives. The MCOs will select which strategy is most appropriate for their membership and its available resources then develop their own interventions. They will be required to apply a health equity focus addressing health outcomes among the most disparate populations first and to meet individual process metrics for each selected strategy. This requirement is explained in more detail in the HealthChoice Disparities Plan section below.

Table 12: Performance Improvement Project Topics for MY 2022 (Baseline Year) - MY 2026

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Quarterly Rapid Cycle PIP)	For pregnant enrollees, this PIP aims to increase the percentage of those who enter prenatal care during the first trimester. This population should be assessed for clinical and social risk factors using Maryland's Prenatal Risk Assessment (PRA).	HEDIS PPC-CH: Prenatal and Postpartum Care: Timeliness of Prenatal Care Each MCO is expected to improve its baseline measurement on HEDIS PPC-CH by 10 percentage points over the life of the project.	**Mandatory:** *Improve completion and use of the Maryland Prenatal Risk Assessment (M-PRA)* **Process Metric:** Increase completion rate *X% above the MCO's baseline during the first measurement year (MY) then increase the goal an additional *Y% above the prior year's rate each subsequent MY. Must show the ratio of # of completed M-PRA/# of unique pregnancies for each rate. **MCO must pick 2 of the additional strategies below:** *Apply Clinical-Community linkages:* **Process Metric:** Increase the percentage of first trimester enrollment in prenatal care by *X% above the MCO's baseline during the first MY then increase the goal an additional *Y% above the prior year's rate each subsequent MY. This increase should directly result from the implementation and continuation of strategic partnerships between a clinical service organization and a non-healthcare organization that supports the needs ofpregnant persons. The first trimester enrollment will be considered as defined by the HEDIS PPC measure. Must show the ratio of # of pregnant persons enrolled in the strategic partnership who also had timely prenatal care/Total # of pregnant persons enrolled in the strategic partnership. *Increase engagement with Medicaid-enrolled doulas and/or home visiting services:*

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			Process Metric: Increase the number of pregnant persons enrolled in Medicaid doula services and/or a home visiting service by *X% every 6 months of each measurement year. Must show the ratio of # of pregnant persons enrolled in doula/home visiting services/Total # of pregnant persons currently enrolled in MCO. *Pregnancy Medical Homes or Group Prenatal Care:* **Process Metric:** Increase the number of pregnant persons enrolled in either a group prenatal care option or Pregnancy Medical Home by *X% above the MCO's baseline during the first MY then increase the goal an additional *Y% above the prior year's rate each subsequent MY. Must include the ratio of # of pregnant persons enrolled in a group prenatal care option or pregnancy medical home/Total # of pregnant persons currently enrolled in the MCO. *Identification of pregnant persons with SUD and integration of substance use management:* **Process Metrics (MUST measure BOTH listed below):** 1. Increase the number of identified pregnant persons with SUD by *X% during the first MY and by *Y% above the prior year's rate for each subsequent MY. Must include the ratio of # of identified pregnant persons with SUD/Total estimated pregnant population with SUD. 2. Improve enrollment of identified pregnant persons with SUD into enhanced case management [such as that under the Maternal Opioid Misuse (MOM) model] by *X% during the first MY and by *Y% above the prior year's rate for each subsequent MY. Must include ratio as # of those enrolled in enhanced case management/Total number of identified pregnant persons with SUD. *X, *Y - indicates that the value should be MCO determined and specific. MCO must submit a justification for why the goal was chosen including any supporting

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			data.
Maternal Health and Infant/Toddler Care During the Postpartum Period (Quarterly Rapid Cycle PIP)	This PIP aims to maximize the benefit of expanded Medicaid coverage for 12 months postpartum by encouraging quality postpartum care including screening for postpartum depression. In addition, this PIP provides an opportunity for MCOs to re-engage families for age-appropriate well-child care visits up through 30 months of age and early childhood immunizations as the state of emergency ends.	HEDIS PPC-AD: Prenatal and Postpartum Care: Postpartum Care HEDIS WCV, W30: Well-Child Visits in the First 30 Months of Life HEDIS Childhood Immunization Status (CIS-3) Apart from CIS-3, each MCO is expected to improve its baseline for each measure by 10 percentage points over the life of the project. Each MCO will perform above the CIS-3 NCQA 90th percentile threshold by the end of the 3-year cycle.	**The MCO must choose 2 strategies from below:** *Increase engagement throughout the 12-month coverage period:* **Process Metric:** Increase the percentage of birthing persons who remain engaged with Medicaid benefits for 12 months after delivery by *X % during the first measurement year then by *Y% above the prior year's rate each subsequent MY. Through engagement, members should attend ALL the following visits: ● Two (2) ACOG-recommended postpartum visits within the first 12 weeks after delivery. A postpartum depression screening and appropriate follow-up should be completed during these visits. ● At least one (1) annual preventive care or a chronic condition management visit Must show the ratio using # of eligible birthing persons attending the listed visits/Total # of birthing persons eligible for the 12-month postpartum coverage period. *Implement electronic postpartum depression screening tool:* **Process Metric:** Increase performance on HEDIS Postpartum Depression Screening and Follow-up (PDS) by *X% from baseline during the first measurement year then by *Y% above the prior year's rate each subsequent MY. Must include ratios as defined by HEDIS PDS. *Apply Clinic-Community linkages on behavioral health referrals and parenting supports:* **Process Metric:** As a direct result of the implementation of strategic partnerships between a clinical service organization and a non-healthcare organization supplying family support services or behavioral healthcare, an increased percentage of at-risk birthing persons complete two (2) postpartum visits within 12 weeks after

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			delivery by *X% from baseline for the first measurement year and increase by *Y% above the prior year's rate each subsequent MY. This strategy should focus on individuals with SUD, challenging SDOH, a positive postpartum depression screen, a history of behavioral health disorders, or a history of DV/IPV, family stressors, and other risk factors identified on the M-PRA. Must include ratio using # of birthing persons referred within the strategic partnership who complete 2 postpartum visits/Total # of birthing persons referred within the strategic partnership. *Value-added benefits for well-child care (Pick one)*: **Process Metric:** Enroll *X% pediatric members, ages birth to 30 months, in at least one option during the first measurement year then increase by *Y% above the prior year's rate each subsequent MY. Must include ratio using # of eligible children enrolled in one of the value-added options whose immunizations are up to date and attended appropriate WCV/# of eligible children enrolled in one of the value-added options. ● Value-added Options: ○ Adverse Childhood Experiences (ACES) Screening and Trauma informed Care Implementation ○ Pediatric Medical Home Model *Promote WCV through engagement with home visiting services, doulas* **Process Metric:** Enroll *X % of the identified disparate populations in home visiting services and/or with a Medicaid-enrolled doula during the first MY then increase by *Y% above the prior year's rate each subsequent MY. Must include ratio using # of eligible children enrolled in home visiting service and/or parent enrolled in doula services who also attended age appropriate WCV up to first year of life/Total # of eligible children enrolled in home visiting service and/or parent enrolled in doula services. *Improve immunization rates:* **Process Metric:** Increase immunization rates under the CIS-3

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			measure by *X% above baseline among identified disparate populations during the first MY then by *Y% above the prior year's rate each subsequent MY. Must include ratio using the parameters of the CIS-3 measure for the selected disparate population. *X, *Y - indicates that the value should be MCO determined and specific. MCO must submit a justification for why the goal was chosen including any supporting data.

Table 13: Performance Improvement Projects (PIPs) and Examples of MCO Interventions, MY 2024

PIP Topic	Examples of MCO Interventions
Timeliness of Prenatal Care and Identification of High-Risk Pregnancies	Implementation of electronic Maryland Prenatal Risk Assessment (M-PRA) forms Collaboration with FQHCs or LHDs to increase provider completion of M-PRA forms Recruitment of doulas into MCO network and partnerships with community-based organizations to increase member engagement and access to doulas Facilitate increasing the number of participating CenteringPregancy sites Develop referral process with community provider for enhanced case management services for pregnant mothers with opioid use disorder
Maternal Health and Infant/Toddler Care During the Postpartum Period	Increasing Providers' Utilization and Documentation of an Electronic Postpartum Depression Screening Tool: The Edinburgh Postnatal Depression Scale (EPDS) Collaboration with community doula organization to provide postpartum services Addressing unmet social needs to improve childhood immunization rates Collaboration with local primary care practice for referrals to Healthy Steps, an early childhood development support program

	Provider incentive program to increase childhood immunizations

HealthChoice Transition of Care Policy

Beginning in January 2015, the Maryland General Assembly required all payers, including Medicaid, to begin including a continuity of health care notice in member communications to let them know their rights when they move from commercial plans to Medicaid MCOs and vice versa. The notice informs Marylanders of the following rights they have when transitioning to a new health plan or MCO:

- Preauthorizations from another company's plan will be honored by the new plan for 90 days or until the course of treatment is completed, whichever is sooner, so long as the participant contacts the new plan and provides a copy of the authorization.
- For HealthChoice MCOs, honoring previous preauthorizations does not apply to dental services, mental health services, substance use disorder services, or other benefits or services provided through the Maryland Medical Assistance fee-for-service program.
- Participants can request a copy of the preauthorization and receive it within 10 days of request if they do not have it beforehand.
- If the participant was receiving services from a provider that is not in the MCO's network, the participant may continue to receive services from the out-of-network provider for 90 days or until the course of treatment is completed. Conditions include acute conditions, serious chronic conditions, pregnancy, or any other condition upon which the new MCO and the out-of-network provider agree.
- The 90-day limitation is measured from the date the participant's coverage starts under the new plan. For pregnancy, the period is extended through the pregnancy and the first visit to a health care practitioner after the baby is born so long as the new plan is notified by the participant, the participant's designee, or a health care provider on behalf of the participant.
- Failure to honor the continuity of care notice is appealable by contacting the MCO, or the participant may contact MDH's HealthChoice Help Line for assistance.

In response to the federal managed care regulations update that began in 2016, Maryland began implementing a transition of care policy for participants transitioning between fee-for-service and managed care, as well as between MCOs. In 2019, Maryland partnered with Chesapeake Regional Information System for Our Patients, also known as CRISP, which serves as the regional health information exchange for Maryland and Washington, DC to develop an IT solution for better data sharing. Through this collaboration, the following systems were implemented:

- For care transition information, all MCOs were required to begin sending daily panel information to CRISP to evaluate when members were new or transitioning from other plans.
- MDH provides CRISP with historical encounter data and fee-for-service claims data for its algorithms to identify the following populations with potentially high risk:
    - Pregnant members
    - Members receiving oncology treatment
    - Members eligible for transplants or who have received transplants
    - Members with three emergency department visits, three inpatient admissions, or a combination within the past six months
    - Children with special health care needs

- If these participants are identified through historical data, CRISP sends a flag to the receiving MCO to let them know about the condition and information about the previous MCO to facilitate care coordination.
- CRISP also created a care alert system for providers and MCOs to share information about participants' care regardless of the payer accessing the data.

MDH, CRISP, and MCOs continue to explore ways to improve the continuity of care for participants through information technology as they move from plan to plan.

HealthChoice Plan to Eliminate Disparities

HealthChoice is working to decrease disparities in health outcomes within the HealthChoice population. Beginning in MY 2023, NCQA required accredited health plans to stratify select HEDIS measures by race and ethnicity to improve the health plans' ability to understand and address disparities in health outcomes within their member population. To prepare for this change, MDH worked with the Maryland Health Connection, which manages Maryland's health benefit exchange, to improve data collection for race and ethnicity. Effective in April 2022, these changes included:

- Switching the response to race and ethnicity questions from an opt-in process to an opt-out process. Applicants now need to proactively indicate that they do not wish to respond to the race and ethnicity questions to skip providing the information.
- Creating more detailed questions to collect more race and ethnicity data. Categories are broadened to be more inclusive of different racial and ethnic identities for fuller reporting.
- Creating a location on the Medicaid eligibility file to share the information with MCOs. The eligibility file now has more robust indicators to share reported data from applicants with MCOs.

As part of the perinatal performance improvement projects (PIPs) that began in MY 2023, MDH asked MCOs to stratify their member data to determine racially/ethnically disparate groups and tailor interventions to address the unique needs and challenges among those populations. MCOs should seek input from these populations to determine their unique barriers and solutions tailored to their needs. MCOs are also required to apply the National Culturally and Linguistically Appropriate Services (CLAS) Standards as they develop their PIP interventions. The MCOs' application of these standards is measured as part of the EQRO's Annual PIP Validation process, and additional feedback is given as part of MDH's Annual PIP Intervention Evaluation. The quality and effectiveness of their interventions are graded as part of the PIP Intervention Evaluation process.

For 2024, Maryland required MCOs to achieve the NCQA Health Outcomes Accreditation by the end of calendar year 2025. All nine MCOs successfully met this requirement. Obtaining and maintaining this accreditation across all MCOs helps ensure the utilization of HealthChoice population data, reinforces an internal and external organizational culture of equity, and identifies opportunities to improve care for all our members. Some MCOs are also voluntarily pursuing the Community-Focused Care Distinction as an additional component to their NCQA Health Outcomes Accreditation status. Pursuit of accreditation in both areas will strengthen the HealthChoice program's ability to assess how well HealthChoice MCOs link individuals to needed

care, especially for special needs populations like individuals with limited English proficiency (LEP). Additionally, Maryland is working with the HealthChoice MCOs to standardize the collection of social determinants of health data through a uniform tool from all nine plans.

Governor Wes Moore's FY 2026 budget reflected a strong commitment to expanding healthcare access and support. The Governor's FY 2026 budget included increased funding for the Medicaid program, which will extend coverage to a greater number of Marylanders, including 200,000 children through the Maryland Children's Health Program. Additional budget allocations include funding for coverage for non-citizen pregnant women, as mandated by the Health Babies Equity Act of 2023 (HB1080), as well as increased support for mental health and substance use disorder programs, and state funding for the Developmental Disabilities Administration. Maryland Medicaid is awaiting budget initiatives and updates for FY 2027.

HealthChoice continues to track the development of a HEDIS measure that focuses on the completion of social determinants of health questionnaires and tools. In partnership with the HealthChoice MCOs, MDH initially selected a modified version of the PRAPARE tool to be adopted by all managed care organizations and reduce fragmentation. However, due to increased licensing costs and other challenges, additional pathways for collecting this information are being considered. The state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP), will act as a central repository for responses to the selected tool, allowing community-based providers, MCOs, and social services agencies to share and act upon the information. MDH also continues to review guidance and contracts from other states to learn additional ways to incorporate a health outcomes and disparities lens into the HealthChoice framework to provide high-quality inclusive care.

Finally, MDH is collaborating across our Medicaid administration to develop a Health Equity Framework to define our priorities and guide our current and future steps. Based upon the [CMS 2022-2032 Health Equity Framework](), MDH has initially set the following:

1. Priority: Expand the Collection, Reporting, and Analysis of Standardized Data
    a. Goal: Improving Collection of Disparity-focused Data and Exploring Measure Stratification
        1. Decrease 'unknown' race/ethnicity category data and improve collection and use in quality metrics/comparisons
        2. Stratify member demographic data by county/zip code level for PHIP measures
        3. Stratify member data by age group for HEDIS measures related to asthma management, preventive care, and vaccine administration
        4. Stratify existing PHIP measures by Supplemental Security Income (SSI) benefit enrollment to identify disparities in access to care for those with physical, intellectual, and sensory challenges
            a. SSI defines disabilities for children (age under 18 years) as having a medically determinable physical or mental impairment, (including an emotional or learning problem) that:
                i. Results in marked and severe functional limitations; and
                ii. Can be expected to result in death; or
                iii. Has lasted or can be expected to last for a continuous period of not less than 12 months.
            b. SSI defines disabilities for adults (age 18 years and over) as having a medically determinable physical or mental impairment, (including an emotional or learning problem) that:

i. Results in the inability to do any substantial gainful activity; and
ii. Can be expected to result in death; or
iii. Has lasted or can be expected to last for a continuous period of not less than 12 months.

c. SSI defines blindness as having a central visual acuity for a distance of 20/200 or less with the use of a correcting lens or a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

b. Goal: Identifying, Standardizing, and Prioritizing SDOH Data
   i. Continue exploring the identification of a standardized tool for MCOs to comply with NCQA screening measures and report data to MDH
   ii. Once a tool is selected, identify a subset of the population to screen and integrate health-related social needs data into program reporting
      1. Data may be stratified to reflect health-related social needs impact on pediatric members vs. adults

2. Assess Causes of Disparities Within Medicaid Programs, and Address Inequities in Policies and Operations to Close Gaps
   a. Goal: Improve MCO's performance on disparity reduction
      i. Require MCOs to continue including a Health Equity Focus in their PIP intervention design
      ii. Require MCOs to maintain NCQA Health Outcomes Accreditation
      iii. Encourage MCOs to pursue Community-Focused Care Accreditation
   b. Goal: Use data collected to identify barriers in MDH and MCO policies and implement changes
      i. Create dashboards to look at disparities data dynamically and identify care gaps by region, MCO, health-related social needs, and age
      ii. Use data to develop HealthChoice requirements to drive better outcomes for individuals needing preventive care and interventions
      iii. Incorporate checkpoints to revisit requirements based on data-driven evaluation of outcomes and focused engagement with MCOs and other stakeholders

Identification of HealthChoice Participants with Special Health Care Needs

In regulation[5], Maryland defines the following populations as special needs populations, and these categories are not mutually exclusive:

- Children with special health care needs
- Participants with a physical disability
- Participants with a developmental disability

[5] COMAR 10.67.04.04–10.67.04.10; 10.67.04.13.

- Pregnant and postpartum women
- Participants who are homeless
- Participants with HIV/AIDS
- Children in state-supervised care

Individuals who receive Supplemental Security Income (SSI) or Social Security Administration (SSA) benefits are part of the eligible populations to participate in HealthChoice. At the time of enrollment, applicants are asked to complete a tool called the Health Services Needs Information (HSNI) form. The HSNI is a questionnaire that assesses whether the applicant has immediate health care needs that require attention from the MCO. Examples of questions from the HSNI include whether the applicant or a member of their household is pregnant, whether the applicant or household member has immediate prescription needs, or whether the applicant or household members have a medical condition that requires an urgent appointment at the time of application completion. These answers are relayed to the MCOs with the enrollment transaction so that their care management teams and onboarding teams can follow up with the new participant.

In addition to the HSNI, if the applicant opts not to complete the tool, MCOs conduct health risk assessments as part of the onboarding process. Current Maryland regulations require the MCOs to make three attempts to contact the participant to complete the risk assessment, and at least one of the attempts must be performed after normal business hours to increase the likelihood of completion. These risk assessments also inform the MCOs of which participants in their plans belong to special needs populations.

Each MCO regularly conducts utilization review to identify participants through claims, authorizations, admissions, and other aggregated information to better target participants who could benefit from care management, enhanced care coordination, and linkage to community resources. For participants such as pregnant women and children in state-supervised care, coordination through the administrative care coordination units at each of the county local health departments assist with identification, referrals to care, and intervention if participants have risk factors requiring specialized care.

In evaluating the quality of care for individuals with special health care needs and in addition to the compendium of HEDIS measures collected for HealthChoice, Maryland developed three measures using encounter data and lead registry data to assess whether adults and children receiving SSI are being connected to ambulatory care and whether younger children between the ages of 12 to 23 months are receiving lead screenings. The measure uses HEDIS definitions for ambulatory care and stratifies this information for individuals enrolled for at least 320 continuous days in the HealthChoice program who qualify based on SSI. Ambulatory care includes visits for primary behavioral health that are reimbursed by the HealthChoice MCOs and excludes emergency department visits and inpatient admissions. Maryland is working to develop benchmarks and targets to evaluate the performance of these measures over time, and Maryland also provides financial incentives to the HealthChoice MCOs to prioritize these populations, historically through the Value-Based Purchasing Initiative (VBPI), which began in MY 2022, through the Population Health Incentive Program (PHIP).

HealthChoice Clinical Practice Guidelines

MCOs are required to use valid, reliable, evidence-based clinical practice guidelines to assist practitioners in approaching healthcare issues in a systematic, appropriate manner per COMAR 10.67.09.09L and 42 CFR 438.236. All the HealthChoice MCOs use Clinical Practice Guidelines with the most

common being Milliman Care Guidelines (MCG; Milliman) and InterQual. MCO guidelines are available to their provider networks via the MCO Provider Manual and their respective websites.

Table 14: HealthChoice Clinical Practice Guideline Links by MCO

MCO	Link to Clinical Practice Guidelines
ABH	https://www.aetnabetterhealth.com/maryland/providers/clinical-guidelines-policy-bulletins.html
CFCHP	https://www.carefirst.com/medicaid/provider/medicaid-clinical-practice-guidelines.html
JMS	https://jaimedicalsystems.com/wp-content/uploads/2025/02/JMS_Provider-Manual-1.25.pdf
KPMAS	https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/ever/healthchoice-provider-manual-md-en.pdf
MPC	https://www.marylandphysicianscare.com/providers/resources/
MSFC	https://www.medstarfamilychoicemd.com/maryland-providers/provider-support/clinical-practice-guidelines
PPMCO	https://hpo-docs.jh.edu/im8GrZkt
UHC	https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/multi/clinical-guidelines/Clinical-Practice-Guidelines-UHCCP-Multi-States.pdf
WPM	https://www.provider.wellpoint.com/global-wp-provider/medical-policies-and-clinical-guidelines

HealthChoice Performance Monitoring and Intermediate Sanctions

In 2011, Maryland introduced an intermediate sanction framework for MCOs known as the HealthChoice MCO Performance Monitoring Policies. The policies included three levels of performance problems (minor, moderate, and major) and provided a list of recommended sanctions for failure to meet performance metrics for consecutive years or a defined number of years within a five-year period. However, MCOs were advised that Maryland has the discretion to impose sanctions without following the prescribed scheme at any time.

In 2015, Maryland revisited the policy and defined four quality assurance areas for review: network adequacy, HEDIS measures, EPSDT/Healthy Kids medical record reviews, and the Systems Performance Review. The tables below share the performance monitoring grid shared annually in the HealthChoice Managed Care Organization Agreement.

In 2025, Maryland further revised the policy to include ineligibility for PHIP participation based on low HEDIS scores and added a fifth quality assurance activity for performance monitoring: Performance Improvement Project Validation. MDH evaluates the HealthChoice Performance Monitoring Policies regularly to ensure its areas of focus align with current priorities and improve its implementation over time.

Table 15: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Minor Problems

	MCO Network Adequacy	HEDIS Performance*	Early and Periodic Screening, Diagnosis, and Treatment/ Healthy Kids Review	Systems Performance Review	Performance Improvement Project Validation
Examples of Minor Problems	Minor provider or recipient complaint.	- One year with 40% or more elements with scores below the National Medicaid HEDIS Mean (NHM). - Two consecutive years with 40% or more elements with scores below the NHM.	Receives less than 80% in one or more components for a review year.	Does not receive a "Met" in an element or component.	Receives a "Low Confidence" finding on the annual EQRO PIP validation.
Enforcement	- Verbal request for clarification. - Corrective Action Plan (CAP) to prevent a future network adequacy problem. - Geo-Access Report.	-Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. -Exclusion from participation in PHIP.	-Written CAP within 45 days of presentation of the preliminary report.	- Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements/components on an annual basis.	- Letter to MCO advising of monitoring policy, PIP validation finding, and enforcement options, along with recommendations from MDH Intervention Evaluation Report.

*Note: For MY 2022 through MY 2023, HEDIS noncompliance increased from 30% to 35% or more elements with scores below the NHM. HEDIS noncompliance increased from 35% to 40% or more elements with scores below the NHM for MY 2024 and future reporting.

Table 16: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Moderate Problems

	MCO Network Adequacy	HEDIS Performance*	EPSDT/Healthy Kids Review	SPR	PIP Validation

Examples of Moderate Problems	Persistent minor provider or recipient complaints PCP to recipient ratio appears inadequate but recipients are still able to access a PCP.	Three years in a row or three years within a five-year period with 40% or more elements with scores below the NHM.	Receives less than 80% in one or more components for two review years -- this score could be for the same component or different components.	Receives an "Unmet" score two years in a row on the same element (without components) or an "unmet" or "partially met" score on the same component.	Receives a "Not Credible" finding on the annual EQRO PIP validation.
Enforcement	- Written CAP within 30 days of finding. - Geo-Access Report. - Financial sanctions. - Required to pay for out-of-network care and transportation.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. - Financial sanctions. - Freeze auto assignments in areas of the state as determined by MDH for one month. - Exclusion from participation in PHIP.	- Written CAP within 45 days of presentation of the preliminary report. - Focused provider education project of specific component for two calendar years.	- Second Partially Met score on the component will be changed to an Unmet score. - Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.	- Letter to MCO advising of monitoring policy, PIP validation finding, and enforcement options, along with recommendations from MDH Intervention Evaluation Report. - Written CAP to address improvement of project plan to increase the confidence level.

*Note: For MY 2022 through MY 2023, HEDIS noncompliance increased from 30% to 35% or more elements with scores below the NHM. HEDIS noncompliance increased from 35% to 40% or more elements with scores below the NHM for MY 2024 and future reporting.

Table 17: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Major Problems

	MCO Network Adequacy	HEDIS Performance*	EPSDT/Healthy Kids Review	SPR	PIP Validation
Examples of Major Problems	- Persistent PCP to recipient ratio appears inadequate (greater than 1:500) but recipients are still able to access a PCP. - No access to OB/GYN and/or no choice of PCP.	- Four years in a row or four years within a five-year period with 30% or more elements with scores below the NHM.	Receives less than 80% in one or more components for three consecutive years, or for three years within a five-year period – this score could be for the same component or different components.	Receives an "Unmet" score three or more years in a row on the same element (without components) or an "unmet" or "partially	Receives a "Not Credible" finding on the EQRO PIP validation for two or more years during the PIP project cycle.

		- Four years in a row or four years within a five-year period with any of the HEDIS VBP measures with scores below the NHM.		met" score on the same component.	
Enforcement	- CAP within 10 days of finding. - Geo Access Report. - Financial Sanction. - Required to pay for out-of-network care and transportation. - Allow recipients in the problem service area(s) to voluntarily disenroll from MCO immediately. - Freeze auto assignments in problem service area(s). - Freeze voluntary enrollment in the problem service area(s). - Freeze the MCO to all future enrollment in the problem service area(s) (moving current recipients into another MCO of their choice). - Additional financial sanctions beyond paying for out-of-network care and transportation. - Contract termination/MCO closure in all affected counties.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. - Freeze auto assignments in areas of the state as determined by MDH for two months for four years with findings and for three months for five years with findings. - Freeze voluntary enrollment in areas of the state as determined by MDH. - Financial sanctions. - Exclusion from participation in PHIP. - Contract termination and MCO closure in all counties.	- Written CAP within 45 days of presentation of the preliminary report. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments or financial sanctions. - Focused provider education project of specific component for three calendar years. - Freeze auto assignments in areas of the state determined by the Department.	- Second Partially Met score on the component will be changed to an Unmet score. - Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions. - MCO will be subject to full SPR review annually.	- Written CAP to address improvement of project plan to increase the confidence level. - Continuation of project until permitted to sunset by MDH.

*Note: For MY 2022 through MY 2023, HEDIS noncompliance increased from 30% to 35% or more elements with scores below the NHM. HEDIS noncompliance increased from 35% to 40% or more elements with scores below the NHM for MY 2024 and future reporting.

Intermediate Sanctions Imposed to Date

To date, Maryland has imposed the following intermediate sanctions on the HealthChoice MCOs in accordance with the Performance Monitoring Policies:

- **HEDIS***
  *MDH and the HealthChoice MCOs agreed to waive MY 2020 sanctions for HEDIS performance monitoring and to exclude it from trending in future years due to the COVID-19 public health emergency. For MY 2022 through MY 2023, HEDIS noncompliance increased from 30% to 35% or more elements with scores below the NHM. HEDIS noncompliance increased from 35% to 40% or more elements with scores below the NHM for MY 2024 and future reporting.
  - ABH: Major HEDIS Problem (MYs 2019, 2021, 2022, 2023, 2024) – Fine and 3-month Auto Assignment Freeze
  - MSFC: Major HEDIS Problem (MYs 2021, 2022, 2023, 2024) – Fine and 2-month Auto Assignment Freeze
  - WPM: Minor HEDIS Problem (MYs 2023, 2024) – Warning letter

- **EPSDT Healthy Kids Medical Record Reviews**
  - ABH: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO
  - CFCHP: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO
  - MPC: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO
  - MSFC: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO
  - PPMCO: Moderate Problem (MYs 2022, 2023; Laboratory Tests/At-Risk Screenings Component – Quarterly CAP and Focused Provider Education Project for two years)
  - UHC: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO
  - WPM: Minor Problem (MY 2023; Laboratory Tests/At-Risk Screenings Component) – Corrective Action Plan to EQRO

- **Systems Performance Review**
  - ABH: Minor Problem (MY 2024; Standard 4: Credentialing and Recredentialing, Standard 5: Enrollee Rights, and Standard 7: Utilization Review) – Corrective Action Plan to EQRO
  - CFCHP: Major Problem (MY 2021 - 2024; Standard 7: Utilization Review) – Fine, Quarterly review of corrective action plan by EQRO.
    - Minor Problem (MY 2024; Standard 5: Enrollee Rights) – Corrective Action Plan to EQRO
  - KPMAS: Minor Problem (MY 2024; Standard 5: Enrollee Rights, Standard 7: Utilization Review, Standard 9: Health Education, and Standard 11: Fraud and Abuse) – Corrective Action Plan to EQRO
  - MPC: Minor Problem (MY 2024; Standard 5: Enrollee Rights) – Corrective Action Plan to EQRO

- MSFC: Minor Problem (MY 2024; Standard 2: Accountability to the Governing Body, Standard 5: Enrollee Rights, Standard 7: Utilization Review, and Standard 9: Health Education) – Corrective Action Plan to EQRO
- PPMCO: Minor Problem (MY 2024; Standard 5: Enrollee Rights and Standard 7: Utilization Review) – Corrective Action Plan to EQRO
- UHC: Minor Problem (MY 2024; Standard 5: Enrollee Rights, Standard 7: Utilization Review, Standard 9: Health Education, and Standard 11: Fraud and Abuse) – Corrective Action Plan to EQRO
- WPM: Major Problem (MY 2022 – 2024; Standard 7: Utilization Review) – Fine, Quarterly review of corrective action plan by EQRO.
  - Minor Problem (MY 2024; Standard 5: Enrollee Rights, Standard 9: Health Education and Standard 11: Fraud and Abuse) – Corrective Action Plan to EQRO

HealthChoice External Quality Review Arrangements and Non-Duplication

Maryland contracts with three vendors for its quality assurance activities:

- Qlarant Quality Solutions, Inc. (Qlarant) is the EQRO. Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing Initiative; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting HEDIS measures, including onsite audits of MCO systems and processes to report data. MetaStar also reviews and approves the CAHPS survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.
- Center for the Study of Services, Inc. (CSS) is the survey administration vendor. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

CMS permits the opportunity for states 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 the opportunity for non-duplication deeming.

Non-duplication, as described in EQRO protocols and 42 CFR §438.360, is intended to reduce administrative burden on the MCOs. When NCQA standards are comparable to federal regulations, and the MCO scored 100% on the applicable NCQA standards, there is an opportunity to “deem,” or consider, the federal regulation as meeting requirements. This process eliminates the need to review the regulation as part of the SPR, thus reducing the administrative burden on the MCO.

MDH initiated this process for the CY 2024 SPR. To qualify for deeming, MDH established the following criteria:

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

Using this information and the NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards (Effective July 1, 2023 – June 30, 2024), Qlarant evaluated whether the MCO qualified for deeming of further review for the Systems Performance Review activity.

Table 18: Systems Performance Review MY 2023 Non-Duplication Deeming Standards Crosswalk

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, 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, 4.7
Standard 5: Enrollee Rights	5.3a, 5.6a, 5.8a
Standard 6: Availability and Accessibility	6.1b, 6.2a, 6.2b, 6.2c, 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, 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.

HealthChoice External Quality Review Recommendations

In Maryland's 2022, 2023, and 2024 Annual Technical Reports, the EQRO recommended various actions for MDH to take. The Quality Strategy goals and targets were not modified; however, MDH did make improvements to individual activities based on the EQRO's feedback. Responses to those recommendations are outlined below in Table 17.

Table 19: Responses to MDH Recommendations from External Quality Review Activities, 2022-2024

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
Performance	Provide a forum for MCOs to discuss barriers	MDH hosts quarterly quality assurance liaison committee	Partially Implemented – Ongoing

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
Improvement Projects (PIPs)	and share best practices to improve rates among all HealthChoice MCOs *Continued recommendation in 2022, 2023, and 2024 ATRs	meetings with MCOs and the quality assurance vendors. During these meetings, MDH hosted discussions about best practices and common barriers faced during the performance improvement project implementation, in addition to providing technical assistance to improve MCOs' proposed interventions and evaluation. MDH has also implemented an annual sustainability survey that provides MCO productivity updates on terminated strategies and best practices within the current PIP cycle interventions. Because the PIPs have moved to rapid cycle evaluation each quarter, MDH has opportunities to identify common barriers in alignment with the quarterly meetings.	Recommendation
Encounter Data Validation (EDV)	Continue to work with MCOs to resolve provider data problems *Continued recommendation in 2022 and 2023 ATRs	MDH, in partnership with its data warehouse vendor, continues to review reports more frequently to determine each MCO's encounter data error rate and actively identifies issues that may impact multiple plans.	Yes - This recommendation has been achieved and not continued in the 2024 ATR.
	Monitor and work with the MCOs to resolve the usage of the MDH Provider Master File and NPI Crosswalk process. *New recommendation in 2024 ATR	MDH and MCOs continue to meet for review and discussion of issues at the Encounter Data Workgroup Meeting.	No - Currently being monitored.
	Encourage MCOs to ensure providers are enrolled on the date of service and verify their status to address the rise in rejected encounters *Continued recommendation in 2022, 2023, and 2024 ATRs	MDH and MCOs continue to encourage providers to enroll with fee-for-service, maintain active status, and use the tools available online to verify a provider's active enrollment.	No - Ongoing Recommendation

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
	Continue to monitor monthly encounter submissions to ensure MCOs submit data timely *Continued recommendation from 2022 and 2023 ATRs	MDH continues to encourage MCOs to monitor the consistency of timely monthly encounter data submissions. New goals are being established to further improve timely submissions.	Yes - This recommendation has been achieved and not continued in the 2024 ATR.
	Automatically denying encounters submitted after the maximum time allotted for an encounter. *New recommendation in 2024 ATR	MDH will monitor the volume of encounters submitted after allowance.	No - Currently being monitored.
	Continue to monitor PCP visits by MCO in future validations *Continued recommendation in 2022 and 2023 ATRs	MDH continues to incorporate monitoring PCP visits as part of its validation.	Yes - This recommendation has been achieved and not continued in the 2024 ATR.
	Ensure appropriate utilization and improvement in the accuracy of the provider reimbursement field on accepted encounters. *New recommendation in 2024 ATR	MDH will monitor the provider reimbursement fields on accepted encounters.	No - Currently being monitored.
	Require MCOs with unusually high volumes of $0 encounters to provide an explanation to MDH and automatically deny $0 encounters submitted without an indicator as enforcement. *New recommendation in 2024 ATR	MDH will monitor the denied encounters to determine MCO best practice and establish goals. MDH will consider enforcement strategies for high volumes of $0 encounters.	No - Currently being monitored.
	Continue to review inpatient visit, ED visit, and observation stay data in encounters and compare trends to look for consistency	MDH continues to monitor these trends as part of its encounter data validation activities.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
	Continue to review and audit participant-level reports for delivery, dementia, participants over age 65, pediatric dental, and missing age outliers in encounter data *Continued recommendation in 2023 and 2024 ATR	MDH continues to monitor encounter anomalies and outliers to verify accuracy.	No – Ongoing Recommendation.
	Instruct MCOs to direct providers to update and maintain accurate billing/claims address information to reduce returned mail for medical record reviews	MCOs will continue its ongoing efforts in keeping provider billing and claims addresses up to date. MDH worked with each MCO via an EQRO-generated report to rectify provider address issues in the provider sample.	Yes - This recommendation has been achieved and not continued in the 2024 ATR.
	Communicate with provider offices and hospitals to reinforce sending all supporting medical record documentation for encounter data review to achieve minimum samples in a timely manner.	MDH continues to work with the MCOs and the EQRO to encourage responsiveness to medical record documentation requests for this activity.	Yes - This recommendation has been achieved and is not continued in the 2023 or 2024 ATRs.
Focused Review of Grievances, Appeals, and Denials	Require MCOs to implement routine quality oversight of report submissions and explore supporting ongoing data quality of reports	MDH and the EQRO work together to share resubmission data with the MCOs. In addition, MDH continues to adjust the submission templates to include formulas and macros that promote accurate reporting. MCOs now utilize attestations when completing their GAD submissions.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.
	Cross-check MCO-reported provider grievances with grievances submitted to MDH to ensure all grievances are counted in MCO reports.	MDH continues to work on an internal process to compare self-reported MCO data to complaint data through its customer service lines.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.
	Clarify the requirements of Hepatitis C preauthorization and appeal reporting requirements to ensure a consistent understanding among MCOs	Hepatitis C medication costs are managed through a separate risk pool and reconciliation process, as outlined in the 2022 HealthChoice MCO Agreement in Appendix L-2. Now that MCOs are responsible for the	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
		preauthorization process, the statistics may be reported through the preauthorization template.	
	Clarify the preauthorization requirements for covered outpatient drugs and the expectation that additional information, if needed to demonstrate medical necessity, be requested at the time of submission of the preauthorization request. *New recommendation in 2024 ATR	MDH released transmittal PT85-25 in June 2025 to clarify MCO timelines for Pharmacy preauthorization decisions.	Yes - This recommendation has been achieved.
	Consider conducting focused record reviews of pharmacy-related denials and appeals to determine key drivers of consistently high volume among MCOs	MDH has established an internal process to review preauthorization denials more closely on at least a semiannual basis.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.
	Consider including compliance with timeframes for sending written acknowledgment of grievance receipt, a written resolution of the grievance, and written acknowledgment of appeal receipt in quarterly reporting	MDH will monitor this requirement through the annual SPR. Transmittal PT19-56 was released in September 2025 to address timeframes for written acknowledgements of enrollee grievances.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.
	Assess the need for additional grievance service categories	MDH continues to evaluate additional grievance and denial categories to MCO reporting, has added new categories, and will continue to add new categories as needed.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.
Network Adequacy Validation (NAV)	Promote standards/best practices for MCO online provider directory information, including: ● Use of consistent lexicon for provider detail information ● Use of placeholders with consistent descriptions for provider details that	MDH continues to utilize feedback from the EQRO's provider directory assessments to develop best practices for online provider directories among MCOs.	Yes - This recommendation has been achieved and is not continued in the 2024 ATR.

Activity	ATR EQRO Recommendation	MDH Response	Recommendation Implemented Yes/No
	are missing, such as “none” or “none specified” rather than blanks ● Require all directories to state the date the information was last updated for easy monitoring		
	Continue to monitor the use of urgent care and emergency department services and review utilization trends to ensure members are not accessing these services due to an inability to identify or access PCPs *Recommendation in 2023 ATR and modified in 2024.	MDH continues to evaluate the availability of resources and data for this recommendation.	No - Ongoing Recommendation.
	Ensure MCOs are providing an adequate provider network to promote access and timeliness of care by monitoring MCO enrollee-to-provider ratios. *Continued from 2023 and 2024 ATRs	MDH is monitoring MCO provider networks through an enhanced Network Adequacy Validation based on the new CMS Protocol 4. MCOs also submit network access and availability reports to MDH’s Provider Network Management team for review on a quarterly basis.	No - Ongoing Recommendation.
	Ensure MCOs are implementing policies and procedures to promote health equity and monitor the availability of diverse providers with language fluencies other than English. *Continued from 2023 and 2024 ATRs	MDH is monitoring through its annual Network Adequacy Validation activities.	No - Ongoing Recommendation.
	Continuing telemedicine appointments for routine or urgent care appointments to accommodate enrollee preferences and needs when appropriate. *Continued in 2022, 2023, and 2024 ATRs	MDH currently permits the use of telehealth for routine and urgent care appointments, as indicated through the NAV reviews.	Yes - This recommendation has been achieved.

Conclusion

As demonstrated in this quality strategy, while Maryland has implemented numerous initiatives to improve health outcomes for adults, children, individuals with chronic illnesses, and pregnant individuals, the impact of the COVID-19 pandemic on healthcare quality is evident in Maryland Medicaid's quality performance, as well as performance nationally. Through quality oversight, collaboration with MCOs and stakeholders, data analysis, health equity initiatives, and performance monitoring, Maryland's quality strategy embraces the principles of continuous quality improvement to contribute to overall improved public health for Marylanders. The objectives and goals identified in our strategy align with HealthChoice's aims to provide healthcare to low-income Marylanders that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. MDH will continue its commitment to customer service, high-quality care, and stewardship through the implementation and reevaluation of this strategy over time.

Appendix A: Reports and Publications

Current and historical quality assurance reports for the following activities may be found on the Maryland Department of Health's **HealthChoice Quality Assurance website**:

- Annual Technical Report
- Systems Performance Review
- Performance Improvement Projects
- Encounter Data Validation
- Population Health Incentive Program
- Early and Periodic Screening, Diagnosis, and Treatment Healthy Kids Medical Record Review
- Consumer Report Card
- Focused Review of Grievances, Appeals, & Denials
- Network Adequacy Validation
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Section 1115 waiver renewal documents may be found here. The Section 1115 HealthChoice evaluations may be found here.

The HealthChoice MCO Agreements by year can be found here.

Appendix B: 2022-2024 Quality Strategy Evaluation

The 2022-2024 Quality Strategy Evaluation can be found on the HealthChoice Quality Assurance website here.

Appendix C: Comment Period Process

This document was made available for public comment for 30 days beginning on Monday, January 26th, with a comment deadline of Wednesday, February 25, 2026, at 5:00 PM. No comments were received.

This document was shared with the Maryland Medicaid Advisory Committee (MMAC) on January 26, 2026, and at the MDH Medical Directors Meeting on Wednesday, February 25, 2026. No comments resulting in edits were received.

Additionally, the document was shared with our Indian Affairs colleagues with an extended deadline to Friday, March 13, 2026. No comments were received.