Qlarant

Maryland
DEPARTMENT OF HEALTH

Medicaid Managed Care Organization

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

Statewide Executive Summary Report

Measurement Year 2022

Submitted April 2024

Table of Contents

Measurement Year (MY) 2022 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

Statewide Executive Summary Report

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Statewide Executive Summary Report

Executive Summary

The EPSDT Program is the federally mandated Medicaid program for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which monitors physical and mental health conditions in children and adolescents through 20 years of age, as defined by the Omnibus Budget Reconciliation Act of 1989. Each state determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

The Maryland Department of Health (MDH) administers the state's Medicaid managed care program, Maryland HealthChoice Program (HealthChoice). Operating since June 1997 under the Centers for Medicare & Medicaid Services' 1115 waiver and Code of Maryland Regulations, the program emphasizes providing quality healthcare that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. The HealthChoice program aims to improve quality and access to coordinated services for qualifying enrollees through nine Medicaid managed care organizations (MCOs).

Per federal regulations, MDH must contract with an external quality review organization (EQRO) to conduct annual, independent reviews of Maryland's HealthChoice program. To meet these requirements, MDH contracts with Qlarant. As the EQRO, Qlarant conducts EPSDT reviews of each HealthChoice MCO.

Since 2007, MDH has conducted an EPSDT program named Healthy Kids, which requires all primary care providers (PCPs) to provide services to HealthChoice children and adolescents through 20 years of age with timely screening and preventive care according to Maryland Schedule of Preventive Health Care standards. Each year, Qlarant completes an annual EPSDT medical record review (MRR) to ensure HealthChoice MCOs meet the MDH-established minimum compliance threshold of 80% for the below components:

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

This report summarizes the EPSDT MRR findings for measurement year (MY) 2022, defined as January 1, 2022 to December 31, 2022. Approximately 764,246 children and adolescents were enrolled in the HealthChoice Program during this period. The following nine MCOs evaluated for MY 2022 were:

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

In MY 2022, Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs provided by The Hilltop Institute of the University of Maryland Baltimore County (Hilltop). A random sample of preventive care encounters per MCO included a 10% oversample. Sample size per MCO provided a 90% confidence level with a 5% margin of error. For MY 2022, there was a total sample of 2,652 preventive care encounters for all MCOs.

Elements within the above components are weighted equally, scored, and added together to derive the final component score. Similarly, elements' composite (overall) score follows the same methodology. The minimum compliance score is 80% for each component. Corrective action plans (CAPs) for MCOs are required if the minimum compliance score is not met.

During the MY 2022 review, a pre-COVID methodology was adopted as a result of collaboration with MDH that required the majority of reviews to be completed onsite. This adaptation caused various barriers and challenges within the framework of implementing these reviews. The following are areas Qlarant noted as most challenging in regards to medical record review completion:

- Nurse reviewers willing to travel onsite to provider offices
- Reviewer availability and scheduling
- Provider office compliance, including participation and lack of education

With these stated challenges, Qlarant worked in close collaboration with MDH to address, monitor, and combat these barriers from having an aversive effect on review completion. The above barriers for medical record review completion were addressed by conducting additional

recruitment for full-time nurses to complete onsite record reviews and by extending the EPSDT task until sample was met. Qlarant continued to conduct outreach to provider offices, with limited offices willing to schedule, until sample size was met.

While attempting to combat and address noted barriers, Qlarant brought these challenges to the forefront during the Quality Assurance Liaison Committee (QALC) discussion. Qlarant discussed the barriers and notable issues with provider compliance. Specific providers were discussed with the MCOs that were the main concern in regards to noncompliance, and what effects lack of participation would have on MCO scoring.

Quality Strategy Highlights

Per the HealthChoice Quality Strategy for 2022-2024[1], MDH has set a task goal based on pre-Covid public health emergency aggregate performance of increasing all EPSDT requirements to 80% or above by MY 2024. Based upon the HealthChoice Quality Strategy, specific HealthChoice performance metrics and targets are displayed in Table 1 below.

Table 1. HealthChoice Aggregate Scores

Requirement: Minimum Compliance Score: ≥80%	HealthChoice Aggregate MY 2022	MDH Quality Strategy Targets for MY 2024
Health & Developmental History	96%	94%
Comprehensive Physical Examination	98%	97%
Laboratory Tests/At-Risk Screenings	85%	87%
Immunizations	95%	93%
Health Education/Anticipatory Guidance	97%	94%
HealthChoice Aggregate Totals	**95%**	**≥94%**

All six components comprising the EPSDT review exceeded the MDH minimum threshold of 80% in MY 2022. Five of the six components exceeded MDH's Quality Strategy Targets for MY 2024. Laboratory Tests/At-Risk Screenings was the only component that fell slightly below the quality strategy goal percentage of 87% by two percentage points.

EPSDT Objective and Methodology

The mission of the Maryland EPSDT/Healthy Kids Program is to improve accessibility and ensure the availability of quality healthcare for HealthChoice children and adolescents through 20 years of age. HealthChoice MCOs are responsible for providing or arranging the full range of healthcare services for Maryland Medicaid enrollees. MCOs contract with providers to deliver covered health services to their enrollees. At its

[1] MDH HealthChoice Quality Strategy

core, the Healthy Kids program is a partnership between healthcare providers, MCOs, public health officials, local health departments, and families.

In support of the program's mission, the objective of the EPSDT MRR is to assess the timely delivery of EPSDT services to children and adolescents enrolled in a HealthChoice MCO. The MRR includes an assessment of MCO performance for the following EPSDT components and their respective subcategories:

Health and Developmental History requires evaluation and includes documentation of:

- Medical, family, and psychosocial histories with annual updates
- Perinatal history through 2 years of age
- Maternal depression screening at child's 1, 2, 4, and 6 month visits
- Developmental history/surveillance through 20 years of age
- Mental health assessment beginning at 3 years of age
- Substance use screening beginning at 11 years of age, younger if indicated
- Developmental screening using an approved, standardized screening tool at the 9, 18, and 24-30 month visits
- Autism screening required at the 18 and 24-30 month visits
- Depression screening beginning at 11 years of age

Comprehensive Physical Exam requires evaluation and includes documentation of:

- A complete assessment of no fewer than five body systems
- Age-appropriate vision and hearing assessments (subjective or objective) at every visit
- Assessment of nutritional status at every age
- Oral assessment at all ages
- Height and weight measurement with graphing through 20 years of age
- Head circumference measurement and graphing through 2 years of age
- Body mass index (BMI) calculation and graphing beginning at 2 years of age
- Blood pressure measurement beginning at 3 years of age

Laboratory Tests/At-Risk Screenings requires evaluation and includes documentation of:

- Newborn metabolic screening test results at birth and again by 8 weeks of age
- Tuberculosis assessment required at 1, 6, and 12 months, and annually thereafter with appropriate follow up for positive or at-risk results
- Cholesterol risk assessment beginning at 2 years of age, and annually thereafter with appropriate follow up for positive or at-risk results
- Dyslipidemia lab test results for 9-11 and 18-21 years of age
- Anemia risk assessment beginning at 11 years of age, and annually thereafter with appropriate follow up for positive or at-risk results
- Anemia test results at 12 months, 24 months, and 3-5 years of age
- Lead risk assessment beginning at 6 months through 5 years of age, with appropriate follow up for positive or at-risk results
- Referral to the lab for blood lead testing or follow up at appropriate ages
- Blood lead test results at 12 and 24 months of age
- Baseline blood lead test results at 3 to 5 years of age, when not done at 24 months of age
- Sexually transmitted infection/human immunodeficiency virus (STI/HIV) risk assessment beginning at 11 years of age, or younger, if indicated, and annually thereafter with appropriate follow up for positive or at-risk results
- Human immunodeficiency virus (HIV) lab test required between the ages of 15 and 18

Immunizations require assessment of need and documentation that:

- The MDH Immunization Schedule is being followed in accordance with the Advisory Committee on Immunization Practices guidelines
- Age-appropriate vaccines are not postponed for inappropriate reasons
- Children and/or adolescents who are delayed in their immunizations are brought current with the MDH Immunization Schedule

Health Education/Anticipatory Guidance requires documentation that the following were provided:

- Age-appropriate anticipatory guidance
- Counseling and/or referrals for health issues identified by the parent(s) or provider
- Referral to dentist beginning at 12 months of age
- Requirements for return visit specified

MY 2022 EPSDT Review Process

Sampling and Provider Outreach Methodology

MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Upon receiving Hilltop's full MY 2022 preventive care encounters sample frame for children and adolescents through 20 years of age, Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs. Qlarant's sampling methodology included the following criteria:

- A random sample of preventive care encounters per MCO, including a 10% oversample.
- Sample size per MCO provided a 90% confidence level with a 5% margin of error.
- Sample included only enrollees through 20 years of age, as of the last day of the measurement year.
- Sample included EPSDT services for enrollees enrolled on the last day of the measurement year, and for at least 320 days in the same MCO. Exception – If the recipient's age on the last day of the selected period is less than 365 days, the criteria is modified to read the same MCO for 180 days, with no break in eligibility.
- Sample included enrollees who had a preventive care encounter (CPT 99381-85 or 99391-95). For children less than 2 years of age who may have had 4-6 preventative visits within a 12-month period, only one date of service was selected.
- Sample included enrollees when visits with CPT 99381-85 or 99391-95 were provided by PCPs and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, or general practice.
- Telehealth appointments were flagged and excluded from the review.

Table 2 compares the sample size selected for each MCO, the minimum sample, and the total sample achieved.

Table 2. MY 2022 EPSDT Sample Size

MCO	Minimum Sample (90% CL with 5% Error)	Maximum Sample (10% Oversample)	Total Sample Reviewed
ABH	265	292	268
CFCHP	266	293	275
JMS	262	289	289
KPMAS	269	296	293
MPC	270	297	278
MSFC	268	295	271
PPMCO	270	297	293
UHC	269	296	279
WPM	270	297	275
Total	**2409**	**2652**	**2521**

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

- **Scheduling Onsite Reviews:** For MY 2022, nurse reviewers conducted all MRRs onsite at the provider offices, except for providers with only one patient in the sample (singles). Qlarant's contracted administrative scheduler worked with the respective offices to determine the date and time of the review. Qlarant required access to the entire medical record to ensure adequate information was available to evaluate compliance with the EPSDT program guidelines. All documentation needed to be present at the time of the record review, as no documentation was accepted after the nurse left the practice site office.
- **Gathering Updated Fax Numbers:** Providers with only one patient in the sample (singles) were initially contacted to obtain their office fax number in order to submit the MY 2022 medical record request. Providers were notified that the fax request for medical records would be submitted to the fax number provided.
- **Faxing Medical Requests:** Qlarant directly faxed each sampled provider a letter with their specific record request.
- **Securely Storing and Receiving Medical Records:** Providers were asked to securely submit medical record information to Qlarant via secure fax or Qlarant's SecureShare portal.
- **Outreach Attempts for Missing/Incomplete Information:** Upon receipt of medical records via secure fax or SecureShare, Qlarant reviewed each record for completeness and outreached providers for any missing/incomplete documentation. Qlarant conducted no more than two outreach attempts for missing/incomplete documentation. MCOs were notified when outreach attempts were exhausted

for specific medical records and provided an opportunity to obtain this information. Any medical records with missing/incomplete information not received by the conclusion of the EPSDT medical record review activity were reviewed "as is" and scored accordingly.

Medical Record Review and Scoring Methodology

Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Prior to reviewing medical records, these nurses were required to complete Qlarant's EPSDT annual training and achieve an inter-rater reliability rate of 90% or above.

Data Collection and Review: A total sample of 2,521 medical records were included in the review for MY 2022 across all HealthChoice MCOs. Abstracted data from the MRRs was entered into Qlarant's EPSDT evaluation tool. Data was organized and analyzed in the following age groups:

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

Within each age group, specific elements were scored based on medical record documentation, as shown in Table 3.

Table 3. MY 2022 Scores and Finding Equivalents

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

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

Elements within a component are weighted equally, scored, and added together to derive the final component score. Similarly, elements' composite (overall) score follows the same methodology. The minimum compliance score is 80% for each component. CAPs are required if the minimum compliance score is not met. New elements or elements with revised criteria are scored as baseline for the MY.

The random sampling methodology considers the following when assessing results:

- Randomized record sampling does not ensure all providers and practices within the MCO network are included in the sample.
- Conclusions about individual provider performance in meeting program requirements cannot be made if the sample size per provider is too small (less than 10 charts) or the case-mix does not include all ages.
- A randomized sample of preventive encounters may include both EPSDT-certified and non-EPSDT-certified providers. Providers who have not been certified by the EPSDT program may not be familiar with the preventive care requirements. However, MCOs are still required by regulation to ensure preventive services are rendered to Medicaid enrollees through 20 years of age.
- MCOs with low membership are likely to have the same providers reviewed every year to meet the minimum record sampling requirement.

Sample. Each record was reviewed for validity and completeness at the time of the onsite or desktop review. In the event a record was classified as invalid (incorrect date of birth, incorrect gender, incorrect date of service, patient not seen by provider, not an EPSDT record, or no record), the review for that particular medical record stopped and it did not count against the total score.

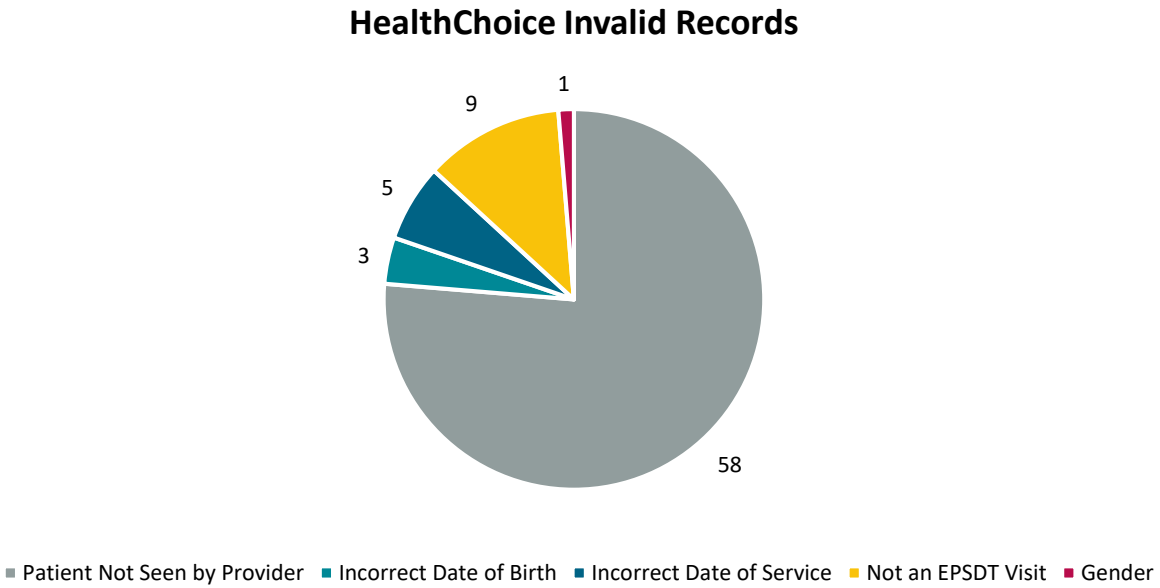
Medical record review samples contained total samples, completed reviews, and invalid records. Within this sample of 2,521 patient records, three percent of the HealthChoice Aggregate total sample was classified as invalid, as shown in Table 4.

Table 4. HealthChoice Summary of Total Sample for MY 2022

MCO	Total Sample	Valid Reviews Completed	Invalid Records	Percent of Invalid Records
ABH	268	256	12	5%
CFCHP	275	266	9	3%
JMS	289	287	2	1%
KPMAS	293	291	2	1%
MPC	278	270	8	3%
MSFC	271	263	8	3%
PPMCO	293	282	11	5%
UHC	279	268	11	4%
WPM	275	262	13	5%
HealthChoice Aggregate	**2521**	**2,445**	**76**	**3%**

Figure 1 illustrates the invalid record totals for each invalid category for all MCOs.

Figure 1. Invalid Record Counts by Type



Accuracy of Medical Record Data Validity: Qlarant extracted a random total sample of 2,521 medical records from Hilltop's data. During onsite or desktop reviews, nurse reviewers verified all medical records matched the patient listing. Medical records were only considered valid if the reviewer successfully verified:

- Patient name
- Date of birth
- Gender
- Date of service
- EPSDT record

Invalid records counted towards the minimum sample, but only valid records were used to complete the review. Invalid records for the MY 2022 EPSDT review consisted of the following categories: incorrect date of birth, incorrect date of service, patient not seen by provider, not an EPSDT visit, and incorrect gender.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas. Each MCO was required to meet the MDH-established minimum compliance rate of 80% for each of the five components. If an MCO did not achieve the minimum compliance rate, the MCO was required to submit a CAP.

Table 5. MY 2022 EPSDT Component Results by MCO

Component	MY 2022 MCO Results									HealthChoice Aggregate Results		
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2020	MY 2021	MY 2022
Health & Developmental History (HED)	94%	94%	99%	100%	94%	95%	94%	95%	94%	94%	95%	96%
Comprehensive Physical Examination (PE)	98%	98%	99%	98%	97%	97%	97%	97%	98%	96%	96%	98%
Laboratory Tests/At-Risk Screenings (LAB)	80%	80%	99%	98%	80%	81%	76%	83%	84%	77%	83%	85%
Immunizations (IMM)	94%	95%	97%	98%	94%	94%	94%	93%	95%	86%	91%	95%
Health Education/ Anticipatory Guidance (HED)	96%	95%	100%	100%	96%	97%	97%	95%	94%	94%	94%	97%
Total Composite Score	**94%**	**94%**	**99%**	**99%**	**94%**	**94%**	**93%**	**94%**	**94%**	**91%**	**93%**	**95%**

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

- All MCOs' total composite scores met the MDH-established minimum compliance threshold of 80%.
- All MCOs met or exceeded the minimum compliance threshold of 80% for each component except for PPMCO's Lab Tests/At-Risk Screenings score of 75%.
- PPMCO had the lowest total composite score of 93% and JMS and KPMAS scored the highest at 99%.

- The Laboratory Tests/At-Risk Screenings component had the greatest range in scores from 75% (PPMCO) to 99% (JMS).
- The component HealthChoice Aggregate scores ranged from 85% (Laboratory Tests/At-Risk Screenings) to 98% (Comprehensive Physical Exam).
- The total HealthChoice Aggregate score has steadily increased from MY 2020 (91%) to MY 2022 (95%).
- The HealthChoice Aggregate score for each component has steadily increased from MY 2020 to MY 2022 with the greatest increase of nine percentage points for the Immunizations components (86% in MY 2020 to 95% in MY 2022).

The following sections describe each component, along with a summary of each HealthChoice MCO's performance.

Health and Developmental History

Rationale: A comprehensive medical and family history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance.

Documentation: Initial personal, family, and psychosocial histories, with annual updates, are required to ensure the most current information is available. Use of a standard, age-appropriate history form (such as the Maryland Healthy Kids Program Medical/Family History) or a similarly comprehensive history form is recommended. An approved screening tool is required for substance abuse, developmental, autism, depression, and maternal depression screenings.

Table 6. MY 2022 Health and Developmental History Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HeathChoice Aggregate
Recorded Medical History	95%	95%	99%	100%	95%	98%	96%	96%	94%	97%
Recorded Family History	91%	89%	99%	100%	91%	92%	92%	93%	91%	93%
Recorded Perinatal History	86%	93%	100%	97%	72%	91%	89%	91%	90%	90%
Recorded Maternal Depression Screening	72%	79%	100%	100%	77%	81%	92%	81%	42%	82%
Recorded Psychosocial History	98%	98%	100%	100%	99%	99%	98%	97%	98%	99%
Recorded Developmental Surveillance/History	98%	98%	98%	100%	98%	99%	97%	98%	98%	98%
Recorded Developmental Screening Tool	89%	88%	100%	100%	89%	96%	87%	95%	91%	93%
Recorded Autism Screening Tool	81%	84%	100%	100%	88%	88%	79%	92%	74%	88%
Recorded Mental/ Behavioral Health Assessment	98%	98%	100%	100%	100%	96%	99%	95%	97%	98%
Recorded Substance Use Assessment	93%	93%	100%	100%	94%	83%	86%	94%	92%	93%
Depression Screening	83%	83%	100%	100%	80%	91%	84%	89%	88%	89%
Component Score	**94%**	**94%**	**99%**	**100%**	**94%**	**95%**	**94%**	**95%**	**94%**	**96%**

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

Health and Developmental History Results

- All MCOs scored well above the minimum compliance threshold (80%) for the Health and Developmental History component score ranging from 94% (ABH, CFCHP, MPC, PPMCO, and WPM) to 100% (KPMAS).
- The HealthChoice Aggregate score for each element exceeded the minimum compliance threshold.
- JMS and KPMAS scored above the HealthChoice Aggregate score (96%) at 99% and 100%, respectively.

- JMS, KPMAS, MSFC, and UHC scored above the minimum compliance threshold for all elements comprising the Health and Developmental History component.
- KPMAS scored 100% for ten of the 11 elements comprising the Health and Developmental History component.
- ABH and CFCHP scored below the minimum compliance threshold for the Recorded Maternal Depression Screening element by eight and one percentage point, respectively (ABH at 72% and CFCHP at 79%).
- MPC scored below the minimum compliance threshold for the Recorded Perinatal History and the Recorded Maternal Depression Screening by eight and three percentage points, respectively (72% and 77%).
- PPMCO scored below the minimum compliance threshold for the Recorded Autism Screening Tool by one percentage point (79%).
- WPM had the lowest score across all elements comprising the Health and Developmental History component for the Recorded Maternal Depression Screening, which scored below the minimum compliance threshold by 38 percentage points at 42%. WPM also scored below the minimum compliance threshold for the Recorded Autism Screening Tool by six percentage points (74%).

Comprehensive Physical Examination

Rationale: 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.

Documentation: A comprehensive physical exam includes documentation of:

- Subjective or objective vision and hearing assessments at every well-child visit.
- Measuring and graphing head circumference through 2 years of age.
- Recording blood pressure annually for children beginning at 3 years of age.
- Oral assessment at each well-child visit, including a visual exam of the mouth, gums, and teeth.
- Nutritional assessment, including typical diet, physical activity, and education, provided with graphing of weight and height, through 20 years of age, on a growth chart.
- Calculating and graphing BMI beginning at 2 years of age.

Table 7. MY 2022 Comprehensive Physical Examination Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Documentation of Minimum 5 Systems Examined	100%	99%	100%	100%	100%	100%	99%	98%	100%	99%
Vision Assessment	96%	96%	97%	92%	93%	93%	93%	93%	94%	94%
Hearing Assessment	95%	95%	97%	91%	94%	92%	92%	93%	92%	93%
Nutritional Assessment	99%	98%	100%	100%	98%	97%	98%	97%	98%	98%
Conducted Oral Assessment	97%	96%	100%	99%	96%	94%	93%	95%	97%	96%
Measured Height	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%
Graphed Height	98%	100%	100%	100%	99%	99%	99%	99%	99%	99%
Measured Weight	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Graphed Weight	98%	100%	100%	100%	99%	98%	99%	99%	99%	99%
BMI Percentile	99%	99%	100%	100%	99%	100%	100%	100%	99%	100%
BMI Graphing	99%	99%	100%	100%	99%	100%	99%	100%	99%	99%
Measured Head Circumference	89%	96%	100%	97%	95%	92%	97%	88%	97%	94%
Graphed Head Circumference	82%	95%	100%	97%	93%	90%	91%	88%	93%	92%
Measured Blood Pressure	98%	94%	100%	96%	94%	96%	97%	99%	98%	97%
Component Scores	**98%**	**98%**	**99%**	**98%**	**97%**	**97%**	**97%**	**97%**	**98%**	**98%**

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

Comprehensive Physical Examination Results

- All MCO component scores and element scores exceeded the minimum compliance threshold (80%).
- Component scores ranged from 97% (MPC, MSFC, PPMCO, and UHC) to 99% (JMS).
- Five of the nine MCOs scored at or above the HealthChoice Aggregate component score of 98% (ABH, CFCHP, JMS, KPMAS, and WPM).
- All MCOs scored 100% for the Measured Weight element.
- JMS scored 100% for 12 of the 14 elements comprising the Comprehensive Physical Exam component.

- ABH had the lowest score across all elements for the Graphed Head Circumference element (82%).

Laboratory Tests/At-Risk Screenings

Rationale: The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis, lead exposure, anemia, and STI/HIV.

Documentation: Assessment results, Preventive Screen Questionnaires, documented lab test results, and completed risk assessments should include:

- A second newborn metabolic screen (lab test) by 8 weeks of age
- Tuberculosis risk assessment beginning at 1, 6, and 12 months of age and annually thereafter
- Cholesterol risk assessment beginning at 2 years of age and annually thereafter
- Dyslipidemia lab test results at 9-11 and 18-21 years of age
- Lead risk assessment at every well-child visit from 6 months through 5 years of age, with appropriate testing if positive or at-risk
- Blood lead test at 12 and 24 months of age
- Baseline/3-5 year blood lead test, if the 24-month test is not documented
- Documented referral to lab for age-appropriate blood lead test
- Anemia risk assessment beginning at 11 years of age and annually thereafter
- Anemia test results at 1, 2, and 3-5 years of age
- STI/HIV risk assessment beginning at 11 years of age and annually thereafter
- HIV lab test required between the ages of 15 and 18

Table 8. MY 2022 Laboratory Test/At-Risk Screenings Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Newborn Metabolic Screen	93%	84%	92%	92%	55%	50%	94%	75%	86%	81%
Recorded TB Risk Assessment	84%	85%	100%	100%	86%	87%	80%	86%	87%	89%
Recorded Cholesterol Risk Assessment	77%	78%	100%	100%	84%	85%	76%	83%	77%	85%
9-11 Year Dyslipidemia Lab Test	59%	72%	96%	82%	62%	64%	53%	71%	75%	72%
18-21 Year Dyslipidemia Lab Test	50%	79%	100%	100%	94%	58%	65%	63%	71%	80%
Conducted Lead Risk Assessment	86%	89%	100%	100%	86%	93%	87%	86%	93%	91%
12 Month Blood Lead Test	83%	81%	97%	95%	83%	86%	80%	83%	89%	86%
24 Month Blood Lead Test	83%	80%	96%	98%	74%	81%	76%	83%	86%	84%
3-5 Year (Baseline) Blood Lead Test	87%	79%	100%	100%	93%	100%	90%	100%	97%	95%
Referral to Lab for Blood Test	91%	83%	100%	100%	87%	87%	85%	86%	86%	90%
Conducted Anemia Risk Assessment	70%	75%	100%	100%	74%	75%	69%	82%	78%	81%
12 Month Anemia Test	84%	78%	98%	94%	82%	79%	77%	81%	87%	85%
24 Month Anemia Test	79%	72%	98%	98%	72%	74%	71%	85%	85%	82%
3-5 Year Anemia Test	79%	54%	100%	100%	100%	75%	85%	94%	97%	90%
Recorded STI/HIV Risk Assessment	80%	86%	100%	100%	84%	83%	77%	93%	93%	89%
HIV Test Per Schedule	92%	63%	100%	100%	67%	86%	67%	89%	86%	89%
Component Score	**80%**	**80%**	**99%**	**98%**	**80%**	**81%**	**76%**	**83%**	**84%**	**85%**

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

Laboratory/At-Risk Screening Results

- Eight of the nine MCO component scores met or exceeded the minimum compliance threshold of 80%.
- Component scores ranged from 75% (PPMCO) to 99% (JMS).
- Only three elements out of 16 (Conducted Lead Risk Assessment, 12 Month Blood Lead Test, and Referral to Lab for Blood Test) resulted in MCO scores above the minimum compliance threshold.
- The HealthChoice Aggregate for the 9-11 Year Dyslipidemia Lab Test element was the only element to score below the minimum compliance threshold at 72%.
- JMS and KPMAS scored above the HealthChoice Aggregate component score (85%) by 14 and 13 percentage points, respectively (JMS at 99% and KPMAS at 98%).
- JMS and KPMAS were the only two MCOs to score above the minimum compliance threshold for all elements comprising the Laboratory Tests/At-Risk Screenings component.
- ABH and MSFC had the lowest scores across all elements at 50% for the 9-11 Year Dyslipidemia Lab Test (ABH) and the Newborn Metabolic Screen (MSFC).
- CFCHP and PPMCO had the most element scores to fall below the minimum compliance threshold, nine out of 16 elements.

Immunizations

Rationale: 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.

Documentation: The VFC Program requires completion of the VFC Patient Eligibility Screening Record for each patient receiving free vaccines. Additionally, federal law requires documentation of the date, dosage, site of administration, manufacturer, lot number, publication date of the Vaccine Information Statement, and name/location of the provider. Immunization components are listed in the table below.

Table 9. MY 2022 Immunizations Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Hepatitis B	96%	98%	100%	99%	97%	97%	95%	96%	97%	97%
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	98%	100%	100%	100%	99%	98%	97%	99%	98%	99%
Haemophilus Influenza Type B (Hib)	97%	100%	100%	100%	98%	97%	97%	99%	97%	98%
Pneumococcal (PCV-7 or PCV-13) [Prevnar]	98%	99%	100%	100%	98%	98%	98%	99%	97%	99%
Polio (IPV)	96%	98%	100%	98%	98%	97%	95%	95%	98%	97%
Measles/Mumps/Rubella (MMR)	96%	98%	100%	98%	98%	98%	95%	96%	98%	97%
Varicella (VAR)	96%	97%	100%	98%	97%	97%	95%	95%	98%	97%
Tetanus/Diphtheria/Acellular Pertussis (TDaP)	87%	95%	100%	97%	96%	95%	95%	91%	98%	95%
Influenza (Flu)	81%	80%	83%	96%	70%	77%	80%	80%	80%	81%
Meningococcal (MCV4)	88%	96%	100%	97%	97%	94%	97%	90%	97%	95%
Hepatitis A	94%	95%	99%	98%	96%	96%	94%	95%	97%	96%
Rotavirus (RV)	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%
Human Papillomavirus (HPV)	83%	91%	100%	96%	93%	91%	93%	92%	95%	93%
Assessed Immunizations Up to Date	90%	90%	89%	96%	86%	91%	91%	88%	90%	90%
Component Score	**94%**	**95%**	**97%**	**98%**	**94%**	**95%**	**94%**	**93%**	**95%**	**95%**

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

Immunizations Results

- All nine MCO component scores and the HealthChoice Aggregate for each element comprising the Immunizations component exceeded the minimum compliance threshold (80%).
- Component scores ranged from 93% (UHC) to 98% (KPMAS).
- Influenza was the only element to have MCO scores below the minimum compliance threshold (MPC at 70% and MSFC at 77%).
- The Rotavirus element had the highest scores with eight MCOs scoring 100% and one MCO (KPMAS) scoring 98%.

Health Education/Anticipatory Guidance

Rationale: 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.

Documentation: At least three anticipatory guidance items or two major topics must be discussed and documented at each Healthy Kids Preventive Care visit. These topics may include but are not limited to, social interactions, parenting, nutrition, health, play, communication, sexuality, and injury prevention. Beginning at 12 months of age, annual routine dental referrals are required for the purpose of educating the parents about appropriate dental care, providing a cursory view of the child's dental health, and familiarizing the child with dental equipment. Educating the family about the preventive care schedule and scheduling the next preventive care visit increases the chances of having the child or adolescent return for future preventive care visits. Additionally, follow-up for missed appointments needs to occur as soon as possible, when the well-child visit is missed, to prevent the child or adolescent from becoming "lost to care" The PCP must specifically document whenever 2-year intervals for preventive care are the usual and customary schedule of the practice instead of annual visits.

Table 10. MY 2022 Health Education/Anticipatory Guidance Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Documented Age – Appropriate Anticipatory Guidance	98%	98%	100%	100%	98%	99%	98%	97%	99%	99%
Documented Health Education/Referral for Identified Problems/Tests	100%	99%	100%	100%	99%	100%	99%	98%	99%	99%
Documented Referral to Dentist	91%	88%	99%	100%	93%	92%	92%	91%	87%	93%
Specified Requirements for Return Visit	96%	93%	99%	100%	93%	96%	98%	94%	91%	96%
Component Score	**96%**	**95%**	**100%**	**100%**	**96%**	**97%**	**97%**	**95%**	**94%**	**97%**

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

Health Education/Anticipatory Guidance Results

- All nine MCOs scored above the minimum compliance threshold (80%) for the component score and all elements comprising the Health Education/Anticipatory Guidance component.
- Component scores ranged from 94% (WPM) to 100% (JMS and KPMAS).
- Four of the nine MCOs met or exceeded the HealthChoice Aggregate score of 97% (JMS, KPMAS, MSFC, and PPMCO).
- KPMAS scored 100% for each element comprising the Health Education/Anticipatory Guidance component.
- WPM had the lowest element score of 87% for the Documented Referral to Dentist element.

Trending Analysis of Aggregate Compliance Scores

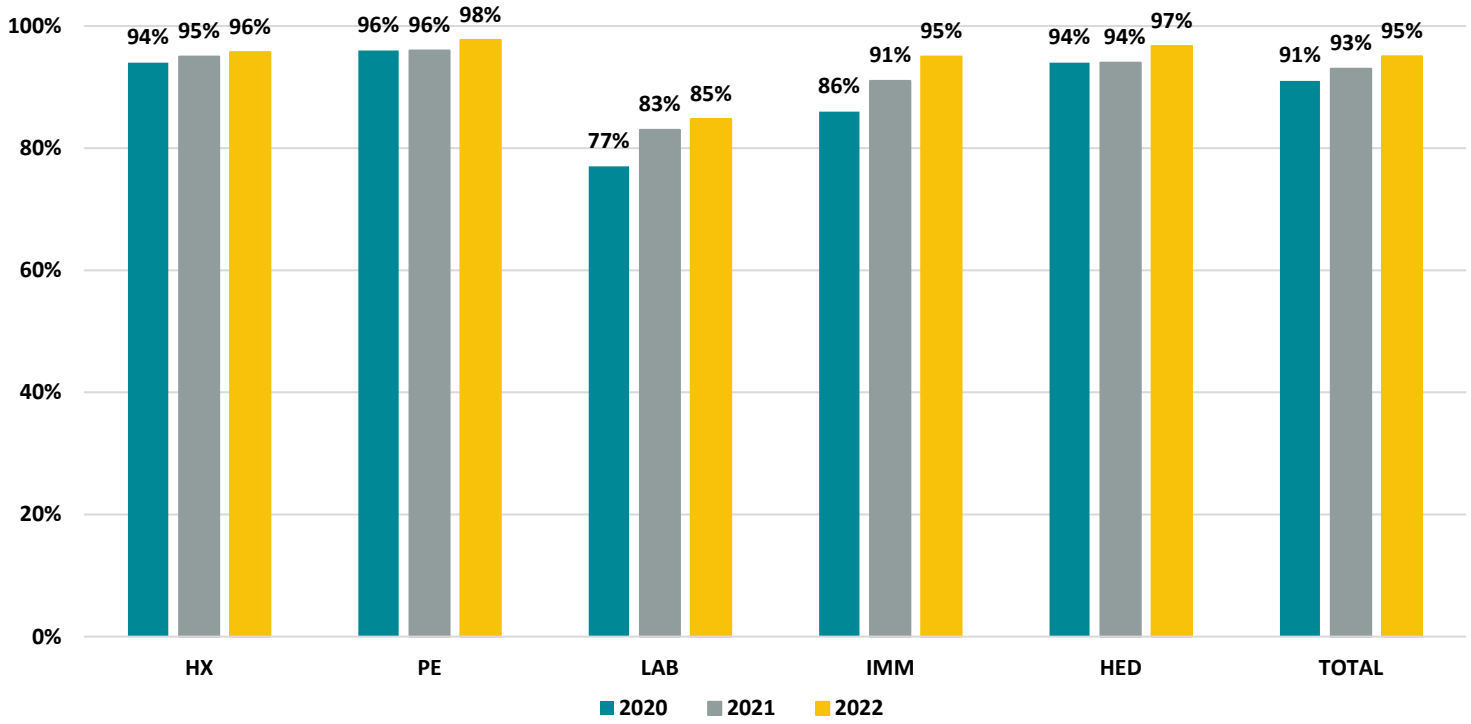
The purpose of a trend analysis is to demonstrate changes in patterns of care at multiple points in time. Score variation is to be expected; not all increases or decreases from MY 2020 through MY 2022 can be interpreted as reflecting differences in quality of care. Scoring for MY 2020 should be reviewed with caution due to the continued impact of the COVID-19 public health emergency.

Table 11 displays the abbreviation used for each component and MCO total composite score used for Figure 2.

Table 11. Component and Composite Score Abbreviations

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

Figure 2. HealthChoice Aggregate Result by Component for MY 2020 to 2022



HealthChoice Aggregate Results:

- All component scores in MY 2022 demonstrated sustained improvement from MY 2020, with a total HealthChoice Aggregate component score increase of four percentage points.
- The Immunizations component displays the most substantial increase, improving four percentage points compared to MY 2021 and nine percentage points compared to MY 2020.
- The Laboratory Tests/At-Risk Screenings component continues to display a substantial increase, improving two percentage points compared to MY 2021 and eight percentage points compared to MY 2020.
- All five components scored above the 80% minimum compliance threshold in MY 2022.

Conclusion

HealthChoice is a mature managed care program and the analysis of the EPSDT medical record review results ensures the MCOs' providers are delivering timely access to healthcare services for its children and adolescents through 20 years of age population according to EPSDT standards. Overall, the MY 2022 EPSDT review demonstrates steady improvement in the HealthChoice Aggregate scores and MCO total composite scores from MY 2020 to MY 2022. All MCOs' total composite scores performed well above the MDH-established minimum compliance threshold of 80% ranging from 93% (PPMCO) to 99% (JMS and KPMAS). The Laboratory Tests/At-Risk Screenings component presents an area of opportunity having scored just five percentage points above the minimum compliance threshold of 80%. The Laboratory Tests/At-Risk Screenings components also contained the lowest scores across the majority of MCOs with 76% (PPMCO) being the lowest.

- **Quality** – Providers, and by extension the MCOs, increase the likelihood of desired health outcomes of timely screening and preventive care by maintaining compliance with the Maryland Schedule of Preventive Health Care standards. Areas of impact during the MY 2022 EPSDT review include:
    - An increase in the likelihood of more timely screening and preventive care across MCOs.
        - All MCOs met the MDH-established minimum compliance threshold (80%) for total composite scores.
        - Additionally, all MCOs, except one, met or exceeded the minimum compliance threshold (80%) for each component. Component scores for the HealthChoice Aggregate score ranged from 85% (Laboratory Tests/At-Risk Screenings) to 98% (Comprehensive Physical Exam).
        - The HealthChoice Aggregate total score has steadily increased from MY 2020 (91%) to MY 2022 (95%).
        - The Laboratory Test/At-Risk Screenings component continues to display a substantial increase across MYs, improving two percentage points compared to MY 2021 (83%) and eight percentage points compared to MY 2020 (77%).

- **Access** – Providers incorporate the timely use of services to achieve optional outcomes. Areas of impact during the MY 2022 EPSDT review include:
    - An increase in the likelihood of healthier children and adolescents.
        - All MCOs scored 100% for the Measured Weight element of the Comprehensive Physical Examination component.
        - All component scores in MY 2022 demonstrated sustained improvement from MY 2020, with a total increase of four percentage points to the HealthChoice Aggregate component score.
    - An increase in the likelihood of age-appropriate health education/anticipatory guidance.
        - All nine MCOs scored above minimum compliance (80%) for the component score and all elements comprising the Health Education/Anticipatory Guidance component. Specifically, component scores ranged from 94% (WPM) to 100% (JMS and KPMAS).

- **Timeliness** – Providers must ensure children and adolescents up to age 20 are receiving timely screenings and preventive care, according to guidelines specified in the Maryland Schedule of Preventive Health Care standards. Areas of impact during the MY 2022 EPSDT review include:
    - An increase in the likelihood of age-appropriate immunizations across MCOs.
        - The HealthChoice Aggregate score for the Immunizations component increased by nine percentage points from MY 2020 (86%) to MY 2022 (95%).
        - All nine MCO component scores and the HealthChoice Aggregate score for each element comprising the Immunizations component exceeded minimum compliance (80%).
        - The Immunizations component displays the most substantial increase, improving four percentage points compared to MY 2021, and nine percentage points compared to MY 2020.
    - An increase in the likelihood that enrollees will receive age-appropriate vaccines or immunizations for Rotavirus (RV).
        - The Rotavirus (RV) element had the highest scores across all MCOs, ranging from 98% (KPMAS) to 100% (ABH, CFCHP, JMS, MPC, MSFC, PPMCO, UHC, and WPM).
    - An increase in the likelihood that enrollees will receive age-appropriate health and developmental history evaluations, comprehensive physical exams, immunizations, and health education/anticipatory guidance.
        - The HealthChoice Aggregate scored one to three percentage points above MY 2024 targets in MY 2022.
    - An increase in the likelihood that enrollees will not receive age-appropriate screenings.
        - The HealthChoice Aggregate fell below the MY 2024 target of 87% for Laboratory Tests/At-Risk Screenings by two percentage points.
        - Component HealthChoice Aggregate scores for Laboratory Tests/At-Risk Screenings ranged from 75% to 99% for compliance scores.
        - Only 3 out of 16 elements (Conducted Lead Risk Assessment, 12 Month Blood Lead Test, and Referral to Lab for Blood Test) resulted in MCO scores above the minimum compliance threshold.
        - The HealthChoice Aggregate for the 9-11 Year Dyslipidemia Lab Test element scored below minimum compliance (80%) by eight percentage points (72%).
    - An increase in the likelihood that enrollees will not receive the Influenza (Flu) vaccine.
        - Influenza was the only element to have MCO scores below minimum compliance (80%), ranging from 70% to 77%.

Corrective Action Plan Process

MDH sets high performance standards for the Healthy Kids/EPSDT Program. In the event the 80% minimum compliance score is not met, MCOs are required to submit a CAP. Qlarant evaluates CAPs to determine whether they are acceptable. In the event that a CAP is deemed unacceptable, Qlarant provides recommendations to the MCOs until an acceptable CAP is submitted.

Required Contents of EPSDT CAPs

Each required CAP must include, at a minimum, the following components:

- Methodology for assessing and addressing the problem.
- Threshold(s) or benchmark(s).
- Planned interventions.
- Methodology for evaluating the effectiveness of actions taken.
- Plans for re-measurement.
- Timeline for the entire process, including all action steps and plans for evaluation.

EPSDT CAP Evaluation Process

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

MY 2022 CAPs

Results of the MY 2022 EPSDT medical record review indicate a required CAP for one MCO, as demonstrated below in Table 12.

Table 12. CAP Summary for MY 2022 EPSDT Review

Component Type	Component Score	MCO	CAP Total
Laboratory Tests/At-Risk Screenings	76%	PPMCO	**1**

PPMCO's CAP for the component Laboratory Tests/At-Risk Screenings was found to lack sufficient information upon its initial submission and review. After receiving technical assistance from Qlarant, PPMCO's CAP was resubmitted with additional information and after review was found to adequately address the component in which the deficiencies occurred. Progress within the CAP component will be reviewed during the MY 2023 EPSDT review.

MCO Recommendations

In an effort to improve the quality of healthcare provided to Maryland's Medicaid enrollees who are less than 21 years of age, the following program recommendations are directed toward all participating HealthChoice MCOs:

- Collaborate with the assigned state Healthy Kids/EPSDT Nurse Consultants to assist in re-educating providers on the Healthy Kids/EPSDT Program requirements and develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards.
- Prepare and encourage provider cooperation and assistance with audit review scheduling and supplying of records.
- Continue to educate the MCO provider network regarding revisions and new standards to the Maryland Schedule of Preventive Health Care using the MCO provider newsletter and/or practice visits by MCO staff.
- Continue to encourage network providers to use the Maryland Healthy Kids Program's age-appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventive services according to the Maryland Schedule of Preventive Health Care.
- Continue to reinforce preventive care standards as they apply to adolescents and young adults assigned to family practice and internal medicine PCPs.
- Continue to assist practices as they implement electronic medical records to ensure all Maryland Healthy Kids Program requirements are incorporated into these tools and records are accessible during audit requests.
- Continue to facilitate the transfer of medical, immunization, and laboratory records when a child is transferred to a newly assigned PCP within the MCO network.
- Continue to utilize MCO data to identify children who are not up to date with EPSDT visits according to the Maryland Schedule of Preventive Health Care, check if children received services from a previous PCP or MCO to prevent duplication, and assist the PCP by scheduling a preventive care visit based on this information.
- Continue to refer to the local health department for assistance in bringing children in for missed healthcare appointments when other outreach efforts have been unsuccessful.
- Continue to remind providers that they are required to enroll in the VFC program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.

MDH Recommendations

The following recommendations are based on results from the MY 2022 reviews:

- MDH should consider an alternate methodology to improve the medical record review process.
- MDH should encourage MCOs performing below the MDH-established compliance threshold to perform frequent monitoring of the quality of clinical care provided to all children younger than 21 years old enrolled in the HealthChoice program.
- MDH should consider resuming implementation of corrective action at the provider level in addition to the MCO level for underperformance in accordance with COMAR 10.67.04.03B(5)(b).
- MDH should consider monitoring the Laboratory Tests/At-Risk Screenings component for root causes in performance as it is still scoring below MDH's quality strategy target goal percentage of 87%.